

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 189213, 188618, 185651, 180937, and 178695, for the above named facility conducted on 09/25/24 and 09/26/24.	S 000		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 41 "Residents". Based on observation, interview, and record review the Administrator failed to provide healthcare services for R2 in accordance with professional standards of practice when Administrator A failed to ensure an assessment for R2's bed assist device was conducted ensuring the device posed no risk for entrapment, confirmed the device was not a restraint, determined R2's ability to safely use the bed assist device and ensure the device was securely attached to the bed. Findings included: - Record review for R2 revealed an admission date of 12/01/23 with diagnoses of Rheumatoid arthritis, Parkinson's disease, Osteopenia, and hypertension.	S3171		

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

TITLE

(X6) DATE

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 1 Review of R2's "Functional Capacity Screen" (FCS) dated 12/01/23 revealed R2 required physical assistance with bathing and dressing. R2 required physical supervision with toileting, transferring, walking/mobility, and eating. R2 lacked the ability to manage her own medications and was occasionally incontinent. R2 had impaired decision making. R2 was able to make herself understood and she understood others. R2 was marked as at risk for falls and impaired vision. R2 used a walker mobility device. R2's FCS lacked documentation in the "Comments" section of a bed assist device. R2's "Negotiated Service Agreement" (NSA) dated 12/01/23 identified the facility would provide the following health services: Qualified nursing staff to administer R2's medications and medical treatments, bathing, and dressing assistance. Facility staff to monitor every two hours while sleeping, R2's "Health Service Plan" (HSP) instructed facility staff to prompt and encourage R2 to dress and provide one staff assistance with transferring at times. R2 ambulated with a walker and required total assistance with showering twice weekly. R2's NSA and HSP lacked a description of the bed assist device, its purpose, R2's ability to safely use the device, and any special instructions on use and monitoring of the device. Observation on 09/26/24 at approximately 03:00 PM of R2's bed revealed a step with two handles on the right side of the bed and an inverted "U" shaped device that slid under the mattress and measured approximately 13 inches in height and	S3171		

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 2 12 inches in width. There was a nylon bag attached to the opening of the "U" shape and there were 2 white cloth rolls between the bed assist device and the mattress. The "U" shaped device was not secured to the bed. Interview on 09/26/24 at approximately 03:15 PM with Administrator B and Licensed Nurse C confirmed R2's medical record lacked an assessment for R2's bed assist device ensuring the device posed no risk for entrapment, confirmed the device was not a restraint, determined R2's ability to safely use the bed assist device and ensure the device was securely attached to the bed. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section.	S3171		

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 3 Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. The Administrator failed to provide healthcare services for R2 in accordance with professional standards of practice when Administrator A failed to ensure an assessment for R2's bed assist device was conducted ensuring the device posed no risk for entrapment, confirmed the device was not a restraint, determined R2's ability to safely use the bed assist device and ensure the device was securely attached to the bed.	S3171		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication	S3215		

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3215	Continued From page 4 aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h) (1) (4) The facility reported a census of 41 "Residents". Based on observation, interview, and record review the Administrator failed to ensure the facility's "Licensed Nurse" (LN) and "Certified Medication Aides" (CMA)'s stored all non-controlled medications managed by the facility in a locked medication room, cabinet, or medication cart. The Administrator further failed to ensure the facility LN did not administer, and the facility CMAs did not dial the insulin pens for residents beyond the manufactures recommended date of expiration for R's 3, 13 and 14. Findings included: - Observation on 09/25/24 at approximately 08:45 AM, there were two medication carts identified by CMA A as the "large cart" and the "small cart" that sat against a half wall that separated the dining area and a common resident area. Between the two carts on the floor	S3215		

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S3215	Continued From page 5 in a plastic grocery bag were 25 cards that contained non-controlled medications, and were labeled from the pharmacy for R's 4 ,5, 6, 7, 8, 9, 10, 11 and 12. Interview on 09/25/24 at approximately 08:45 AM confirmed the plastic grocery bag contained 25 cards of partially used medications for R's 4, 5, 6, 7, 8, 9, 10, 11 and 12, that were to be sent back to the pharmacy. Review of the facility policy titled "Medication Storage Policy and Procedures" and was reviewed on 08/01/24 revealed the following; "Policy: The licensed nurse will ensure all medications and biologicals managed" by the facility "are stored in a locked medication room, cabinet, or medication cart ..." "Procedure: 1. a. non-controlled medications will be stored in the medication room, cabinet, or cart under single lock." Interview on 09/26/24 at approximately 03:15 PM with Administrator B and LN C confirmed all medications managed by the facility are to be secured. The Administrator failed to ensure the facility's LN and CMAs stored all non-controlled medications managed by the facility in a locked medication room, cabinet, or medication cart. - Observation on 09/25/24 at approximately 08:50 AM CMA A unlocked the "large" medication cart in the top drawer on the right side were the following insulin pens that lacked the date of expiration after they were opened:	S3215			

