STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	**17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted on 05/20/2026 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint reference numbers 3001279 and 2992524 were investigated. The facility census on the first day of the survey was 56, and the sample included three residents. Based on this survey, the facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to provide individualized care and services related to dementia care (a progressive mental disorder characterized by failing memory and confusion) for Resident (R)1, who displayed wandering behaviors into other resident's rooms. Findings Included: - R1's Electronic Medical Record (EMR) documented diagnoses of dementia, need for continuous supervision, adjustment disorder (a short-term, intense emotional or behavioral reaction to a stressful life change that is disproportionate to the event), muscle weakness, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), Post-Traumatic Stress Disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and cognitive communication deficient (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and	F0744		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	**17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 1 safety awareness). The “Admission Minimum Data Set” (MDS) dated 01/23/26 documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The MDS documented R1 required setup or clean up assistance for eating and oral hygiene. R1 required partial to moderate assistance for showers and bathing. The MDS documented R1 was independent for other Activities of Daily Living (ADLs) and mobility. The MDS documented R1 exhibited wandering behavior daily. The MDS documented the wandering behavior did not significantly intrude on the privacy or activities of others. The “Cognitive Loss / Dementia Care Area Assessment” (CAA), dated 01/23/26, documented R1 was at risk for potential alterations in his cognitive status. The CAA documented R1 had poor adjustment disorder with anxiety and PTSD. The CAA documented R1 used a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) due to exit seeking. R1's 01/21/26 “Care Plan” documented R1 was at risk for potentially leaving the neighborhood or facility unsupervised related to dementia, and anxiety. The “Care Plan” documented the following interventions: 01/21/26 – directed staff to attempt redirection as needed. If R1 became aggressive, staff were to make sure he was safe and monitor him from a distance. The intervention directed staff to reapproach when R1 was calm. 01/21/26 – WanderGuard placed on right wrist. WanderGuard for personal safety. 01/21/26 – directed staff to check WanderGuard bracelet placement and function daily. Other care plan WanderGuard intervention directed staff to replace the WanderGuard as needed and change it every three months. 01/21/26 – directed staff to notify R1’s primary care provider (PCP) as needed for concerns or an increase in his behaviors. R1's 01/29/26 “Care Plan” documented R1 stayed on the facility’s memory care unit. The “Care Plan”	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	**17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 2 documented R1 had cognitive loss and had exit seeking behavior due to his diagnosis of dementia. The “Care Plan” documented the following interventions: 04/28/26 – documented R1 had a desire to help some of the female residents in his neighborhood. The intervention directed staff to attempt to redirect R1 when it happened and notify R1’s PCP as needed. 05/15/26 – directed staff to call R1’s daughter or his spouse if R1 became agitated or exhibited exit seeking behaviors. R1's 01/29/26 “Care Plan” documented R1 was at risk for potential alteration in cognitive function and mood related to dementia, adjustment disorder, anxiety, and PTSD. The “Care Plan” documented R1 stayed on a secure memory unit for his safety. The “Care Plan” documented the following interventions: 01/29/26 – directed staff to engage R1 in simple, structured activities that avoid overly demanding tasks. 01/29/26 – directed staff to provide R1 with cueing, reorient, and supervise as needed. 01/29/26 – Directed staff to provide a program of activities that accommodates R1’s abilities. The intervention recorded R1 loved walking. The “Care Plan” lacked interventions that addressed R1’s wandering into other resident’s rooms. A “Social Services” note dated 01/19/26 documented R1 was very confused in the late afternoon and wandered in and out of other resident’s rooms. A “Behavior Note” dated 01/28/26 at 04/24 PM documented R1 was exit seeking, banged on exit doors, and wandered in other resident’s rooms. A “Social Services” note dated 01/28/26 at 05:31 PM documented care team met with R1’s daughter and wife by phone. The note documented R1 was fairly calm during the day but became exit seeking and anxious as the day progressed. The note documented R1 would either look for his car or wanted to go home. The note documented R1 may	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 3 wander in other residents' rooms. A "Behavior Note" dated 03/13/26 at 02:28 PM documented R1 was observed walking out of the room next to his without pants on. The note recorded R1 had a shirt and pull-up on. The note