STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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 represents the findings of a resurvey with attached complaint #179775 at the above named assisted living facility conducted on 07/17/23 and 07/18/23.	S 000		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 26 residents with three residents included in the sample and one closed record review. Based on interview, and record review the operator failed to ensure designated facility staff ensured the "Functional Capacity Screen" (FCS) for Resident (R) 2 accurately reflected her functional capacity for transfers and toileting and the "FCS" for R4 accurately reflected her functional capacity for cognition at the times of the screenings. Findings included: - Record review for R2 revealed an admission date of 07/30/22 with diagnoses of muscle weakness, hemiplegia and hemiparesis following cerebral infarction, and repeated falls. The 07/12/23 "Functional Capacity Screen"	S3082		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3082	Continued From page 1 (FCS) identified R2 was independent with toileting and transfers. The 07/12/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff would provide R2 toileting checks twice a night. The "NSA/HSP" failed to identify the services staff provided for transfers. The 07/17/22 "Resident Roster" provided by the facility revealed R2 was marked for assistance with activities of daily living (ADL's). - Record review for R4 revealed an admission date of 03/13/20 with a diagnosis of cerebral infarction. The 02/04/23 "FCS" identified R4 had short-term and long-term memory loss, memory/recall, and decision-making impairments. The 02/04/23 combined "NSA/HSP" failed to identify the services staff provided R4 for cognitive impairments. The 07/17/22 "Resident Roster" provided by the facility revealed R4 was not marked for impaired cognition. On 07/17/23 at 11:29 AM Administrative Staff A stated the "NSA" and "HSP" were combined in one document. On 07/17/23 at approximately 03:49 PM Administrative Nurse B confirmed the score for transfers and toileting on R2's "FCS" and the score for cognition on R4's "FCS" were not accurate.	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3082	Continued From page 2 The 01/2023 facility's "Functional Capacity Screen" policy documented: "Designated facility staff shall ensure that each resident's functional capacity screening at the time of screening is accurately refleted on that residents screening form." The operator failed to ensure designated facility staff ensured the "FCS" for R2 accurately reflected her functional capacity for transfers and toileting and the "FCS" for R4 accurately reflected her functional capacity for cognition at the times of the screenings.	S3082		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3085	Continued From page 3 by: KAR 26-41-202(a)(1) The facility reported a census of 26 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 1 described the services he would receive based on his "Functional Capacity Screen" (FCS) for transfers; and the "NSA" for R4 described the services she would receive based on her "FCS" for toileting, transfers, and walking/mobility. Findings included: - Record review for R1 revealed an admission date of 02/22/22 with diagnoses of cerebral palsy and communication deficit disorder. The 04/28/22 "FCS" identified R1 required physical assistance with transfers and was sometimes understandable and usually understood others during communication. The 04/28/22 combined "NSA/Healthcare Service Plan" (HSP) failed to identify the services provided for transfers and communication. - Record review for R4 revealed an admission date of 03/13/20 with a diagnosis of cerebral infarction. The 02/04/23 "FCS" identified R4 required physical assistance with toileting, transfers, and walking/mobility.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3085	Continued From page 4 The 02/04/23 combined "NSA/HSP" failed to identify the services staff provided R4 for toileting, transfers, and walking/mobility. On 07/17/23 at 11:29 AM Administrative Staff A stated the "NSA" and "HSP" were combined in one document. On 07/17/23 at approximately 03:49 PM Administrative Nurse B confirmed R1's "NSA" failed to identify the services provided based on his "FCS" for transfers and communication and R4's "NSA" failed to identify the services provided based on her "FCS" for toileting, transfers, and walking/mobility. The facility's 07/2018 "Service Plan Initiation" policy documented "The service plan will be based on an assessment. . ." The operator failed to ensure the "NSA" for R1 described the services he would receive based on his "FCS" for transfers; and the "NSA" for R4 described the services she would receive based on her "FCS" for toileting, transfers, and walking/mobility.	