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3215	Continued From page 6 A Levemir insulin pen with approx. 250 Units and labeled with R3's name. A Lispro insulin pen with approximately 160 Units and labeled with R13's name. A Glargine insulin pen with approximately 120 Units and labeled with R14's name. Interview on 09/25/24 at approximately 08:50 AM with CMA A confirmed the insulin pens lacked the date they were opened, or an expiration date. Interview on 09/26/24 at approximately 03:15 PM with Administrator B and LN C confirmed all insulin pens should have the expiration date on the pen, or the date the pen was opened. Review of the manufacture's guidelines for the Levemir insulin pen recommended to dispose of the pen after 42 days, even if there is insulin left in the pen. Review of the manufacture's guidelines for the Lispro insulin pen recommended once the pen was opened for use it should be thrown away after 28 days. Review of the manufacture's guidelines for the Glargine insulin pen and be used for up to 28 days after you have taken it out of cool storage. The Administrator failed to ensure the facility's LN and CMAs stored all non-controlled medications managed by the facility in a locked medication room, cabinet, or medication cart. The Administrator further failed to ensure the facility LN did not administer, and the facility CMAs did not dial the insulin pens for residents beyond the	S3215		

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3215	Continued From page 7 manufactures recommended date of expiration for R's 3, 13 and 14.	S3215		
S3255 SS=F	26-41-105 (b) Resident Records Confidential (b) Each administrator or operator shall ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential, unless release is required by any of the following: (1) Transfer of the resident to another health care facility; (2) law; (3) third-party payment contract; or (4) the resident or legal representative of the resident. K.A.R. 26-41-105 (b) The facility reported a census of 41 "Residents". Based on observation, interview, and record review the Administrator failed to ensure the duplicate copies of resident records awaiting destruction were kept confidential and securely stored, when there was a pile of duplicate records sitting on top of a small shredder behind the nurse desk in the front of the facility. Findings included: - Observation on 09/25/24 at approximately 08:33 AM, there was a small paper shredding in the northeast corner of the open space behind the nurse desk with a stack of papers measuring approximately 12 inches in height. The top very top page had printed in large bold letters on the front lower left corner "DNR" (Do Not Resuscitate) with R15's name typed in at the top of the page. The second page down was a copy	S3255		

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3255	Continued From page 8 of telephone provider orders. Interview on 09/26/24 at approximately 03:15 PM with Administrator B and LN C confirmed the presence of duplicate medical records, and they further confirmed they were awaiting to be shredded. Review of the facility provided policy titled "Medial Records Storage Policy" revealed; Section 4. Storage Requirements; Physical Storage: "Medical records should be stored in a secure area with restricted access." Section 5. Access Control; "Only authorized personnel should have access to medical records." "Access logs should be maintained to track who views or modifies records." Section 7. Destruction of Records; "Records should be securely destroyed when the retention period has expired." "For paper records, shredding is required ..." The Administrator failed to ensure the duplicate copies of resident records awaiting destruction were kept confidential and securely stored, when there was a pile of duplicate records sitting on top of a small shredder behind the nurse desk in the front of the facility.	S3255		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:	S3280		

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 9 (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-104 (d) (3) The facility reported a census of 41 "Residents". Based on interview and record review the Administrator failed to ensure a quarterly review of the facility's emergency management plan with employees and residents. Findings included: - Record review of the facility binder titled "Fire Book" revealed the contents were of the monthly fire drills and the annual evacuations. Interview on 09/26/24 at approximately 02:20 PM with Administrator B confirmed the facility emergency preparedness is provided at the time of hire for new employees and at the time of admission for newly admitted residents. Administrator A further confirmed the quarterly review of the emergency management plan has	S3280		

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 10 not been provided to staff or residents. Review of the facility provided policy titled "Disaster and Emergency Management Policy and Procedures" revealed the following; "6. All new employees" of the facility will "receive training on disaster and emergency preparedness policies and procedures as a part of a new employee orientation, reviewed annually thereafter." "7. The disaster and emergency preparedness policies and procedures" of the facility "are reviewed with residents upon move in to" the facility "and quarterly." "9. The Administrator / Operator will ensure the Emergency Plans are available to the staff, residents, and visitors, and maintain documentation of reviews." The Administrator failed to ensure a quarterly review of the facility's emergency management plan with employees and residents.	S3280		