

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #191417, 191376, and 190964 of the above named facility conducted on 10/28/24.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (A) (B) The facility reported a census of 39 "Residents" (R)'s. Based on observation, interview, and record review the Administrator failed to protect R1 from abuse and neglect when "Certified Medication Aide" (CMA) C assisted R1, the cognitively impaired resident in her wheelchair, out the front door of the facility at 11:15 PM, silenced the door alarm, and returned to the inside of the building. CMA C did not return to check on R1 after he assisted R1 out of the building. R1 self-propelled herself down a steep driveway down to a busy two-lane residential road, up a sloped street, and was found by local law enforcement approximately 333 steps from the front door of the facility at 11:33 PM with an outside temperature of 69 degrees Fahrenheit,	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 wearing a long red sleeve shirt and pants. R1 was returned to the facility by "Emergency Medical Services" (EMS) at 12:18 AM. - Findings included: - Record review for R1 revealed an admission date of 03/26/2018 with diagnoses of Hypertension, Alzheimer's Dementia, Atrial Fibrillation, Insomnia, Anemia, Cognitive Communication Deficit, Dysphagia, Depression, and Anxiety. Review for R1's "Functional Capacity Screen" (FCS) dated 03/28/24 revealed R1 required physical assistance with bathing, dressing, and eating. She required supervision with toileting, transferring, and mobility. R1 lacked the ability to manage her own medications / medical treatments. R1 was usually continent, and had impaired short-term memory, long-term memory, memory/recall, and decision making. She was able to make herself understood and she understood others. R1 was marked as at risk for falls, impaired hearing, wandering, and impaired decision making. R1 used a wheelchair mobility device. Review of R1's "Negotiated Service Agreement" (NSA) dated 03/28/24 identified qualified nursing staff would manage R1's medications, provide assistance of one staff for bathing, dressing, and toileting. Under the section titled "Other" it was written; "Elopement Risk: Encourage to stay in common area during hours awake", and check R1 every two hours at night. Review of R1's "Resident Care Plan" dated 03/28/24 had written under the date in the top	S3026		

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S3026	Continued From page 2 right corner of the page; alert and oriented times one, wheelchair, vapes. Facility staff were to assist R1 with dressing in the morning and evening, administer R1 medications, provide supervision when R1 transferred, and at the bottom of the page was written; "Elopement Risk": staff were instructed to encourage R1 to stay in the common area while she was awake, check on her every two hours at night, and monitor her for exit seeking. If R1 was exit seeking staff were instructed to provide one-on-one activity, monitor closely and call R1's "Durable Power of Attorney" (DPOA), "she will sit with her." Review of the facility provided document titled "Care Plan" revealed R1 and her room number, she was identified as a fall and elopement risk. R1 was an assist with all activities of daily living, and staff were instructed to encourage R1 to stay in the common area during awake hours and check on her every 2 hours at night. "Elpmnt" (Elopement) Facility staff were to provide one on one and monitor closely and call R1's daughter to talk to her. Review of the facility security camera system on 10/28/24 at 01:42PM revealed the security system time stamp was 12:45PM. This is a 63-minute time difference. Review of the facility provided security system footage time stamped 10/21/24 revealed the following events: At 10:01 PM an individual came in the front door. At 10:03 PM the individual left. Interview on 10/28/23 at approximately 01:45 PM with Administrator A confirmed the individual seen	S3026		

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S3026	Continued From page 3 in the video footage at 10:01 PM was the pharmacy deliver person. At 10:05 PM R1 was observed self-propelling her wheelchair into the front common area of the building. At 10:06 PM R1 was observed self-propelling her wheelchair down the south hall. At 10:07PM CMA C was observed going down the south hall. At 10:09 PM R1 was observed at the back door at the end of the south hall. At 10:10PM R1 was observed going north on the south hall towards the common resident area of the facility. At 10:13PM CMA C walked past R1, who was self-propelling her wheelchair in the common resident area of the facility, and CMA C continued down the east hall of the facility. At 10:14PM R1 was observed self-propelling her wheelchair to the front door and was successful in opening the front door and was halfway out the front door when CMA C went to the door and assisted R1 out the door. CMA C came in the door, silenced the door alarm, and returned to the interior of the facility. At 11:05PM a local police officer was observed walking into the building using the laundry room door. The local police officer went to the nurse desk located in the front common area and left the camera view. At 11:07PM the local police officer and CMA C appeared by the nursing desk in the front common area. At 11:09PM the local police officer, CMA C, and "Certified Nurse Aide" (CNA) D were in the front common area and at 11:10PM CNA D left with the police officer. At 11:16 CMA C went out the front door of the facility.	S3026		