recorded R1 was taken back to his room and the bathroom was covered in bowel. The note documented R1 used pull-up to wipe himself and threw it in the toilet. The note further recorded his trash can was full of urine and he was taken to the shower room and cleaned up by staff. A "Health and Status Note" dated 04/12/26 at 04:34 AM documented R1 was alert to self with confusion per baseline. The note documented R1 was observed wandering in the hallway and had entered other residents' rooms at the beginning of the shift, around 11:00 PM. The note further recorded R1 stated he was looking for his keys so he could leave. The note further recorded R1 was not easy to redirect as he was agitated with redirections. A facility investigation document dated 04/27/26 with intake number of 2992524 recorded on 04/22/26, Certified Nurse Aide (CNA) M entered R2's room and witnessed R2 laying in bed with her pants down to her thighs. The document recorded R1 was observed standing next to R2's bed and appeared to be touching R2's abdominal area. The document further recorded CNA M went to get a nurse and they entered the room together to try and get R1 to leave R2's room. The document recorded R1 refused to leave the room and stated R2 was his wife. The document recorded staff explained they needed to take R2 to the restroom and they were able to escort R1 out of the room. The document recorded camera footage revealed R1 entered R2's room approximately 10 minutes after R2 had gone into her room. The document recorded it was estimated R1 was in R2's room for approximately five minutes prior to CNA M entering the room. The document recorded CNA M reported neither resident appeared to be in distress. R1 was placed on 15 minute checks for 72 hours following the incident and a urine analysis (UA - diagnostic test that examines a urine sample) was ordered for R1. A "Health Status Note" dated 04/23/26 at 12:51 PM documented R1 remained on 15-minute checks. The note documented R1 was observed wandering in and out of other residents' rooms but was easily	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 4 redirectable. A “Health Status Note” dated 04/23/26 at 10:39 PM documented R1 was on 15-minute visual checks. The note documented R1 continued to wander in the hallway and other resident’s rooms. The note documented redirection had been successful. A “Behavior Note” dated 04/25/26 at 09:07 PM documented R1 was very restless and exit seeking at the beginning of the shift. The note documented R1 was ambulating up and down the hallway and at times was peeking in other residents’ rooms. The note documented R1 was redirected each time. The note recorded R1 ambulated without his walker, and staff would offer his walker and redirect him. The note recorded R1 was observed to have been visibly agitated and asked how he could get out of there. A “Health Status Note” dated 04/27/26 at 04:20 PM documented it was reported that R1 had wandered into another resident’s room with another resident. The note documented that the residents were redirected to the day area and staff would continue to monitor. A notarized witness statement for CNA M, with a signed date of 04/28/26, documented CNA M responded to the resident’s call light and found R2 lying in her bed with her pull-up and pants halfway down. The witness statement documented R1 was present and touched R2. CNA M documented when she asked R1 why he was touching her R1 stated he was helping her. CNA M documented she asked R1 to step out and he refused, stating R2 was his wife. CNA M documented she prioritized R2’s safety and notified the Certified Medication Aide (CMA) immediately. An untitled document with R1’ name at the top and dated 05/02/26 recorded 15-minute rounding checks for R1. The document recorded a note from 07:45 PM to 09:00 PM that R1 was wandering in the hallway, exit seeking. The note further recorded R1 was wandering in and out of other residents’ rooms. A “Health Status Note” dated 05/03/26 at 01:54 AM documented R1 continued on 15-minute checks throughout the evening and night shift. The note recorded R1 wandered in the hallway seeking an exit	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	**17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 5 and in and out of other residents' rooms during the evening shift. The note documented redirection was successful. A "Health Status Note" dated 05/08/26 at 08:15 AM documented 15-minute checks had been discontinued as of 05/06/26. Interdisciplinary Team (IDT) reviewed and discussed. Note documented R1 continued to wander but has been redirectable when going into other residents' rooms. UA was collected and awaiting results. The note recorded that the provider would treat if indicated. On 05/20/26 at 02:33 PM, R1 sat in a recliner in the common area with other residents and staff, listening to music. On 05/20/26 at 01:50 PM, CNA M stated when the incident occurred on 04/22/26, she was in another room helping a resident. She stated once she finished with that resident, she went to the nurse's station and saw R2's call light was on. She stated she went to answer R2's call light and found them in the room together. She stated she had no idea R1 was in R2's room until she walked in. She stated R2's pants were pulled down to about her knees. She