

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S 000                                                                    | INITIAL COMMENTS<br><br>The following represent the findings of an abbreviated survey with review of facility report #183800 at the above assisted living conducted on 11/07/23.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | S 000                                                                                             |                                                                                                                          |                                                                    |
| S3026<br>SS=K                                                            | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101(f)(1)(B)<br><br>The facility reported a census of 34 residents with four residents included in the sample. Based on observation, interview, and record review the administrator failed to protect four cognitively impaired Residents ((R) 1, R2, R3, and R4) at risk for elopement from neglect by the failure to provide adequate staff elopement training and the failure to secure all exit doors. This failure placed R1 in immediate jeopardy when on 10/31/23 the cognitively impaired resident went through an unsecured door from the dining area of the facility to a service area and exited the facility through a fire door, without staff knowledge. She walked outside, unsupervised, | S3026                                                                                             |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 1</p> <p>for approximately two blocks and was eventually found walking on a sidewalk near the street by a neighbor of the facility. The local police returned the resident to the facility approximately 45 minutes after she left.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Record review for R1 revealed an admission date of 08/12/23 with a diagnosis of hypertension.</li> </ul> <p>The 08/11/23 "Functional Capacity Screen" (FCS) identified R1 as independent with transfers and walking/mobility; she had short-term memory, memory recall, and decision-making cognitive difficulties; and was marked for falls, wandering and inappropriate behavior.</p> <p>The 08/11/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified R1 resided in a secure memory care facility for cognitive difficulties. Staff would maintain a safe environment and attempt to anticipate and meet needs daily for falls. Staff would keep entry and exit doors locked, ensure all staff members were aware of R1's safety risks, ensure the resident's elopement bracelet was on and functioning properly every shift. Staff would use the facility's safety system to alert everyone in case R1 tried to leave and monitor the safety system to ensure it was functioning properly for wandering. Staff would report any inappropriate behavior and/or physical/verbal aggression to the nurse and executive director immediately.</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 2</p> <p>The 08/11/23 "Behavior Assessment" documented R1 aimlessly paced and wandered several times a week. R1 was generally restless, fidgety, and had no ability to sit still several times a day. R1 attempted to get to a different place, tried to get out of building, leave inappropriately, and/or tried to get into locked areas once or twice a week.</p> <p>The 11/07/23 "Resident Roster" provided by the facility documented R1 was marked for wandering behavior.</p> <p>The 08/11/23 (before elopement) "Elopement Risk Assessment" documented R1 scored 35 points, which indicated a high risk for elopement.</p> <p>The 10/31/23 (after elopement) "Elopement Risk Assessment" documented R1 scored 60 points, which indicated a high risk for elopement.</p> <p>The 10/31/23 "Occurrence Note" documented R1 exited the facility at approximately 05:50 PM through a side door. She walked down the street and was discovered by a neighbor. The neighbor had the resident get in her car and then notified police. R1 had cut off her "Resident Monitoring System" alarm bracelet before exiting the building.</p> <p>The 11/01/23 "Facility Reported Incident" report sent to the state agency documented R1 had Alzheimer's disease and further revealed the following:</p> <p>On 10/31/23 at 05:47 PM R1 walked through the dining room and to the service door. She held down the bar on the door for 30 seconds until the</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 3</p> <p>door opened. Video surveillance footage revealed she walked in front of the building and staff did not hear the door alarm.</p> <p>At 05:52 PM Maintenance Staff C and D went out of the kitchen into the service area and heard the alarm. They turned the alarm off and exited out the service door.