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S3026	Continued From page 4 At 11:18 local EMS brought R1 in the front door of the facility, CMA C and CNA D walked in the front door of the facility. Review of CMA C's signed witness statement dated 10/21/24 revealed that on 10/21/24 at approximately 11:40PM R1 "escaped exiting the front door" while CMA C was receiving medications from the pharmacy delivery person. CMA C wrote that R1 exited the door and left while their attention was "with other activities", and "she left the building pushing the door". CMA C continued to write "after a while" an officer arrived and asked if the facility was missing a resident, and when they "checked" it was confirmed that R1 was not in the facility. Review of CMA C's witness statement dated "May" 2024 he wrote "The incident happened on October 21, 2024." CMA C wrote while he was working on the medication cart at approximately 12:03AM a local police officer came in the building and asked if the facility was missing a resident. He wrote that he and CNA D checked and confirmed R1 was missing. CMA C wrote the officer informed them at this time R1 had been found. CMA C wrote; "To the best of my knowledge this incident did not happen due to negligence, instead it happened while I was working on the medication cart due to my assignments, and while the CNA was helping other residents." Review of CNA D's witness statement revealed that at approximately 11:40PM on 10/21/24 she saw R1 in the hallway of the facility. She stated that at "12:11" AM CMA C told her that there was a local police officer in the facility and that she went with the officer to confirm the individual they found was their resident. CNA D wrote that she	S3026		

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S3026	Continued From page 5 "Didn't know how" R1 got outside. R1 did not know the door codes and CNA D didn't hear any alarms go off. Review of the facility provided document titled "Kansas Standard Offense Report" dated 10/21/24 and signed by local officer E revealed that the "Incident date" was 10/21/24 and started at 11:33PM. The incident ended at 12:25AM. Interview on 10/28/24 at approximately 02:40PM with Administrator A and "Licensed Nurse" (LN)B confirmed CMA C did not follow the facility "Elopement" policy that he signed on 04/04/24, that instructed him to notify the Administrator immediately in the case of a missing resident. LN B confirmed that she received a text message on 10/22/24 at 02:24AM from CMA C stating that R1 "Escaped" the front door while CMA C was receiving medications from the pharmacy delivery driver. He texted to LN that R1 went from the front door and to the "back yard of the facility" and "after a few minutes" a local police officer notified them of R1 being outside the facility. LN B stated she opened her investigation at 06:00AM on 10/22/24. Administrator A and LN B confirmed they reviewed the facility security camera footage and found where CMA C assisted R1 out the front door and did not return to check on her. They further confirmed they interviewed CMA C and he denied knowing R1 left the facility. Administrator A confirmed that CMA C did not work another shift and was terminated on 10/24/24. On 10/28/24 at 04:35 PM Administrator A was notified that R1 had been in Immediate Jeopardy on 10/21/24 for approximately 63 minutes, when CMA C assisted the cognitively impaired resident who used a wheelchair mobility device, out the front door of the facility at 11:15 PM until 12:18	S3026		

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S3026	Continued From page 6 AM when R1 was returned to the facility by EMS. The Administrator failed to protect R1 from abuse and neglect when CMA C assisted R1, the cognitively impaired resident in her wheelchair, out the front door of the facility at 11:15 PM, silenced the door alarm, and returned to the inside of the building. CMA C did not return to check on R1 after he assisted R1 out of the building. R1 self-propelled herself down a steep driveway down to a busy two-lane residential road, up a sloped street, and was found by local law enforcement approximately 333 steps from the front door of the facility at 11:33PM with an outside temperature of 69 degrees Fahrenheit, wearing a long red sleeve shirt and pants. R1 was returned to the facility by "Emergency Medical Services" (EMS) at 12:18 AM. The facility provided abatement plan included the following: CMA C was suspended on 10/22/24 and terminated following the investigation. Staff training on elopement, abuse and neglect was completed on 10/23/24. Camera Monitoring Implementation: the Administrator will conduct periodic checks of the camera footage to monitor for compliance and safety. To be started on 10/31/24. Care Plan training for the nursing team to ensure all staff understand the resident needs and safety protocols will be held on 11/01/24.	S3026		