

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER CARE HAVEN HOMES - SOUTHMOOR		STREET ADDRESS, CITY, STATE, ZIP CODE 7010 WEST 69TH TERRACE OVERLAND PARK, KS 66204		
(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 a resurvey with complaint number 192614 at the above named Home Plus conducted on 06/05/25 and 06/09/25.	S 000		
S5026 SS=J	26-42-101 (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 26-42-101(f)(1)(B) The facility reported a census of eight residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to protect one resident from neglect when cognitively impaired Resident (R) 2 exited the facility through an unlocked door to the outside courtyard and exited the courtyard through an unlocked gate without staff knowledge. She was found approximately 700 feet east of the facility and returned 39 minutes later by a neighbor and law enforcement. This placed the resident in immediate jeopardy.	S5026		

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

TITLE

(X6) DATE

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S5026	Continued From page 1 Findings included: - Record review for R2 revealed an admission date of 08/29/24 with the following diagnoses: dementia and generalized anxiety disorder. The 08/27/24 "Functional Capacity Screen" (FCS) identified R2 required supervision for bathing, dressing, and toileting; was independent with transfers, walking/mobility and eating; had short-term memory and memory/recall impairments and was marked for falls and unsteadiness, but not marked for wandering. The 08/29/24 "Negotiated Service Agreement" (NSA) and/or "Service Plan Report" (SPR) identified facility staff provided stand by assist with bathing, dressing, and toileting. R2's record lacked evidence of documentation of an elopement risk assessment for R2. Review of "Progress Note Observations" from 08/29/24 to 06/06/25 revealed 20 staff entries which reported R2 wandered and/or was exit seeking. The 12/29/24 at 06:11 PM "Progress Note Observations" by Licensed Nurse F documented facility staff reported at 04:30 PM that R2 eloped from the facility without staff knowledge and returned with the assistance of a neighbor and law enforcement. The 12/30/24 at 10:36 AM "Complaint/Incident Investigation Report" by Administrative Nurse D reported that resident R2 exited the unlocked door to walk outside in the gated secured area	S5026		

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S5026	Continued From page 2 and exited through west side gate. A neighbor notified facility at 04:30 PM and Certified Medication Aide (CMA) I escorted R2 back into the facility. The 01/02/25 facility's "Investigation" to the department by Administrative Nurse D documented that according to camera footage R2 exited facility back door at 03:51 PM and was seen walking east in front of the facility at 03:54 PM. A neighbor accompanied by law enforcement notified the facility and the resident was returned to the facility at 04:30 PM. Upon further investigation it was revealed R2 had exited facility grounds via an unlocked west gate. Review of facility's Emergency Management Plan "EMP" quarterly reviews failed to include missing resident. On 06/05/25 at 10:45 AM Administrative Nurse D confirmed R2's "FCS" had not been updated to show wandering behavior. On 06/05/25 at 10:52 AM Administrative Staff Nurse D verified that an elopement risk assessment had not been completed for R2. On 06/05/25 at 02:28 PM Administrative Staff A confirmed EMP quarterly reviews failed to include missing resident, and the facility did not conduct elopement drills. Observation on 06/05/24 at 01:03 PM at the direction of Administrative Nurse D revealed on the day of incident R2 exited the back yard through unlocked west gate and walked unaccompanied approximately 700 feet to the east through a residential area where she was	S5026		

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S5026	Continued From page 3 noticed by a neighbor. The facility's location is near a busy four lane street with a speed limit of 40 miles per hour "mph". The weather on 12/29/24 at 12:53 PM according to www.Wunderground.com was a temperature of 53 degrees Fahrenheit with a wind speed of 12 mph. Observation on 06/05/25 at 11:26 AM noted R2 wandered around the kitchen, dining room, and the common area. She did not attempt to exit any doors. Administrative Nurse D reported R2 was anxious due to increased facility activity. The undated facility's "Resident Lost or Elopement" policy instructed staff how to react when a resident was missing. The policy failed to address interventions to keep independently mobile, cognitively impaired residents safe from exiting the building/premises without staff knowledge. The Immediate Jeopardy for R2 was removed on 12/29/24 when the following actions were implemented as documented by the facility in the "Abatement Plan" and accepted by the department on 06/05/29 at 05:09 PM. 1. On 12/29/24 nurse properly secured gate by putting padlock in correct hole of gate latch. memory care courtyard keys were removed from staff access. A sign that read "keep door locked placed on each memory care courtyard door. 2. On 12/29/24 owner/operator inspected gate lock and placed a carabiner with "Do Not Remove" tag in vacant gate latch hole to eliminate the potential for gate lock to be applied	S5026		

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S5026	Continued From page 4 incorrectly. 3. On 12/29/24 07:00 PM shift change caregivers verified secured gate. Gate lock checks are completed every shift change, 07:00 AM and 07:00 PM. 4. On 12/29/24 staff completed routine safety checks on resident every two hours. 5. On unknown date facility manager filled gate holes with steel putty. 6. Scheduled elopement training for all staff to be completed Wednesday, June 18, 2025. 7. Updated resident care plan includes resident right to walk in secured back yard and staff to check every 30 minutes when she is outside.	S5026		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(2) The facility reported a census of eight residents with three included in the sample. Based on interview and record review the operator failed to ensure designated staff conducted a "Functional Capacity Screen" (FCS) for Resident (R) 2	S5085		

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S5085	Continued From page 5 following a significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for R2 revealed an admission date of 08/29/24 with diagnoses of dementia and generalized anxiety disorder. The 08/27/24 "Functional Capacity Screen" (FCS) identified R2 required supervision for bathing, dressing, and toileting; was independent with transfers, walking/mobility and eating; had short-term memory and memory/recall impairments and was marked for falls and unsteadiness, but was not marked for wandering. Review of "Progress Note Observations" from 08/29/24 to 06/06/25 revealed 20 staff entries reported R2 wandered and/or was exit seeking. The 12/29/24 at 06:11 PM "Progress Note Observations" by Licensed Nurse F documented facility staff reported at 04:30 PM that R2 eloped from the facility without staff knowledge and returned with the assistance of a neighbor and law enforcement. On 06/05/25 at 10:45 AM Administrative Nurse D confirmed that R2's FCS had not been updated to show wandering behavior for R2. The operator failed to ensure designated staff completed an "FCS" for R2 following a significant change in condition.	S5085		