</p> <p>At approximately 06:00 PM an unidentified neighbor who lived near the facility saw R1 walking down the sidewalk, pulled over, asked R1 if she needed help, and noticed she was confused. The neighbor invited R1 into her car while she contacted the police, called the sister facility next door, and then called the facility where R1 resided. Staff asked the neighbor where she was and ran outside to get R1, but lost phone contact. When staff regained phone contact, the neighbor informed staff police had arrived and were going to take R1 back to the facility.</p> <p>R1's "Resident Monitoring System" alarm bracelet log for August 2023 documented staff checked her bracelet to ensure it was on and functioning 16 out of 19 available day shifts; nine out of 20 available evening shifts; and two out of 20 available night shifts. R1's elopement alarm bracelet log lacked evidence of documentation her bracelet was checked 32 times out of 59 total opportunities.</p> <p>R1's "Resident Monitoring System" alarm bracelet log for September 2023 documented staff checked her bracelet to ensure it was on and functioning 24 out of 30 available day shifts; 14 out of 30 available evening shifts; and zero</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 4</p> <p>out of 30 available night shifts. R1's elopement alarm bracelet log lacked evidence of documentation her bracelet was checked 52 times out of 90 total opportunities.</p> <p>R1's "Resident Monitoring System" alarm bracelet log for October 2023 documented staff checked her bracelet to ensure it was on and functioning 18 out of 31 available day shifts; 13 out of 31 available evening shifts; and three out of 31 available night shifts. R1's elopement alarm bracelet log lacked evidence of documentation her bracelet was checked 59 times out of 90 total opportunities.</p> <p>Review of the weekly "Door, Locks, and Alarms" test log sheets from 08/22/23 to 10/30/23 revealed each had a column to designate each door location and a date column with a checkbox to indicate each door had been checked. The test log was blank except for the location column documented "All" and the date column documented "true." The test log sheet lacked documentation how many exit doors were in the facility and that each door with its location was tested and functioned properly.</p> <p>Review of the weekly "Resident Monitoring Systems" test log sheets from 08/22/23 to 10/30/23 had a column to designate each door location and a date column with a checkbox to indicate each door had been checked. The test log was blank except for the location column documented "All functional" and the date column documented "true." The test log sheet lacked documentation which doors in the facility were installed with the "Resident Monitoring System" and that each door with its location was tested</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 5</p> <p>and functioned properly.</p> <p>The 09/07/23, 09/26/23, 10/27/23, and 10/30/23 weekly "Resident Monitoring Systems" test log sheets lacked documentation the system was tested at each door.</p> <p>The 04/19/23 (before elopement) staff in-service roster documented several topics including elopement was discussed and signed by 24 staff. The in-service roster lacked documentation that Maintenance Staff C and D were in attendance.</p> <p>The 10/30/23 and 10/31/23 (after elopement) staff in-service documented 21 staff attended including Maintenance Staff C and D.</p> <p>Observation on 11/07/23 at 01:41 PM revealed the route R1 took to exit the building. The first door from the dining area to the service area was unlocked and the alarm did not activate when the door was opened. The second door from the service area to outside the facility had a contact alarm installed at the top of the door and a keypad locked alarm. The door opened after pushing on the bar for 15-30 seconds. The contact alarm and keypad alarm both activated. Facility staff typed in the code to turn off the keypad alarm. The contact alarm silenced when the door was closed.</p> <p>Observation on 11/07/23 at 01:51 PM revealed a possible route R1 walked after she exited the building. The route was down a sidewalk next to a residential street with a speed limit of 20 miles per hour (MPH). The spot where R1 was found by a neighbor took approximately six minutes to walk and was two blocks from the facility.</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 6</p> <p>Observation on 11/07/23 at 02:15 PM revealed R1 ambulated in the hallway with one staff assistance. She was able to state her name and her profession. R1 was unable to name her location. She was concerned about the live turtles she had put in her pockets and brought inside the facility from the courtyard. She could tell the name of her "friend" who had the turtles. She asked if the weather was nice outside but did not exhibit exit-seeking behavior at that time.</p> <p>Observation on 11/07/23 at 03:25 PM revealed the first door from the dining area to the service area alarm did not activate. The second door from the service area to outside alarm activated and was audible in the common area.