STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046040	A. BUILDING: _____ B. WING _____	06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF OLATHE NORTH	791 N SOMERSET TERRACE OLATHE, KS 66062

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey with compliant investigation 81542 conducted at the above named assisted living facility on 6-15-15 and 6-16-15.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced	S3028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3028	Continued From page 1 by: KAR 26-41-101(f)(3) The facility reported a census of 36 residents. The sample included 4 closed record review residents. Based on record review and interview for 2 (#2, #4) of 4 discharged residents, the operator failed to ensure each allegation of abuse, neglect or exploitation shall be reported to the department within 24 hours and an investigation shall be started when the operator receives notification of an alleged violation. Findings included: - Record review for resident #2 revealed admission on 3-24-15 with diagnoses Hypothyroidism, Hypertension and Osteoarthritis. The functional capacity screen dated 3-24-15 recorded resident required physical assistance with bathing, dressing, toileting, and walking/mobility; supervision with eating and unable to perform transfers and management of medication and treatments. Occasionally incontinent of bladder. Cognition: problems with short term memory, memory/recall and decision-making. No problems with communication. Current problems/risks identified included impaired vision and impaired hearing. Resident used walker and wheelchair. The negotiated service agreement/health care service plan dated 3-24-15 recorded services for physical assistance with bathing twice a week, toileting, and walking/mobility; supervision of dressing and transfers. Facility staff to manage medications and treatments. Clinical Notes stated the following:	S3028		

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S3028	Continued From page 2	S3028		

4-7-15 at 1:27 pm: "Received a call from (certified staff D) at approximately 11:20 pm stating that during 1st round of the evening, (certified staff E) found (resident #2) lying on the floor in his/her bedroom. Certified staff D stated that resident's arm was bleeding and had a laceration above the right elbow. Certified staff D stated when he/she asked resident to move his/her arms and legs, he/she was able to move them freely. After vital signs taken, resident was assisted into wheelchair and taken to the front for (family member) to come and pick him/her up to take to the emergency room. Resident was transported to the hospital emergency room for evaluation and treatment..." Signed by licensed staff B.

4-7-15 at 1:42 pm: "Spoke with (resident's family member) and was given an update on condition. Family member stated that resident has a fractured right hip and femur and would not be returning to facility..." Signed by licensed staff B.

Interview on 6-15-15 at 2:20 pm with licensed staff B stated resident was "very confused", most of the time would "just look at you and smile", was "nonverbal." "He/she would smile and nod his/her head and agree with you" when someone talked to him/her. Confirmed he/she failed to report the unwitnessed fall in which the resident was unable to state what happened and which resulted in a fractured hip and femur. Further confirmed he/she failed to investigate this incident.

For resident #2, the operator failed to ensure an unwitnessed fall in which the resident was unable to tell what happened and experienced a fractured hip and femur was reported to the department within 24 hours and investigated.

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S3028	Continued From page 3	S3028		

- Record review for resident #4 revealed admission on 12-14-13 with diagnoses Senile Dementia, Hypertension, Depression, Aphasia and Encephalopathy.

The functional capacity screen dated 2-17-15 recorded resident unable to perform bathing, eating, and management of medications; physical assistance with dressing, and toileting; and independent with transfers and walking/mobility. Frequently incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Communication: rarely or never understandable and sometimes understands. Current problems/risks identified included: Falls, wandering, socially inappropriate behavior and impaired decision-making.

The negotiated service agreement/health care service plan dated 2-17-15 recorded services for staff assistance with bathing twice a week; physical assistance with dressing, and toileting; staff assistance with all aspects of eating, interventions for managing behaviors and facility to administer medications and treatments.

Clinical Notes stated the following:
12-13-14 at 4:59 pm: "1 centimeter red, unopen area under right eye...black/bruised areas noted under 2nd and 3rd left toenails. No complaint of pain. resident unable to state what might have caused this." Signed by licensed staff G.
12-18-14 at 6:32 pm: "Resident displayed increased anxiety/restlessness this evening due to the increase in activity related to holiday party with families. He/She was noted to be walking quickly throughout the building, difficult to redirect

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S3028	Continued From page 4 and hostile toward staff. He/She was later found sitting on eh floor at the back of the building after an unwitnessed fall..." Signed by licensed staff F. Interview on 6-15-15 at 4:30 pm with licensed staff B and administrative staff A both confirmed the injury of unknown origin and the unwitnessed fall in which resident was unable to state what had happened were both unreported. For resident #2, the operator failed to ensure an injury of unknown origin and an unwitnessed fall in which the resident was unable to state what had happened were reported to the department within 24 hours and investigated.	S3028		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 36 residents. The sample included 4 closed record review residents. Based on record review and interview for 1 (#3) of 4 discharged residents, the operator failed to ensure documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the action.	S3261		

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S3261	Continued From page 5 Findings included: - Record review for resident #3 revealed admission on 10-9-14 with diagnoses Alzheimer's Disease, Anxiety, Convulsions, Hypertension, Impulse Control Disorder, Chronic Kidney Disease and Peripheral Vascular Disease. The functional capacity screen dated 10-17-14 recorded resident required physical assistance with bathing; independent with dressing, toileting, transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Continent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Communication: usually understandable and sometimes understands. Current problems/risks identified included: Wandering and Socially Inappropriate Behavior. The negotiated service agreement/health care service plan (NSA/HCSP) dated 10-17-14 recorded services for physical assistance with bathing twice a week; verbal cueing and supervision with dressing; Medication Management and management of Behavior. Review of medical record revealed last entry dated 11-12-14 at 8:32 pm: "Resident was transferred onto gurney and out of facility per emergency medical services to (hospital)." Signed by licensed staff C. The facility provided a discharge date for resident #3 of 11-16-14 on a list of discharged residents. The record lacked documentation of outcome of hospitalization.	S3261		

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S3261	Continued From page 6 Interview on 6-15-15 at 12:49 pm with administrative staff A and licensed staff B stated resident #3 "had behavioral issues" and was discharged to a geripsych hospital on 11-12-14 and never returned. Confirmed there were several conversations with resident's family and these conversations were not documented in the record. Further confirmed the record lacked documentation of what happened to the resident's medications and belongings. For resident #3, the operator failed to ensure documentation of communication with resident's family and what happened to the resident, his/her medications and belongings.	S3261		