

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/26/2023
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of an abbreviated survey with review of facility report #177676 and complaint investigations #177592, #175070, #174556, #173970, #173610, and #173277 at the above named assisted living conducted on 01/25/23 and 01/26/23.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 37 residents with five residents included in the sample. Based on observation, interview, and record review the administrator failed to protect one resident from neglect by the failure to ensure staff were aware of what to do if a resident left the facility, unsupervised. This failure placed Resident (R)110 in Immediate Jeopardy when she exited the facility through a fire door and staff did not perform a head count to determine who was missing. R110 fell outside, in the dark, in 27-degree weather and was found by neighbors who heard her moaning.	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3026	Continued From page 1 Findings included: - Record review for R110 revealed an admission date of 10/17/18 with the following diagnoses: multiple sclerosis (MS) and syncope (temporary loss of consciousness) with collapse. The 10/14/22 "Functional Capacity Screen" (FCS) identified R110 required supervision with bathing and management of medications and treatments; was independent with dressing, toileting, transfers, walking/mobility with rollator walker, and eating; had memory recall and decision-making cognitive impairments; and was marked for impaired vision and impaired decision making. The 10/14/22 "Negotiated Service Agreement" (NSA) identified facility staff would provide assistance with bathing twice a week; would administer medications; she wore reading glasses for impaired vision and had a durable power of attorney (DPOA) for impaired decision-making. The 11/23/23 "Nurse's Note" by Administrative Nurse B documented R110 exited the facility and was found by neighbors on the ground, on the south side of the facility. The neighbors called 911 and notified Certified Medication Aide (CMA) D when R110 complained of left hip pain due to the fall. R110 was sent to the hospital for evaluation and admitted. A nurse from the hospital notified Administrative Nurse B that all tests performed at the hospital resulted in negative results.	S3026		

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S3026	Continued From page 2 The 01/24/23 at 11:10 AM "Nurse's Note" by Administrative Nurse B documented R110 returned to the facility from the hospital and sat in the dining room for a meal. R110 seemed to "track well" and went off topic often. When staff asked about her exiting the facility and falling, R110 stated she did not know. If the nurse went with her to the door, she was sure she could explain what happened. The 01/24/23 at 12:05 PM "Nurse's Note" by Administrative Nurse B documented staff continued to monitor R110 hourly for distress, pain, and/or elopement. R110's record lacked evidence of an elopement risk assessment. Review of the 01/23/23 "Incident Report" to the revealed the following: R110 was alert and oriented times three with confusion and forgetfulness. CMA D notified Administrative Nurse B on 01/22/23 at approximately 08:45 PM that R110 exited the building, unsupervised, and suffered a non-injury fall. She was found by neighbors who called 911 and was transported by ambulance to the hospital for evaluation of left hip pain. Administrative Nurse B notified Owner F who instructed her to report the incident to the department the next morning. Administrative Nurse B instructed Maintenance Director E on 01/23/23 (the day following the incident) to check all exit doors and alarms. Review of the facility's investigation report dated 01/23/23 with witness statements submitted to the department revealed the following: The door	S3026		

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S3026	Continued From page 3 alarms went off at 08:00 PM. CMA D and CNA C were the only two staff in the facility at the time. They checked all doors and did not see any residents outside. CNA C checked the rooms of residents known to be at risk of elopement. A neighbor from across the street came to the door at 08:25 PM to inform CMA D someone was outside on the ground. CMA D followed the neighbor outside and found R110 on the ground. While CMA D went inside the facility to get paperwork for the fire department, the ambulance had arrived, and paramedics loaded R110 inside and took her to the hospital. CNA C was doing laundry when CMA D informed her R110 had fallen outside and was sent to the hospital. An undated statement by Maintenance Director E documented all door alarms were checked and found to be working. The facility's records lacked evidence of staff training to complete a head count before the incident. On 01/25/23 at 01:31 PM a door at the end of the hall was opened and an audible alarm was heard. On 01/25/23 at 01:33 PM Environmental Services Staff G opened the door and checked if anyone was outside. Other staff knocked on resident's doors to complete a head count and Administrative Staff A walked around the building outside to check if anyone had exited the building. On 01/25/23 at 03:11 PM Administrative Nurse B stated R110 never exhibited wandering or exit-seeking behavior before the incident. R110	S3026		

