STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175551	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Olathe	21250 West 151st Street Olathe, KS 66061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834 The facility identified a census of 69 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1 remained free from neglect. On 07/22/24, R1, who was cognitively intact but diabetic (individual with a chronic disease that results in too much glucose in the blood), legally blind, and had bilateral lower extremity amputations (surgical removal of a limb), wheeled himself outside around 08:00 PM without letting staff know and without his cell phone. R1 tipped over in his wheelchair and was unable to get up or contact staff for assistance. R1 laid on the ground and called out for staff to assist him though no one came to help. R1 remained outside on the ground from around 08:00 PM on 07/22/24 until early the next morning. On the morning of 07/23/24, another resident's family member observed R1 on the ground outside, alerted the staff, and the staff then went outside and assisted R1 back inside. The facility neglected to provide the standard of care and follow R1's Care Plan to check on R1 overnight every two to three hours. As a result, R1 laid outside in the tall grass on the ground overnight, for at least 10 hours while the weather ranged from 77 degrees Fahrenheit (F) to 65 degrees F . The facility's neglect in providing the necessary care for R1, placed R1 in immediate jeopardy. Findings Included: - R1's Electronic Medical Record (EMR) documented diagnosis of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), absence of right leg below knee, absence of left leg above knee, legal blindness, neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), visuospatial deficit (difficulties with processing information about 3D objects, which can affect a person's spatial awareness and ability to judge distances), a need for assistance with personal care, and weakness. (continued on next page)

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 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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 used a wheelchair and had limb prosthesis (artificial body part). The MDS further documented R1 as independent for oral, personal, and toileting hygiene, and changing from lying to seated position on side of the bed. The MDS document R1 required set up or clean up assistance for eating, upper body dressing, change from a sit to lying position, and chair to bed, or bed to chair transfers. The MDS documented R1 required substantial, maximal assistance for bathing, lower body dressing, and shower or tub transfers. The ADL [Activities of Daily Living] Functional / Rehabilitation Potential Care Area Assessment (CAA), dated 09/23/23, documented R1 needed help with ADL and mobility. The CAA documented contributing factors of neuromuscular dysfunction of bladder, right below knee amputation, and left above knee amputation. Risk factors that impacted ADLs were legal blindness, balance deficits during transfers, and potential for further decline in ADLS and mobility. The Visual Function CAA dated 09/23/23, documented R1 was legally blind, had diabetes mellitus with retinopathy (noninflammatory disorders that damage the retina, the light-sensitive tissue at the back of the eye that senses light) and cerebrovascular accident (stroke) with left side vision loss. R1's Care Plan with an initiated date of 09/16/22, documented R1 had an ADL self-care performance deficit. R1's Care Plan with an initiated date of 10/12/22, documented R1 had impaired visual function related to legal blindness, diabetes mellitus with and cerebrovascular accident with left side vision loss and neglect. An intervention with an initiated date of 10/12/22 directed staff to arrange items in R1's room in order to promote independence. An intervention with an initiated date of 11/17/22, documented R1 used an assistive device, right bed assist bar, and staff were to reposition and turn in bed. R1's Care Plan with an initiated date of 10/12/22 documented R1 had bowel and bladder incontinence related to mobility impairment and neuromuscular dysfunction of bowel and bladder. R1's Care Plan intervention with an initiated date of 10/12/22 (revised and resolved date on 08/02/24, after the incident) documented R1 was incontinent and directed staff to check as required for incontinence. An intervention with an initiated date of 09/12/23 (revised and resolved on 08/02/24) directed staff to offer upon R1 rising, before and after meals, at bedtime, and every two to three hours as needed. R1's Care Plan lacked interventions related to R1's ability to go outside without staff assistance or supervision until after the occurrence. The plan was updated on 07/23/24 to direct the resident should have his cell phone on him when he goes outside. An Encounter note dated 07/23/24 documented R1 exited the building during the previous evening and went with his wheelchair off the sidewalk into a field next to the building. The note documented R1 was blind, got lost and turned around, and R1's wheelchair tipped backwards into the long grass. The note documented R1 was unable to get himself off the ground and was outside of the building overnight. The note further documented the morning of 07/23/24, R1 was seen in the field and brought inside. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing note dated 07/23/24 documented a witness saw R1 as he sat outside by his wheelchair around 06:30 AM. The note documented day shift staff approached R1 as he sat next to his wheelchair, and R1 was alert, oriented and he stated he had gone outside for fresh air and went off the sidewalk path. The note further documented R1 stated his wheelchair started to tip backwards slowly and he landed on his backside. A Nursing note dated 07/23/24 documented a witness found R1 outside in the grass with his wheelchair behind him and a nurse and two Certified Nurse Aides (CNA) assisted R1 from the ground to his wheelchair and brought him back inside. The note documented R1 stated he went outside to get fresh air, got turned around, and got lost. The note further documented R1 stated while he attempted to find his way back, his wheelchair slowly fell backwards, and he fell on to the ground. An Encounter note dated 07/30/24 documented R1 sustained a fall during the previous week in the middle of the night, from his wheelchair. The note documented R1 was outside the building overnight. An untitled document, provided by the facility, documented the dates and times R1 accessed the facility doors and elevators. The document noted R1 accessed the main entrance on 07/22/24 at 08:15 PM. The document lacked evidence of R1 accessed any facility doors after 08:15 PM. An untitled document provided by the facility recorded a timeline of events related to R1 on 07/22/24. The document recorded the following: 07/22/24 at 07:27 PM R1 depressed his call light. 07/22/24 at 07:30 PM staff answered and silenced the call light. 07/22/24 at 08:15 PM R1 punched his room number at the front door keypad to exit the building. 07/22/24 at 08:16 PM Licensed Nurse (LN) I saw resident outside in front of the building, LN I approached R1 and let him know the clouds were dark and it may rain. The document recorded R1 stated he wanted to catch a breath of fresh air and then he would be back in. LN I approached R1's nurse on duty, LN G, and let her know R1 was out front. LN G stated R1 was fine to be outside by himself, as he always did that, and he would be alright. 07/23/24 at 06:30 AM a visiting family member alerted staff that there was someone outside sitting in the grass next to his wheelchair. 07/23/24 at 06:30 AM staff exited the building and went to where R1 was at. The documented recorded at that time R1 stated he got off his normal path, then it got too dark, and he could not see anything. R1 stated his wheelchair got stuck and he tried to get it unstuck and it slowly tipped backwards, and he landed on his back in the tall grass. The document further recorded R1 stated he did not lose consciousness at any point. R1 stated he did not normally go out after dark and stated it was later than he usually went out. R1 stated he wheeled around the building and tried to find the door but was unable to. The documented recorded R1 stated he did not take his cellphone with him and that he usually took it out with him. R1 denied pain. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	07/23/24 at 06:35 AM R1 was brought into the building and taken to his room where he was transferred into bed and a nurse assessed R1's skin. R1's skin was intact with a slight rash to his backside. The document recorded R1 did not have any pain or itching to the rash and R1 thought it was due to the grass. 07/23/24 at 06:57 AM R1 depressed call light and staff responded and silenced call light at 07:01 AM. 07/23/24 at 07:00 AM the nurse practitioner was onsite and assessed the resident and new orders were obtained. 07/23/24 at 08:49 AM the lab company arrived to draw stat (immediate) labs. 07/23/24 at 09:24 AM the lab results finalized in their computer. 07/23/24 at 12:30 PM an order was received to start intravenous (IV-administered directly into the blood stream via a vein) fluids times one bag total . LN I's untitled, undated, statement documented that on 07/22/24 at around 08:15 PM, LN I heard the front door alarm going off. LN I went and found R1 had opened the doors to get outside and the doors had not closed properly, which set the alarm off. The document recorded R1 sat in his wheelchair right outside the main doors. LN I asked R1 if he was okay to be out there, and R1 responded he was okay, he wanted some fresh air, and he would be back in after a while. LN I documented he went and asked R1's nurse if R1 was okay to be out there, and R1's nurse verbalized that R1 was okay adding that R1 always went out and came back. LN G's untitled statement provided by the facility, dated 07/23/24, documented LN G gave R1 his medications and insulin (hormone used to lower blood glucose levels) at approximately 07:00 PM. LN G documented she saw R1 about 08:30 PM to 