

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF OLATHE SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 751 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 citations represent the findings of a resurvey with a complaint 197955 at the above named Assisted Living conducted on 08/04/26.	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: KAR 26-41-204(i) The facility reported a census of 37 residents with three residents included in the sample. Based on observation, interview, and record review the facility failed to ensure designated staff completed an assessment for Resident (R)102 to safely use his bed assist device (transfer pole) for transfers. Findings included: - Record review for R102 revealed an admission date of 05/23/25 with a diagnosis of dizziness. The 03/31/26 "Functional Capacity Screen" (FCS) identified R102 required staff supervision with transfers. The 03/31/26 "Negotiated Service Agreement" (NSA) identified R102 required supervision with transfers but did not mention the use of a transfer	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: N046038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/04/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF OLATHE SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 751 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
S3171	Continued From page 1 pole. There was no subsequent addendum to the NSA to address the use of a transfer pole. Review of R102's medical record revealed that it lacked evidence of documentation of a bed assist device assessment for the use of a transfer pole. Observation on 08/04/26 at approximately 02:00 PM revealed a transfer pole was appropriately installed next to R102's bed. On 08/04/26 at approximately 02:00 PM, R102 stated the transfer pole was recently installed in his room. On 08/04/26 at 02:44 PM Licensed Nurse (LN) B stated R102's family recently ordered a transfer pole, and maintenance staff installed it for him. LN B stated she did not complete an assessment for R102 to use the transfer pole. The facility failed to ensure designated staff completed an assessment for R102 to confirm he was able to safely use his bed assist device for transfers.	S3171			
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall	S3211			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF OLATHE SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 751 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
S3211	Continued From page 2 place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (3) The facility reported a census of 37 residents. Based on observation and interview, the facility failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications. Findings included: - Observation on 08/04/26 at 09:32 AM of the "Three-hundred hall" medication cart revealed the following OTC medications not labeled with the full name of the resident: One bottle of Spring Valley B12 (supplement) One bottle of Amazon Basics prebiotic and probiotic (supplement) One bottle of Rugby Melatonin three milligrams (supplement) One bottle of TUMS (antacid) Observation on 08/04/26 at 09:41 AM of the "One-hundred/Two-hundred hall" medication cart revealed the following OTC medications not labelled with the full name of the resident: One bottle of AZO Cranberry (supplement) On 08/04/26 at 09:40 AM Certified Medication	S3211		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF OLATHE SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 751 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
S3211	Continued From page 3 Aide (CMA) C stated when a family member brought in OTC medications the bottles went to the nurse to check and the full name of the resident should be placed on the bottle. On 08/04/26 at approximately 02:00 PM Administrative Staff A stated the facility did not have a specific policy for OTC medication labeling but followed state regulations on the matter. The facility failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		