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S3026	Continued From page 4 was able to follow instructions and during group shopping activities would meet back up front at the scheduled meet-up time. Administrative Nurse B confirmed an elopement risk assessment had not been completed for R110. On 01/25/23 at 04:28 PM R110 ambulated independently with walker from the dining area to the activities room and sat down in a chair. She did not appear to be agitated, anxious, restless, or exit-seeking. On 01/25/23 at approximately 04:28 PM R110 stated she did not remember going outside of the facility. She remembered "waking up," it was dark and cold, and she had trouble getting back on her feet. She recalled the ambulance came and took her to the hospital. On 01/26/23 at 09:47 AM Administrative Nurse B stated elopement training after the incident was completed one-on-one with each staff member. On 01/26/23 at 12:29 PM CNA C stated she was working in the facility the evening R110 exited the building. When the alarm went off, she went to check residents' rooms who she thought might leave the facility. She did not perform a head count of all residents. She did not remember being trained to complete a head count before the incident. She was provided training that day (01/26/23) to complete a head count when the alarms went off. On 01/26/23 at 12:49 PM CMA D stated she was working in the facility the evening R110 exited the building. When the alarm went off, she was not sure which door the resident exited the	S3026		

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S3026	Continued From page 5 building from. She went out the back door and checked the back area for residents. Then she went out the front door and looked for residents. She was beginning to go down the hallway of R110's room to look out the door at the end of the hallway when the neighbor came to the front door to tell her a resident had fallen outside. R110 was wearing a top, pants, shoes, socks, and a light jacket. R110 could not remember how she got out of the facility or what she was doing. Elopement training was provided to staff once a year. On 01/26/23 at approximately 12:49 PM CMA D pointed out the door R110 had exited the building from and the location she was found. CMA D stated the neighbors who found R110 had arrived home for the evening and heard her moaning from across the street. Observation on 01/26/23 at approximately 12:49 PM revealed it was approximately 10-12 steps along a sidewalk from the door where R110 fell near the edge of the sidewalk. There was a three to four-inch drop from the edge of the sidewalk to the ground. The ground sloped downward toward the residential street which was approximately 50 feet from the door with houses on the other side of the street. The weather on 01/22/23 at approximately 08:45 PM according to Wunderground.com was 27 degrees Fahrenheit (F) with a wind speed of 6 mile per hour (MPH). The facility's undated "Elolements" policy documented: "Everyone in the building is to stop what they are doing immediately (as long as	S3026		

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S3026	Continued From page 6 residents are safe). CMA is to look at alarm board and find out what door is alarming. . . begin doing a head count." The administrator failed to protect R110 from neglect by the failure to ensure staff were aware of what to do if a resident left the facility, unsupervised. This failure placed R110 in Immediate Jeopardy, when she exited the facility through a fire door and staff did not perform a head count to determine who was missing. The following actions were taken by the facility on or before 01/26/23 to protect the residents: 1. One-on-one education and review of the elopement policy with all staff. Completed on 01/23/23. 2. Following an incident will test door alarms once each shift for seven days, then test door alarms daily. 3. Revise the elopement policy to assign the CMA or nurse to begin a physical head count stat. All staff will be educated on the change by 01/30/23. 4. New video cameras were installed on all hallways including exit doors. 5. Ensure R110 wears her call-light pendant during all waking hours and keeps on bedside table while sleeping. 6. R110's Healthcare Service Plan updated that she was elopement risk. Elopement risk assessment completed in 180 days. 7. R110 encouraged to stay in common area during waking hours; staff to monitor hourly for seven days while she was in her room. 8. One staff member will assist R110 upon entering/exiting the facility.	S3026		

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S3026	Continued From page 7 The abatement plan was accepted by the department on 01/26/23 at 04:06 PM.	S3026			