</p> <p>On 11/07/23 at approximately 03:25 PM Administrative Nurse B confirmed the alarm was not loud enough to be heard at the end of the hallways in the facility.</p> <p>Observation on 11/07/23 at 03:58 PM revealed R1 wore a "Resident Monitoring System" alarm bracelet on her right wrist.</p> <p>The weather on 10/31/23 according to wwwWunderground.com was a temperature of 68 degrees Fahrenheit (F) with seven MPH wind speed.</p> <p>On 11/07/23 at 11:31 AM Administrative Nurse B stated all exit doors in the facility were alarmed with a contact alarm. When the door was shut and made contact, the alarm was silenced. The facility ordered a new alarm system, which had to be turned off with a keypad code.</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 7</p> <p>On 11/07/23 at 11:35 AM Administrative Staff A stated a contact alarm was on all the doors and nothing prevented the residents from going through the doors to the outside. If an alarm activated staff would go outside to check and do a headcount of the residents. The second door from the service area to outside, which R1 used to exit the building had a new contact alarm installed, but staff had to be in the vicinity of the alarm to hear it.</p> <p>On 11/07/23 at 01:41 PM Administrative Staff A stated the alarm on the first door from the dining area to the service area was not currently working. The first door from the dining area to the service area and the second door from the service area to outside the facility were the only doors that were not installed with lacked a "Resident Monitoring System" alarm.</p> <p>On 11/07/23 at 02:07 PM Administrative Staff A stated Maintenance Staff C and D were from a consulting company and were not in the facility often. Maintenance Staff C and D knew the code to turn off the keypad alarm from the service area to outside the facility Administrative Staff A confirmed Maintenance Staff C and D were not trained on the elopement policy prior to R1 exiting the building without staff knowledge.</p> <p>On 11/07/23 at 03:29 PM Administrative Staff A stated at least one staff was always in the dining area near the first door from the dining area to the service area. There was not a designated staff person, but staff practiced teamwork and communicated with one another to ensure one of them was always in the front dining area while</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 8</p> <p>the other one was busy attending to residents.</p> <p>On 11/07/23 at approximately 03:39 PM<br/>Administrative Staff A stated she expected staff<br/>to check R1's "Resident Monitoring System"<br/>alarm bracelet was on and functioning once a<br/>shift which was three times every day.</p> <p>On 11/07/23 at 03:55 PM Certified Medication<br/>Aide (CMA) E stated she observed a "Resident<br/>Monitoring System" alarm bracelet was in place<br/>when R1 returned to the facility after she eloped<br/>on 10/31/23.</p> <p>On 11/07/23 at 03:59 PM Licensed Nurse F<br/>stated it was reported to her that R1 had cut off<br/>her "Resident Monitoring System" alarm bracelet.<br/>She had cut off her bracelet before.</p> <p>On 11/07/23 at 04:04 PM Licensed Nurse F and<br/>CMA E stated another staff reported to Licensed<br/>Nurse F that R1 had removed her "Resident<br/>Monitoring System" alarm bracelet, but the staff<br/>had replaced it.</p> <p>On 11/07/23 at approximately 04:04 PM<br/>Administrative Staff A confirmed police brought<br/>R1 back to the facility on 10/31/23 at 06:28 PM<br/>which was 43 minutes R1 was outside of the<br/>facility.</p> <p>The administrator failed to protect cognitively<br/>impaired R1 from neglect by the failure to<br/>provide adequate staff elopement training and<br/>the failure to secure all exit doors.</p> <p>- Record review for R2 revealed an admission<br/>date of 07/29/23 with a diagnosis of Alzheimer's</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 9</p> <p>disease.</p> <p>The 10/11/23 "FCS" identified R2 was independent with transfers and walking/mobility; he had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; and was marked for wandering.</p> <p>The 10/11/23 combined "NSA/HSP" identified R2 resided in a secure memory care facility for cognitive difficulties; and ensure all staff members were aware of R2's safety risks for wandering.</p> <p>The 11/07/23 "Resident Roster" provided by the facility documented R2 was marked for wandering behavior.</p> <p>The 10/11/23 "Elopement Risk Assessment" documented R2 scored 40 points, which indicated a high risk for elopement.</p> <p>Review of the weekly "Door, Locks, and Alarms" test log sheets from 08/22/23 to 10/30/23 revealed each had a column to designate each door location and a date column with a checkbox to indicate each door had been checked. The test log was blank except for the location column documented "All" and the date column documented "true." The test log sheet lacked documentation how many exit doors were in the facility and that each door with its location was tested and functioned properly.