09:00 PM going down the hallway. The statement further documented shortly after, LN I asked LN G if R1 was okay to be outside and LN G told LN I Yes and that R1 sometimes went outside for fresh air. The statement further documented CNA M told LN G she gave R1 some Sprite and ice at about 12:30 AM. The statement documented R1 normally slept through with one to two bathroom stops and put his call light on for assistance back to his bed from the toilet. The statement further documented LN G reported she spoke with R1 and R1 told her he went outside a second time without letting anyone know. CNA M's untitled statement, provided by the facility and dated 07/23/24, documented CNA M saw R1 around 08:30 PM or 09:00 PM in a hallway. CNA M documented LN I came and asked LN G if it was okay to let R1 outside. The statement further documented R1 asked CNA M for a diet Shasta and ice and the statement recorded CNA M gave them to R1 around 12:30 AM. The statement documented R1 usually put on his call light when he needed something, or when he needed help in the bathroom. The statement further documented R1 went back out without saying anything to staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LN H's untitled statement, provided by the facility and dated 07/23/24, documented that around 06:30 AM, LN H was notified R1 was found outside. LN H documented she assessed R1's skin, assessed his vital signs and blood glucose, and R1 denied any pain or discomfort. The statement further documented R1 stated he went outside at 10:00 PM on 07/22/24 and fell backwards out of their wheelchair. The statement documented R1 denied he hit his head, R1 was alert and oriented, had no new skin issues and his range of motion was within normal limits. Staff initiated neurological checks and the nurse practitioner was onsite and assessed R1. Certified Medication Aide (CMA) R's untitled statement, provided by the facility and dated 07/23/24, documented night shift was giving report when another resident's daughter-in -law came out into the hallway to notify staff that there was a resident in the field next to his wheelchair. CMA R documented CNA M, and LN G ran out the dining room door and found R1 on the far corner of the field as he sat next to his wheelchair and yelled for help. The statement further documented as staff approached R1, they asked if he was okay and how long he had sat outside. R1 stated he was okay and said he wanted to get back inside. CMA R documented staff transferred R1 into his wheelchair and brought him back inside and then a nurse began to assess him. According to Wunderground.com the temperature at 08:00 PM on 07/22/24 was 77 degrees F. and the temperatures dropped to a low of 65 degrees F. at 06:00 AM on 07/23/24. On 08/19/24 at 12:04 PM R1 sat on a bed in his room. He had a right leg below the knee amputation and left leg above the knee amputation. R1 stated that he was unable to see out of his right eye and was only able to see about 10 feet in front of him out of his left eye as long as there was light. R1 stated if the area was too dark, he would be unable to see anything at all. R1 stated that he went outside, through the main door, around 08:00 PM on 07/22/24. R1 stated he liked to go out around sunset to relax and said that he believed the staff were unaware he went outside initially. R1 stated he did not intend to be outside for long; however, as it got dark, he found it difficult to see. He became disoriented and was unable to find his way back to the main entrance to the facility. R1 further stated he managed to stay on the sidewalk for part of the evening and propelled himself up and down the sidewalk yelling for help as he searched for a way back inside. R1 stated he expected someone to come look for him eventually, but no one did. R1 stated as the night went on, one of the wheels on his wheelchair went off the edge of the sidewalk. He stated he attempted to use his one prosthetic leg to push himself back onto the sidewalk; however, his wheelchair went backwards off the sidewalk, and he ended up tipping over, on his back, in a small field on the left side of the building. R1 stated he laid on his back, in the tall grass, and was unable to get himself off the ground and back into his wheelchair. R1 further stated that he was scared and believed it may have been over for him as he laid on the ground. He stated he was unsure where he was and was not sure anyone would ever find him. R1 stated he was also afraid that his blood glucose may drop overnight, due to his diabetes, and that he may not have made it if someone did not find him. R1 stated he did not have his cell phone with him at that time and was unable to call the facility for help. R1 stated staff found him in the early morning and that he had been outside all evening. He stated CMA R was the staff member that found him; however, he stated there were other staff that came out to assist. R1 stated one of the staff members asked him what time he had gone outside, and after he told them, he heard one of the staff stated, you have been outside for almost 12 hours. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/19/24 at 12:54 PM Administrative Nurse D stated if a resident was care planned for scheduled checks, such as a check and change for incontinence, then the expectation was that staff would check the resident and pass that information on to other staff. Administrative Nurse D stated he did not believe there was documentation of when staff checked on the residents; however, the expectation was that information would have been passed on verbally during report. On 08/19/24 at 03:24 PM CMA R stated she was one of the staff that found the resident outside. CMA R stated she was in report and another resident's family member told staff a resident was outside on the ground in the grass. CMA R stated she went outside with the two-night shift staff, LN G and CNA M, to get R1 and found him in the small field, on the left side of the facility, near the base of a small hill in the tall grass. CMA R stated the resident was facing the toward the street and was hollering for help. She stated R1 was a little confused at the time and that R1 stated it was too dark for him to see during the night and he got turned around and went down the hill near the sidewalk before he tipped over into the grass. CMA R stated facility administration viewed the camera footage and R1 had gone outside around 08:00 PM the night before and had not come back inside. CMA R stated the grassy area was bumpy and she did not believe the resident could have got back into his wheelchair or made it back to the facility on his own once he went out into the grass. CMA R stated LN H held the door open for staff to bring R1 back into the facility but did not go out to assist that morning. CMA R stated LN G and CNA M were the two staff that worked during the night shift with R1 and were let go due to the incident. CMA R stated she believed R1 was likely scared out there all night and staff would sometimes see coyotes or other animals out in that field during the early morning hours. On 08/19/24 at 03:46 PM LN H was unavailable for interview. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/19/24 at 04:04 PM Administrative Staff A stated she got a call at 07:00 AM, the morning R1 was found, informing her the resident was outside. Administrative Staff A stated her understanding was R1 had lowered his wheelchair to the ground outside and he was spotted through a window waving to staff. Administrative Staff A stated the previous Director of Nursing (DON) spoke to LN G and CNA M about the incident and the two staff no longer worked at the facility. Administrative Staff A stated at first, staff believed R1 went out that morning and lowered himself to the ground during the early morning hours; however, she stated after the facility completed a full investigation, and spoke with R1, they realized R1 was outside overnight. Administrative Staff A stated the facility staff reviewed video footage and saw R1 had went out that evening and used his own code to exit the building through the main entrance. Administrative Staff A further stated the facility did not report the incident as neglect due to the resident had a BIMS of 15, R1 wanted to go outside, it was his right to go outside and R1 did not suffer any injuries. She further stated LN G and CNA M reported that they had checked on the resident and brought him things during the night. Administrative Staff A stated the resident does not like people in his space and would use his call light if he wanted or needed something, and that may have been why LN G and CNA M did not check on him during the night. Administrative Staff A stated staff not checking on the resident was not part of the focus, and they were more concerned to find out if R1 had been outside all night. She further stated she believed it was a quick incident at first and it was discussed with the previous DON, and the regionals, and it was decided the facility would not report the incident. Administrative Staff A stated the reasons discussed for not reporting the incident were related to R1's high BIMS score, the fact R1 wanted to go outside and that he did not have any harm. Administrative Staff A stated it was fair to assume if staff would have checked on R1, during the night, they would have known he was not in the building. Administrative Staff A stated LN G and CNA M did tell her they checked on R1 during the night and brought him items he requested; however, the facility realized this was not true after they reviewed video footage and door access records for that evening. The facility's Abuse: Prevention of and Prohibition Against policy with an original date of 11/2017, documented it is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them to the resident that has resulted in or mat result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, anguish, or emotional distress. On 08/19/24 at 06:09 PM, the facility received the Immediate Jeopardy [IJ] Template and was informed that the facility failure to ensure R1 remained free from neglect placed R1 in IJ. (continued on next page)

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