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	N046109	A. BUILDING: _____ B. WING _____	C 10/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CRESTONE SENIOR LIVING	21810 W. 119TH STREET 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 represents the findings of a resurvey with attached complaint 196680, 196967, 197111, 199802, and 199850 at the above-named assisted living facility conducted on 09/30/26 and 10/05/26. The facility reported a census of 66 residents with five included in the sample.	S 000		
S3060 SS=F	26-41-106 Community Governance (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the facilitation of the organization of at least one resident council, each of which shall meet at least quarterly to provide residents with a forum to provide input into community governance. (b) Each administrator or operator shall ensure the accommodation of the council process by providing space for the meetings, posting notices of the meetings, and assisting residents who wish to attend the meetings. (c) In order to permit a free exchange of ideas and concerns, each administrator or operator shall ensure that all meetings are conducted without the presence of facility staff, unless allowed by the residents. (d) Each administrator or operator shall respond to each written idea and concern received from the council, in writing, within 30 days after the meeting at which the written ideas and concerns were collected. The administrator or operator shall ensure that a copy of each written idea or concern and each response is available to surveyors. This REQUIREMENT is not met as evidenced by: KAR 26-41-106(a)	S3060		

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

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S3060	Continued From page 1 Based on interview and record review the facility failed to ensure the facilitation of quarterly resident council with a forum to ensure input into community governance. Findings included: - During entrance interview on 09/30/26, Administrative Staff A stated there is "no official resident council." On 09/30/26 at approximately 10:55 AM Administrative Staff A confirmed no meetings have been held for community governance. The facility failed to ensure the facilitation of quarterly resident council with a forum to ensure input into community governance.	S3060		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) Based on interview and record review the facility failed to ensure that each individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreements for	S3101		

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S3101	Continued From page 2 Resident (R) 2 and R3. Findings included: - Record review for R2 revealed an admission date of 07/20/26 with a diagnosis of atrial fibrillation. The 07/28/26 Functional Capacity Screen (FCS) FCS identified R2 required physical assistance with bathing, dressing, mobility, and management of medications. She was at risk of falls and had impaired vision and hearing. The 07/28/26 combined NSA and Healthcare Service Plan (HSP) indicated staff managed medications, provided partial assistance with dressing, and provided clutter free walkways to prevent falls; hospice provided bathing service. The NSA/HSP indicated the resident and her daughter participated in the development of the document and failed to include signatures of the those individuals. An NSA/HSP signed by all individuals involved in the development was requested on 10/05/26 at 10:50 AM which the facility failed to provide. - Record review for R3 revealed an admission date of 05/30/25 with a diagnosis of hypertension. The 08/10/26 FCS identified R3 was independent with bathing, dressing, toileting, transfers, mobility, eating, and management of medications. She was at risk of falls and had impaired vision. The 08/10/26 NSA/HSP indicated R3 would establish a routine in the community and had an apartment with a fall indicator in place to prevent falls. The NSA/HSP indicated the resident	S3101		

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S3101	Continued From page 3 participated in the establishment of the NSA/HSP and failed to include her signature. On 10/05/26 at approximately 01:44 PM Administrative Nurse B confirmed R2 and R3's NSAs lacked signature pages including all those involved in the development of the agreements. A policy regarding NSAs or HSPs was requested on 10/05/26 at 02:30 PM which the facility failed to provide. The facility failed to ensure that each individual involved in the development of the NSA signed the agreements for R2 and R3.	S3101		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) Based on record review and interview, the facility failed to ensure the Negotiated Service Agreement (NSA) for Residents (R) 2 and R3 named the licensed nurse responsible for implementing and supervising their Healthcare Service Plans (HSPs). Findings included:	S3165		