stated R2 was lying in bed and R1 was standing next to the bed, touching R2. She stated she asked what R1 was doing, and R1 stated he was helping R2. She stated she asked R1 to stop, and he stated R2 was his wife and he was helping her. CNA M stated R2 was not reacting negatively to the situation and appeared to behave as she always did. She stated R1 refused to leave the room at first. She stated she told R1 she had to take R2 to the bathroom and R1 sat in a chair in R2's room. She stated when she came out of the bathroom, R1 was no longer in the room. She stated she reported it to a CMA and they told the nurse, and it was reported up the chain. She stated staff cannot force R1 out of other residents' rooms and if they try to make him leave, he gets agitated. CNA M stated she has worked with these residents since the incident and R2 has not shown any signs of distress or behavioral changes that she has observed. CNA M stated R1 still goes into other residents' rooms and if staff tell him to leave R1 will state that it is his room and that he has been there for 10 years. She stated he would get agitated and angry so the nurse will usually tell staff to leave him alone and let him stay in the room, as he will come out by himself. She stated so that is what they do. She stated if he is observed trying to go into other rooms or heading	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 6 toward R2's room, she will try to guide him back to his room. She stated R1 sometimes tried to physically help other residents and there have been times he thought other residents were his wife. CNA M stated R1 wanders a lot, has tried to get off the unit, and would kick the doors to escape. She stated he did this prior to the incident and still does it. CNA M stated the only intervention she knew of was the 15-minute checks were added. She stated she did not know if there was something else planned for R1 as far as interventions. She stated staff do check on him more frequently. She stated sometimes R2 will stand up, look at R1 and head to her room. She stated R1 will stand up and follow her. She stated staff called out and tried to guide him to his room. She stated R1 an R2 used to do that a lot but now only do it once in a while. On 05/20/26 at 02:07 PM, Licensed Nurse (LN) G stated R1 wanders a lot. She stated when he wanders, other residents tend to follow him because they also want to leave. She stated, in reference to the note she documented on 04/27/26 at 04:20 PM, R1 was wandering the halls and had gone into a room that was not his, came out, and then went into another room that was not his. She stated CNA N came and told her to come down the hall to the room they were in. She stated when she entered the room R3 was lying in the bed, and CNA N was between the residents. She stated the room did not belong to R3 either but R3 was in bed. She stated the residents that these rooms belonged to were not in the rooms at the time. She stated R3 entered the room then R1 entered after her. She stated she believed the residents were trying to find a way out of the unit. She stated CNA N told her she found R1 hovering over R3 while she was in the bed. She stated she did not observe that when she entered the room as CNA N was already between them. LN G stated R3's room is right across from R1's room, and when he leaves his room, he often goes right into her room. She stated she did not know if R1 realized it was her room or not. She stated she does not know if R1 knew enough to know which room belongs to which resident. She stated she was only speculating. She stated staff keep an eye on R1 and redirect him as needed. On 05/20/26 at 02:21 PM, LN H stated she worked with R1 while he was on 15-minute checks she worked the memory care unit frequently. She stated R1 wandered prior to the incident between him and R2. She stated R1 frequently goes into other resident rooms as he never really knows where his room	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	**17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 7 was. She stated they have cameras at the nurse's station and if she saw R1 go into another resident room she would get up and redirect him. She stated any staff in the hall would redirect him if they saw R1 go into another resident room. LN H stated she knew of one other time R1 tried to go into R2's room. She stated she saw R1 head that direction and she got up to follow him down there. She stated by the time she got down there R1 was in the foyer and had not made it all the way into R2's room. She stated she noticed R2 did not come out of her room and join activities as much for three days after the incident between the two of them. She stated she was not sure if it was related to the incident or not as R2s family spent more time with her via FaceTime and in person during that period. She stated R2 has been out to activities and has been at her baseline since. She stated with R1 staff were doing what they always did without the 15-minute checks. She stated staff just observe R1, and if he was not in a common area or if staff saw him wandering, someone would check to see where he was going. On 05/20/26 at 03:20 PM, CNA N stated she worked full time and was familiar with the residents on the memory care unit. She stated R3 was following