

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/17/2024
NAME OF PROVIDER OR SUPPLIER  The Healthcare Resort of Olathe		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834</b></p> <p>The facility identified a census of 62 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to identify an elopement for Resident (R) 1 as potential neglect and report to the State Agency (SA) as required. This placed R1 at risk for unidentified and ongoing neglect.</p> <p>Findings Included:</p> <p>- R1's Electronic Medical Record (EMR) documented diagnosis of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), altered mental status, dementia (progressive mental disorder characterized by failing memory, confusion), generalized muscle weakness, repeated falls, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and a need for assistance with personal care.</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The MDS documented R1 used a wheelchair and was independently mobile. The MDS further documented R1 was independent for most activities of daily living (ADL). The MDS documented R1 had no wandering behaviors.</p> <p>The Cognitive Loss / Dementia Care Area Assessment (CAA), dated 09/30/23, documented R1 triggered for the Cognitive Loss / Dementia CAA due to a BIMS score of less than 13 and disorganized thinking.</p> <p>The Functional / Rehabilitation Potential CAA, dated 09/30/23, documented R1 had both self-care and mobility deficits. The CAA further documented R1 had problems with balance and cognition. The CAA documented nursing provided ADL, mobility, and transfer assistance for R1.</p> <p>R1's Care Plan with an initiated date of 10/25/21, documented R1 was at risk for impaired cognitive function, dementia, or impaired thought process related to psychotropic (alters mood or thought) drug use and dementia. An intervention with an initiated date of 11/05/21 directed staff to monitor, document and report to the physician (MD) any changes in cognitive function, specifically changes in decision making ability, memory, recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. Interventions with an initiated date of 10/28/21 documented R1 was independent with wheelchair propulsion and required assistance of one staff member for transfers. R1's plan of care did not address elopement potential.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An investigation document provided by the facility titled [R1] Investigation dated 09/11/24 documented a timeline of events related to R1's elopement. The document recorded the following: On 09/11/24 at 07:15 AM to 07:20 AM Certified Nurse Aide (CNA) M entered R1's room and woke her up, ensured R1 had what she needed, and oversaw the transfer from R1's bed to her wheelchair. On 09/11/24 at 07:26 AM facility camera footage revealed R1 left her room and went straight to the northwest exit door, where R1 exited the building. On 09/11/24 at 07:32 AM R1 was seen at the back door with staff as they brought R1 back inside the building. On 09/11/24 at 07:33 AM staff contacted the Assistant Directors of Nursing (ADON) and made them aware. On 09/11/24 at 07:36 AM staff contacted Administrative Nurse D and made him aware. Administrative Nurse D requested a head-to-toe assessment on R1 and a head count of the entire unit. On 09/11/24 at 07:37 AM Administrative Nurse D called Administrative Staff A The investigation document further recorded R1 did make it outside of the building for six minutes. The document recorded when R1 was at the northwest door, R1 did press on the door for 15 seconds before the door released. The door was checked by the Administrative Staff A, Administrative Nurse D, and the maintenance director. The documented further recorded the door alarm was working and functioned properly; however, they all felt as though the door alarm could have been louder to draw more attention to the door being opened.</p> <p>An undated and unnotarized interview with CNA M conducted by Administrative Nurse D and titled [R1] Investigation documented CNA M got R1 up between 07:15 AM and 07:20 AM. CNA M informed R1 it was time for breakfast and supervised R1's transfer from her bed to her wheelchair. CNA M informed R1 she could go to the dining room when she was ready. CNA M then left R1's room between 07:25 AM and 07:30 AM to get the next resident up for the day. CNA M reported they were still helping another resident when they were made aware R1 had left the unit and it had been within five to ten minutes of leaving R1. CNA M reported that he was informed R1 was brought in from the parking lot.</p> <p>Consultant GG's untitled and undated statement, provided by the facility, documented R1 was found in the parking lot around 07:30 AM when Consultant GG pulled into the parking lot that morning. The statement documented R1 appeared okay and reported she had used the back door to get out. Consultant GG documented she took R1 inside.