</p> <p>Observation on 11/07/23 at 03:25 PM revealed the first door from the dining area to the service area alarm did not activate. The second door from the service area to outside alarm activated</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 10</p> <p>and was audible in the common area.</p> <p>On 11/07/23 at approximately 03:25 PM<br/>Administrative Nurse B confirmed the alarm was<br/>not loud enough to be heard at the end of the<br/>hallways in the facility.</p> <p>The administrator failed to protect cognitively<br/>impaired R2 from neglect by the failure to<br/>provide adequate staff elopement training and<br/>the failure to secure all exit doors.</p> <p>- Record review for R3 revealed an admission<br/>date of 06/06/23 with diagnoses of Alzheimer's<br/>disease and amnesia.</p> <p>The 09/12/23 "FCS" identified R3 as<br/>independent with transfers and walking/mobility;<br/>he had short-term and long-term memory,<br/>memory recall, and decision-making cognitive<br/>difficulties; and was marked for wandering.</p> <p>The 09/12/23 combined "NSA/HSP" identified R3<br/>resided in a secure memory care facility for<br/>cognitive difficulties. Staff were to ensure entry<br/>and exit doors were always locked for safety and<br/>all staff members were to be aware of R3's safety<br/>risks for wandering.</p> <p>The 11/07/23 "Resident Roster" provided by the<br/>facility documented R3 was marked for<br/>wandering behavior.</p> <p>The 09/21/23 "Elopement Risk Assessment"<br/>documented R3 scored 13 points which was at<br/>risk for elopement. He wandered and was easily<br/>distracted.</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 11</p> <p>Review of the weekly "Door, Locks, and Alarms" test log sheets from 08/22/23 to 10/30/23 revealed each had a column to designate each door location and a date column with a checkbox to indicate each door had been checked. The test log was blank except for the location column documented "All" and the date column documented "true." The test log sheet lacked documentation how many exit doors were in the facility and that each door with its location was tested and functioned properly.</p> <p>Observation on 11/07/23 at 03:25 PM revealed the first door from the dining area to the service area alarm did not activate. The second door from the service area to outside alarm activated and was audible in the common area.</p> <p>On 11/07/23 at approximately 03:25 PM Administrative Nurse B confirmed the alarm was not loud enough to be heard at the end of the hallways in the facility.</p> <p>The administrator failed to protect cognitively impaired R3 from neglect by the failure to provide adequate staff elopement training and the failure to secure all exit doors.</p> <p>- Record review for R4 revealed an admission date of 10/20/23 with a diagnosis of dementia.</p> <p>The 10/20/23 "FCS" identified R4 as independent with transfers and walking/mobility; she had short-term memory, memory recall, and decision-making cognitive difficulties; and was marked for falls.</p> <p>The 10/20/23 combined "NSA/HSP" identified R4</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 12</p> <p>resided in a secure memory care facility for cognitive difficulties; and staff were to maintain a safe environment for falls.</p> <p>The 11/07/23 "Resident Roster" provided by the facility documented R4 was marked for wandering behavior.</p> <p>The 10/20/23 "Elopement Risk Assessment" documented R4 as at risk for elopement. She had a diagnosis of dementia. A "Resident Monitoring System" alarm bracelet was in place and would be checked daily for placement and weekly for functioning.</p> <p>Review of the weekly "Door, Locks, and Alarms" test log sheets from 08/22/23 to 10/30/23 revealed each had a column to designate each door location and a date column with a checkbox to indicate each door had been checked. The test log was blank except for the location column documented "All" and the date column documented "true." The test log sheet lacked documentation how many exit doors were in the facility and that each door with its location was tested and functioned properly.</p> <p>Review of the weekly "Resident Monitoring Systems" test log sheets from 08/22/23 to 10/30/23 had a column to designate each door location and a date column with a checkbox to indicate each door had been checked. The test log was blank except for the location column documented "All functional" and the date column documented "true." The test log sheet lacked documentation which doors in the facility were installed with the "Resident Monitoring System" and that each door with its location was tested</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 13</p> <p>and functioned properly.</p> <p>The 09/07/23, 09/26/23, 10/27/23, and 10/30/23 weekly "Resident Monitoring Systems" test log sheets lacked documentation the system was tested at each door.