

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2023
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF OLATHE NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 791 N SOMERSET TERRACE OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of an abbreviated survey with review of facility report #184740 at the above named assisted living conducted on 12/27/23.	S 000		
S3026 SS=K	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 36 residents. Based on observation, interview, and record review the administrator failed to protect ten residents identified at risk for elopement by the failure to secure all exit doors. This failure placed R1 in immediate jeopardy when on 12/18/23 at 11:25 PM the cognitively impaired resident went through an unsecured door from the hallway to the enclosed courtyard of the facility, without staff knowledge. The staff located the resident, lying on the concrete sidewalk by the gazebo and bushes at 04:24 AM, approximately 5 hours after she exited the facility.	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 11/12/23 with diagnoses of vascular dementia and delusional disorder. The 11/12/23 "Functional Capacity Screen" (FCS) identified R1 as independent with transfers and required supervision for walking and mobility. She had short-term memory, long term memory, memory recall, and decision-making cognitive difficulties. The 11/12/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff would provide reminders for R1 to use her walker for walking and mobility. R1 resided in a secure memory care facility for cognitive difficulties. Staff were to maintain a safe environment. The 11/22/23 (before elopement) "Elopement Risk Assessment" documented R1 scored 29 points, which indicated a high risk for elopement. It included behaviors of restlessness, altered perception, and wandering. The 11/28/23 (before elopement) "Admission/Annual/Bi-Annual/Sig Change Assessment" marked as "Quarterly" was marked for no history of elopement, no wandering, and/or no behaviors/exit seeking. The assessment identified R1 as frequently anxious and tearful. The 12/19/23 at 03:57 PM "Nurses Note" documented staff were unable to locate R1. Certified staff notified Administrative Staff they were unable to locate R1 at 04:18 AM. After a	S3026		

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S3026	Continued From page 2 complete building search staff found R1 outside, on the ground, in the courtyard at 04:31 AM. R1 was transferred to the hospital and admitted for hypothermia and unwitnessed fall. The 12/28/23 "Facility's Investigation Report" submitted to the state agency documented Certified Nurse Aide (CNA) C reported to Administrative Staff A over the phone that R1 could not be located after a search of the building. Administrative Staff A instructed CNA C and Certified Medication Aide (CMA) D to search the facility again, including the courtyard. Staff found R1 lying on the ground in the courtyard at 04:24 AM. The report documented a review of the facility's video surveillance footage, which included the following timeline: 12/18/23 at 10:44 PM - CMA D and CNA E entered R1's apartment during rounds. 10:52 PM - R1 walked out of her apartment to the salon area. CMA D assisted R1 back to bed. 10:59 PM - R1 left her apartment and walked down the hall, sat in a chair until 11:07 PM, and walked to the TV common area. 11:10 PM - R1 took off her shoes, opened an exit door to the courtyard, and closed the door again. 11:25 PM - R1 put her slippers back on and walked out through the courtyard door. 12/19/23 at 12:27 AM - CNA C took R1's roommate to their shared apartment. 01:54 AM - CNA C began rounds but did not enter R1's apartment. 03:55 AM - CMA C entered R1's apartment and began searching the building. The 12/19/23 "Witness Statement" by CNA C documented she looked in R1's room around	S3026		

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S3026	Continued From page 3 04:25 AM and found R1's roommate was in R1's bed. CNA C could not see R1. CNA C and her co-worker searched the facility and found R1 in the middle of the courtyard lying on the concrete sidewalk with a skin tear on her left arm and the resident was cold. The 12/19/23 "Witness Statement" by CMA D documented CNA C found R1 outside in the courtyard "freezing." R1 was unable to talk or stand so staff obtained a wheelchair to assist R1 inside the facility. Review of the "Hospital Records" documented R1 was lethargic and unresponsive to verbal stimuli. She was found outside lying on concrete in the cold weather for an unknown amount of time. R1's body temperature at 05:28 AM was 86.7 degrees Fahrenheit (F). Review of the weekly "Door, Locks, and Alarms" test log sheets for November 2023 revealed door locks and alarms were checked weekly and were working. The weather on 12/18/23 at 11:30 PM according to www.Wunderground.com was a temperature of 24 degrees F with six mile per hour (MPH) wind speed. The weather on 12/19/23 at 04:30 AM according to www.Wunderground.com was a temperature of 25 degrees F with 12 MPH wind speed. The 12/27/23 "Resident Roster" provided by the facility documented nine residents were marked for wandering. The facility failed to identify R1 for wandering on the resident roster.	S3026		

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S3026	Continued From page 4 Observation on 12/27/23 at 02:38 PM revealed the south door to the courtyard had a deadbolt lock in place. The north door to the courtyard had a keypad lock in place with the alarm activated. A plastic cover was over the keypad lock system at the nurse's station. Observation on 12/27/23 at 02:41 PM revealed R1 ambulated from the common area to the conference room with a rolling walker and one staff assistance. A resident monitoring system bracelet was on her left ankle and there were multiple bruises and scabs on both hands, wrists, and forearms. On 12/27/23 at approximately 01:02 PM Administrative Staff A stated the courtyard doors were left unlocked so residents and staff could go through the courtyard. After the incident a deadbolt lock was installed so no one could go in or out the door. The north door had a keypad lock and was alarmed. Any residents wishing to go out to the courtyard had to be escorted by staff. She confirmed the "NSA" and "HSP" were combined in one document. On 12/27/23 at 01:53 PM Administrative Staff A stated a staff member had stepped out to the courtyard twice during the night on 12/18/23 and 12/19/23 to smoke and did not see R1. She stated R1 did not call out for help. On 12/27/23 at 03:19 PM CMA F stated she checked R1 every two hours during the day but did not know how often she was checked during the night shift.	S3026		

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S3026	Continued From page 5 On 12/27/23 at approximately 03:31 PM Administrative Staff A confirmed nine other residents exhibited wandering behavior. 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 out of the facility. The administrator failed to protect ten residents at risk for elopement from neglect by the failure to secure all exit doors. This failure placed R1 in immediate jeopardy when she exited through an unsecured door from the hallway to the enclosed courtyard of the facility without staff knowledge. She walked outside, unsupervised, and was found lying on the concrete sidewalk by the gazebo and bushes. The staff located resident at 04:24 AM approximately 5 hours after she exited facility. The Immediate Jeopardy was removed on 12/27/23 when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department at 04:15 PM. 12/19/23 at 07:00 AM staff day and night shift staff were educated to complete two-hour visual checks of residents. Staff not to use the courtyard doors and to keep them locked and alarmed. 12/19/23 at 08:00 AM maintenance arrived, and a deadbolt lock was installed on the south courtyard door. Only the Executive Director has the key. An auto-locking system was installed on the north courtyard door.	S3026		

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S3026	Continued From page 6 3. 12/19/23 all staff were educated before the start of their next scheduled shift on alarm panel, keep courtyard doors locked, escort residents into the courtyard, and no staff smoking in courtyard allowed. 4. 12/19/23 and 12/21/23 elopement drills completed. 5. 12/20/23 solar lights installed along the sidewalks in the courtyard. 6. 12/21/23 a transparent plastic cover was installed over the alarm panel in the nurse's station to prevent accidental disengagement of alarms. Motion sensor lights were installed on the gazebo in the courtyard.	S3026		