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S3165	Continued From page 4 - Record review for R2 revealed an admission date of 07/20/26 with a diagnosis of atrial fibrillation. The 07/28/26 Functional Capacity Screen (FCS) FCS identified R2 required physical assistance with bathing, dressing, mobility, and management of medications. She was at risk of falls and had impaired vision and hearing. The 07/28/26 combined NSA/HSP listed Administrative Nurse J as the licensed nurse responsible for supervising the HSP. - Record review for R3 revealed an admission date of 05/30/25 with a diagnosis of hypertension. The 08/10/26 FCS identified R3 was independent with bathing, dressing, toileting, transfers, mobility, eating, and management of medications. She was at risk of falls and had impaired vision. The 08/10/26 NSA/HSP for R3 listed Administrative Nurse J as licensed nurse responsible for implementing and supervising the HSP. During entrance interview on 09/30/26 at 11:12 AM Administrative Staff A stated Administrative Nurse B was responsible for completing and supervising all resident FCSs, NSAs, and HSPs. On 10/05/26 at approximately 12:02 PM Administrative Nurse B confirmed that she had not revised the NSAs for all residents to list her as the nurse responsible and Administrative Nurse J no longer worked for the facility. A policy regarding NSAs was requested on 10/05/26 at 02:30 PM which the facility failed to	S3165		

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S3165	Continued From page 5 provide. The facility failed to ensure R2 and R3's NSAs named the licensed nurse responsible for implementing and supervising their HSPs.	S3165		
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 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	S3215		

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S3215	Continued From page 6 expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) Based on observation and interview, the facility failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations. Findings included: - Record review for R2 revealed an admission date of 07/20/26 with the following diagnoses: vitamin D deficiency, hypertension, and atrial fibrillation. The 07/28/26 Functional Capacity Screen (FCS) identified R2 required physical assistance with management of medications. The 07/28/26 "Comprehensive Resident Evaluation" which indicated it was the facility's combined Negotiated Service Agreement (NSA) and Healthcare Service Plan (HSP). The NSA/HSP identified facility staff ordered, prepared, and administered medications. Observation on 10/05/26 at 01:25 PM of R1's bathroom revealed the following medications: One bottle acetaminophen 650 (milligrams) mg, 100 caplets One bottle calamine lotion Two boxes lidocaine 4% patches, 6 patches One bottle adult multivitamin, 160 gummies One bottle magnesium 200 mg, 90 gummies	S3215		

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S3215	Continued From page 7 One bottle vitamin D3 2000 international units, 150 gummies One bottle B 12 3,000 mcg, 90 gummies One bottle calcium 600 mg, 150 softgels One 6.1 ounce container Metamucil One bottle calcium carbonate 1000 mg, 72 chewable tablets One box Systane lubricant eye drops, 3 bottles 10 milliliter each On 10/05/26 at 01:25 PM Certified Medication Aide D confirmed staff administered R1's medications and R1 should not have medications in her bathroom. - Observation on 09/30/26 at 11:21 AM revealed the medication room had a refrigerator with an opened box that contained an unsealed vial of Tubersol. The vial lacked a date to indicate when it was opened. The box and the vial of Tuberculin read to discard 30 days after opening. On 09/30/26 at approximately 11:33 AM Administrative Staff A confirmed the Tubersol vial was opened and not dated. The facility's 03/17/26 "Medications" policy and procedure stated medications were stored in a locked area, failing to indicate who would have access to the locked medications. The policy further instructed staff to store medications in accordance to labeled instructions. The facility failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations.	S3215		

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S3280	Continued From page 8	S3280		
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: (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: KAR 26-41-104(d)(3)(4) Based on record review and interview, the facility failed to ensure disaster and emergency preparedness by ensuring quarterly review of the facility's emergency management plan with all staff and residents and the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location. Findings included: - Quarterly reviews of the facility's Emergency	S3280		