R1 on 04/27/26. She stated when she walked into the room R1 was hovering over R3 while R3 was in the bed. She stated they were fully clothed. She stated R3 was lying in the bed somehow. She sated R3 does not ambulate well, R3 can sit down but cannot lay herself down. She stated she did not know how R3 got laid down in the as R3 did not have the strength to swing her legs up into the bed to lay down. She stated she thought R1 my have put R3 in the bed, but that was only an assumption since R3 could not do it on her own. She stated she did not witness any touching, only that she saw R1 hovering over R3 when she entered the room. She stated R1 tried finding a way out of the facility and R3 was going with him. She stated R1 kept saying they were going to get out together. CNA N stated R1 had a lot of agitation to leave the unit. She stated exit seeking was normally for R1 prior to the incident between R1 and R2 and R1 frequently tired to get into other resident rooms. She stated R1 constantly tired to find a way out. She stated when R1 wanders and exit seeks, other residents will follow him at times. She stated R3 had tried to exit seek on her own, but it was not as frequent. She stated R1's wandering has riled up other residents and they would exit seek more often when he did and they would follow each other. She stated she did not believe R1 focused more on the female residents. She stated she was not aware of any other interventions for R1.	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 8 She state they had him on 15 minute checks previously. She stated staff always try to watch R1 and redirect him as needed. She stated it was a dementia unit and it was hard for staff to stop resident behaviors. She stated even if they closed the doors R1 would open them. She stated staff were basically just watching R1 and redirecting as needed. On 05/20/26 at 04:08 PM, Administrative Nurse D stated the facility provider assessed R1 the day following the incident between R1 and R2. She stated the provider ordered labs and they put R1 on 15-minute checks. She stated the 15-minute checks were discontinued on 05/06/26 as R1 had not tried to go into other resident rooms and did not have any further physical contact with other residents. She stated R1 did wander a lot and did occasionally go into other resident rooms. She stated R1 was not difficult to redirect. She stated staff kept an eye on him to make sure he was not going into other residents' rooms. She stated other than that there has been no real medication changes or anything. Administrative Nurse D stated there were no other specific interventions. She stated since admission R1 has slowed down some on the exit seeking. She stated he still does it but not as much as when he first arrived. She stated R1 was being followed by a psych provider, and they were aware of the incident between R1 and R2. She stated there was nothing added specifically due to the incident as the psych provider was seeing R1 more for his physical behaviors and agitation. She stated R1 was really trying to get out of the facility. She stated she was unaware of the incident where R1 was hovering over R3 while she was in bed. She stated she was told about an incident where R1 tried to help transfer another resident, but not him hovering. She stated there was no specific all staff education done related to the incident. She stated staff responded appropriately to the situation. She stated they discussed the expectation for staff to watch R1 more closely, but they did not do ANE with staff due to the incident. On 05/20/26 at 04:34 PM, Administrative Staff A stated they had the 15-minute checks to make sure R1 was not exhibiting similar behaviors toward anyone else. He stated R1 was not so there was not a need to continue them. Administrative Staff A stated R1 has wandered into other resident rooms, and it was common behavior for people on that unit. He stated he felt like staff responded appropriately to the incident between R1 and R2. He stated staff	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET , OLATHE, Kansas, 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) COMPLETION DATE
F0744 SS = D	Continued from page 9 followed policy and procedures at the time. He stated they intervened, reported it and did everything they should have. Administrative Staff A stated R1's aggression has kind of subsided compared to when he first arrived in the facility. He stated the expectation for staff was to redirect R1 out of other residents' rooms and not allow him to stay in them. The facility's "Hazardous Wandering and Elopement (Unwitnessed Exit)" policy with a revised date of 04/06/26, documented Definition of wanderer: Aimless or purposeful motor activity that causes a social problem such as getting lost, leaving a safe environment, or intruding in inappropriate places. To minimize risks associated with wandering is to identify wandering-prone individuals on admission. Residents who display wandering behavior after admission to the community will be assessed and appropriate interventions included immediately in the Health Service Plan or Negotiated Service Agreement or Care Plan. Individualized reassessments, evaluations and individualized interventions will be ongoing, as appropriate for the residents.	F0744		