S3085		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3171	Continued From page 5 by: KAR 26-41-204(i) The facility reported a census of 26 residents with three included in the sample and one closed record review. Based on observation, interview, and record review the operator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for Resident (R) 2. Findings included: - Record review for R2 revealed an admission date of 07/30/22 with diagnoses of muscle weakness, hemiplegia and hemiparesis following cerebral infarction, and repeated falls. The 07/12/23 "Functional Capacity Screen" (FCS) identified R2 was independent with toileting, transfers, required supervision with walking/mobility, and was marked for falls. The 07/12/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff would provide R2 toileting checks twice a night, a call light within reach when she was in her room, encouragement to wear proper footwear, and keep pathways free of clutter to prevent injury from falls. Transfers were not addressed on R2's "NSA/HSP." R2's record lacked evidence of documentation of a bed assist device assessment. Observation on 07/18/23 at 09:25 AM revealed a	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3171	Continued From page 6 U-shaped bed assist device attached to the right side of R2's bed. On 07/17/23 at 11:29 AM Administrative Staff A stated the "NSA" and "HSP" were combined in one document. On 07/17/23 at approximately 03:05 PM Administrative Staff A confirmed R2's record lacked evidence of documentation of a bed assist device assessment. The 08/2017 facility's "Bedrail Assessment" policy documented "After the facility has attempted alternatives to bed rails and determined that these alternatives failed to meet the resident's assessed needs, the facility. . . will assess the resident for risks of entrapment and possible benefits of using the bed rail." The operator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for R2.	S3171		
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	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3261	Continued From page 7 by: KAR 26-41-105(f)(11) The facility reported a census of 26 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action taken when Resident (R) 3 developed a pressure wound on his left heel. Findings included: - Record review R3 revealed an admission date of 10/24/19 diagnoses of Parkinson's Disease. The 06/30/23 "Functional Capacity Screen" (FCS) identified R3 required supervision with management of medications and was marked for impaired vision and impaired hearing. The 06/30/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff would provide R3 management of medications; he self-administered nasal spray and creams; he wore glasses for impaired vision and bilateral hearing aids for impaired hearing. The 06/30/23 "Wellness" progress note documented R3 returned to the facility and did not complain of any pain or discomfort and had no other concerns. The 07/13/23 "Physician Progress Note"	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3261	Continued From page 8 documented R3 had an unstageable pressure ulcer to his left heel. R3's record from readmission on 06/30/23 to 07/17/23 lacked evidence of documentation of skin monitoring and interventions to prevent pressure wounds by licensed facility staff prior to a pressure wound on his left heel and lacked evidence of documentation of the pressure wound after it developed, including wound size (length, width and depth), odor, tissue characteristics (including drainage, granulation) and any signs of infection. On 07/17/23 at approximately 03:49 PM Administrative Nurse B confirmed R3's record lacked evidence of documentation of skin monitoring and pressure wound on his left heel. The 09/2017 facility's "Documentation and Charting for Assisted Living" policy documented "Documentation of all incidents, symptoms, and other indications of a change in medical condition to include the time of occurence, actions taken, and the results of the action." The operator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, and results of the action taken when R3 developed a pressure wound on his left heel.	S3261		
S3395 SS=F	28-39-255 LAUNDRY (c) Laundry facility. (1) The facility shall store soiled laundry in a	S3395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3395	Continued From page 9 manner which prevents odors and spread of disease. (2) If laundry is processed in the facility, the facility shall provide washing and drying machines. The facility shall arrange the work area to provide a "one-way flow" of laundry from a soiled area to a clean area. (3) The facility shall provide a work counter and a locked cabinet for storage of chemicals and supplies. (4) The facility shall provide a handwashing lavatory with a non-reusable method of hand-drying within or accessible to the laundry facility. This REQUIREMENT is not met as evidenced by: KAR 28-39-255(c)(3) The facility reported a census of 26 residents. Based on observation and interview the operator failed to ensure the cabinet in the laundry area remained locked to protect the health and safety of residents and the public. Findings included: - Observation on 07/17/23 at 11:49 AM of the laundry area revealed the door was unlocked with a cabinet inside that was also unlocked. The cabinet contained three gallon-size containers of detergent and a cleaner for laundering. The three containers had labels which read "Keep out of reach of children."	S3395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046092	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET 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
S3395	Continued From page 10 On 07/17/23 at approximately 11:49 AM Administrative Staff A confirmed the laundry cabinet was not locked. The operator failed to ensure the cabinet in the laundry area remained locked to protect the health and safety of residents and the public.	S3395		