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S3280	Continued From page 9 Management Plan with all residents and staff were requested verbally and via email on 09/30/26 at 10:53 AM. The facility failed to provide quarterly reviews with residents since the last survey. Review of in-service logs for staff revealed the following reviews of the emergency management plan: The unsigned and undated "July 2025" "In-Service Record" revealed the facility reviewed emergency policies and procedures. On 10/03/25, the facility reviewed elopement drills. On 01/09/26, the facility completed a disaster drill walk through and discussed winter weather. On 03/06/26, the facility failed to review any part of the emergency management plan. On 07/10/26, the facility reviewed emergency policies and procedures. On 09/11/26, the facility reviewed "topic points for fire drills." The facility failed to review the entire emergency management plan for the fourth quarter of 2025, and the first and second quarters of 2026. On 09/30/26 at 01:44 PM Administrator A confirmed the in-services each quarter did not cover the entire emergency management plan. The facility failed to provide documentation an annual emergency drill was conducted since last survey including all residents, and the minimum number of staff on duty at one time that included an evacuation of all residents to a secure location. Interview on 09/30/26 at 01:44 PM with	S3280		

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S3280	Continued From page 10 Administrator A confirmed she was unable to locate an annual emergency drill completed in 2025, one had not been completed yet in 2026, the next was scheduled for October of 2026. The facility's "TRAINING FOR A POTENTIAL EMERGENCY Orientation and Training Guide" indicated all new employees were to be trained responsibilities during emergencies. The guide had a section for local training requirements when more stringent requirements were needed and failed to indicate continued training to be quarterly for all staff members. The facility failed to ensure disaster and emergency preparedness by ensuring quarterly review of the facility's emergency management plan with all staff and residents and an annual evacuation drill of all residents to a secure location.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be	S3298		

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S3298	Continued From page 11 required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (d) The facility had a main kitchen where food was stored and prepared for all residents with a satellite kitchen in memory care for serving to memory care residents. Based on interview and record review the facility failed to ensure food was served at the proper temperature to memory care residents. Findings included: - Review of the food temperature logs for 08/02/26 through 09/25/26 revealed food temperatures were not recorded for 49 of 55 breakfast meals, 29 of 54 lunch meals, and 36 of 54 dinner meals. On 09/30/26 at 11:58 AM Dietary Staff E stated the food is brought from the main kitchen to memory care around 11:30 AM with a plan to start serving at 12:00 PM therefore the expectation was to take temperature again prior to serving. On 09/30/26 at approximately 12:05 PM Administrative Staff A confirmed the food temperature logs were not completed for each meal. Dietary guidelines for Americans 2005 recommended using a clean thermometer that measured the internal temperature of cooked	S3298		

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S3298	Continued From page 12 food to make sure food is cooked to and held at proper temperatures and to keep food out of the "danger zone" (40 degrees Fahrenheit to 140 degrees Fahrenheit) where bacteria can multiply rapidly. A policy regarding taking food temperatures was requested which the facility failed to provide. The facility failed to ensure food was served at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (e) The facility had a main kitchen where food was stored and prepared for all residents with a satellite kitchen in memory care for serving to memory care residents. Based on observation and policy review the facility failed to ensure food items were stored under safe conditions. Findings included: - Observation on 09/30/26 at 11:58 AM in the memory care kitchen revealed one one-pound bag marshmallows and one two-pound bag of	S3299		

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S3299	Continued From page 13 light brown sugar unsealed allowing the food to be exposed to contaminants and pests. On 09/30/26 at approximately 11:59 AM Administrative Staff A confirmed the foods were unsealed. - Observation on 09/30/26 at 02:58 PM in the main kitchen revealed a reach-in refrigerator labeled "kitchen cooler" with the following foods with no date opened or prepared: One 16-ounce squeezable whipped topping One five-pound container cottage cheese One individual serving size container of cheesecake Two to-go containers with salad On 09/30/26 at approximately 03:00 PM Dietary Staff F confirmed the foods lacked dates they were opened or prepared. - Observation on 09/30/26 at approximately 03:15 PM in the main kitchen revealed the kitchen line refrigerator stored the following foods with no label indicating what it was and/or the date opened or prepared: One squeezable container Dietary Staff F called Mayo One five-pound bag of shredded parmesan cheese 13 containers of prepared foods in facility storage containers On 09/30/26 at approximately 03:00 PM Dietary Staff F stated three containers prepared yesterday, the cheeses were two days ago, and the rest were today. He confirmed the foods lacked dates they were opened or prepared.	S3299		