</p> <p>Observation on 11/07/23 at 03:25 PM revealed the first door from the dining area to the service area alarm did not activate. The second door from the service area to outside alarm activated and was audible in the common area.</p> <p>On 11/07/23 at approximately 03:25 PM Administrative Nurse B confirmed the alarm was not loud enough to be heard at the end of the hallways in the facility.</p> <p>The administrator failed to protect cognitively impaired R4 from neglect by the failure to provide adequate staff elopement training and the failure to secure all exit doors.</p> <p>On 11/07/23 at 01:20 PM Administrative Nurse B stated the "NSA" and "HSP" were combined in one document.</p> <p>On 11/07/23 at approximately 04:04 PM Administrative Staff A stated the facility had five exit doors. All were alarmed with a "Resident Monitoring System" except for the first door from the dining area to the service area and the second door from the service area to outside the facility.</p> <p>On 11/08/23 at 09:29 AM via email a keypad door alarm test log for functioning was requested which the facility failed to provide.</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 14</p> <p>On 11/08/23 at 03:49 PM via email Administrative Staff A confirmed the facility did not have a policy regarding staff's response to door alarms. Staff were instructed to check the area outside the door and do a head count of residents.</p> <p>On 11/08/23 at 03:49 PM via email documentation of staff education on how to respond to door alarms was requested which the facility failed to provide.</p> <p>The facility's undated "Missing Resident Policy and Procedure Resident Care" policy documented: all necessary steps should be taken in the event a resident wandered away from the facility. The policy lacked documentation of what staff should do if a door alarm was activated.</p> <p>The administrator failed to protect four residents at risk for elopement from neglect by the failure to provide adequate staff elopement training and the failure to secure all exit doors. This failure resulted placed R1 in immediate jeopardy when cognitively impaired R1 went through an unsecured door from the dining area to a service area and exited the facility through an egress fire door without staff knowledge. She walked outside, unsupervised, for approximately two blocks and was eventually found walking on a sidewalk near the street by a neighbor of the facility. The local police returned the resident to the facility approximately 45 minutes after she left.</p> <p>The Immediate Jeopardy was removed on 11/08/23 when the following actions were</p> | S3026                                                                                             |                                                                                                                          |                                                                    |

Kansas Department on Aging

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046040</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/07/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE HOMESTEAD OF OLATHE NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>791 N SOMERSET TERRACE</b><br><b>OLATHE, KS 66062</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S3026                                                                    | <p>Continued From page 15</p> <p>documented by the facility in the "Abatement Plan" and accepted by the department at 12:24 PM.</p> <ol style="list-style-type: none"> <li>On 10/30/23 at 06:28 PM a Certified Nurse Aide (CNA) was instructed to provided one-on-one care for R1 until further notice.</li> <li>On 10/30/23 at 07:00 PM the administrator provided staff education on door alarms and instructed that one staff was to remain in the front living area at all times.</li> <li>On 10/30/23 at 10:00 PM a new contact alarm was put on the second door from the service area to outside the facility. Informed staff one-on-one care for R1 was no longer necessary but night shift would provide frequent checks.</li> <li>All new staff members to be educated on all alarm systems before their shift starts the first day of work.</li> <li>On 11/07/23 new keypad locked door alarms were installed that will not silence until the code is entered. All staff were trained on the new keypad alarm beginning on 11/07/23 with evening and night shift. All other staff will be trained before their next scheduled shift.</li> <li>The new keypad locked door alarms will be checked weekly by the consulting maintenance team. The first door from the dining area to the service area and the second door from the service area to outside the facility will be checked daily by the administrator.</li> </ol> | S3026                                                                                             |                                                                                                                          |                                                                    |