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S3299	Continued From page 14 A policy for food storage was requested on 10/05/26 at 02:30 PM which the facility failed to provide. The facility failed to ensure foods were stored under safe conditions.	S3299		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207 (c) Based on interview and record review the facility failed to ensure compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two residents and three staff. Findings included:	S3310		

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	N046109	A. BUILDING: _____ B. WING _____	C 10/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CRESTONE SENIOR LIVING	21810 W. 119TH STREET 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
S3310	Continued From page 15 - Record review for Resident (R) 1 revealed an admission date of 05/22/26 with a diagnosis of dementia. R1's record lacked evidence of documentation a TB skin test was administered within seven days of residency. - Record review for R2 revealed an admission date of 07/20/26 and diagnosis of atrial fibrillation. The first step of the two-step TB skin test (TST) for R2 was administered on 07/20/26, read 07/22/26, and was negative. R2's record lacked evidence of documentation a second step of the TB skin test was administered. On 10/05/26 at approximately 01:40 PM Administrative Nurse B confirmed R1's TB TST was not administered and R2's second step of TB TST was not administered. - Review of Certified Nurse Aide (CNA) G's employee record revealed a hire date of 09/18/25. Review of CNA G's record revealed an initial step of the TB TST was administered 09/09/26 and second step on 09/25/26. CNA G's record lacked evidence of documentation a TST was administered within seven days of employment. On 09/30/26 at 04:05 PM Administrative Staff A confirmed CNA G's record lacked evidence of documentation TB testing was completed within seven days of employment.	S3310		

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S3310	Continued From page 16 - Review of Certified Medication Aide (CMA) H's employee record revealed a hire date of 04/30/26. CMA H's record lacked documentation a TST was completed within seven days of employment. On 09/30/26 at 04:05 PM Administrative Staff A confirmed CMA H's record lacked evidence of documentation TB testing was completed within seven days of employment. - Review of CMA I's employee record revealed a hire date of 09/10/26. CMA I's record lacked documentation a TST was completed within seven days of employment. On 09/30/26 at 04:05 PM Administrative Staff A confirmed CMA I's record lacked evidence of documentation TB testing was completed within seven days of employment. The facility's 03/17/26 "TB Tracking: Residents" policy indicated an initial TB skin test was to be administered no later than the day of move in and a second step one to three weeks later. The facility's 06/10/26 "TB Tracking: Employee" policy indicated each employee would have an initial TB skin test completed and read prior to working in the facility. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident was to receive a two-step TB skin test within seven days of employment or admission.	S3310		

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S3310	Continued From page 17 The facility failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		
S3400 SS=F	28-39-255 DIETARY AREAS (d) Dietary areas. A dietary area or areas shall provide for sanitary meal preparation or service for residents. (1) The facility shall provide disposal of waste by incineration, mechanical destruction, removal or a combination of these. The facility shall use containers with tightly fitting lids to store waste. (2) Ceilings in the dietary areas shall be cleanable by dustless methods, such as vacuum cleaning or wet cleaning. These areas shall not have exposed or unprotected sewer lines. This REQUIREMENT is not met as evidenced by: KAR 28-39-255(d) Based on observation and interview the facility failed to ensure the dietary area provided for sanitary meal preparation. Findings included: - Observation on 09/30/26 at 02:58 PM of the main kitchen revealed the doors and handles of four refrigerator and freezer units were visibly soiled and sticky to touch. The floor tile and grout had multiple variations in colors indicating layers of grime and debris. A "chef's cleaning" schedule was initialed with a line drawn straight down for	S3400		

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S3400	Continued From page 18 "organizing and cleaning refrigerators" each day for the previous 5 days. Interview on 09/30/26 at approximately 03:15 PM of Administrative Staff A confirmed the dietary area was not sanitary. The facility failed to ensure the dietary area provided for sanitary meal preparation.	S3400		