</p> <p>On 09/16/24 at 01:38 PM observation of the facility rear parking lot, and surrounding area, revealed the northwest door opened to a sidewalk with one on and off ramp on the east side of the sidewalk. The area surrounding the sidewalk had a tall curb that connected to the parking lot. The sidewalk near the northwest door was close to the facility's dumpsters. The edges of the rear parking lot had tall curbs that surrounded the entire perimeter. The east side of the parking lot had one entrance and exit for vehicles and connected to a road that ran north and south and had a posted speed limit of 10 miles per hour (mph). The road on the east side of the building connected to a busy road toward the front of the building with two lanes of traffic that ran each direction and posted speeds of 45 miles per hour.</p> <p>On 09/16/24 at 02:22 PM R1 sat in her wheelchair, in her room. R1 had a Wander Guard bracelet to her right wrist.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/17/24 at 12:09 PM in a joint interview with Administrative Staff A and Administrative Nurse D, Administrative Staff A and Administrative Nurse D stated they believe staff may have been complacent in responding to the alarm, and that perhaps they thought someone else would get the alarm as they were busy helping other residents. Administrative Nurse D stated elopements would be reported to the SA on a case-by-case basis. Administrative Nurse D stated he had spoken with the regional staff about the elopement and said if R1 had been at risk for elopement or if there would have been harm or an injury then it would have been reported to the SA. Administrative Nurse D stated it happened so quick; the facility didn't report it. Administrative Nurse D stated they wanted to make sure they got interventions in place and discussed it with the regionals. He further stated the facility made the final decisions on whether it was reported, but took the advice from the regionals, and their advice was no, that it did not need to be reported because of how quick it was and there was no harm. Administrative Nurse D stated the facility was on top of it with interventions and education, and if it would have been a bigger thing then it would have been reported.</p> <p>The facility's Elopement/Unsafe Wandering policy with an original date of 06/2018 documented it is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. The facility will notify the appropriate State Agency in accordance with state requirements: [SPECIFY REQUIREMENTS HERE]. Notification to the appropriate State Agency will be made within twenty-four (24) hours of the serious accident/incident. A narrative summary of each incident/accident will be forwarded to the appropriate State Agency within five (5) days .</p> <p>The facility's Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment policy with an original date of 11/2017, documented in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but: not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury. Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: the administrator, the State Survey Agency, and Adult Protective Services (as appropriate).</p> <p>The facility failed to identify an elopement for R1 as potential neglect and report to the SA as required. This placed R1 at risk for unidentified and ongoing neglect.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47834</p> <p>The facility identified a census of 62 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to provide adequate staff response to door alarms to prevent cognitively impaired and independently mobile Resident (R)1 from eloping from the facility. On 09/11/24 at 07:26 AM R1 pressed the release bar on the northwest emergency exit door for 15 seconds, opened the door, and exited the facility. The door alarm sounded but no staff responded, therefore, staff were unaware R1 exited the facility. R1 wheeled herself down the sidewalk of the rear parking lot. Therapy Consultant GG arrived for work around 07:32 AM and observed R1 outside near the facility dumpsters on the northwest side of the building and alerted facility staff. Staff assisted R1 back inside the facility and assessed for injuries though none were noted. The failure of facility staff to respond to the door alarms in order to ensure R1's safety and prevent cognitively impaired R1 from exiting the facility without staff supervision or knowledge, placed R1 in immediate jeopardy.</p> <p>Findings Included:</p> <p>- R1's Electronic Medical Record (EMR) documented diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), altered mental status, dementia (progressive mental disorder characterized by failing memory, confusion), generalized muscle weakness, repeated falls, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and a need for assistance with personal care.</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The MDS documented R1 used a wheelchair and was independently mobile. The MDS further documented R1 was independent for most activities of daily living (ADL). The MDS documented R1 had no wandering behaviors.</p> <p>The Cognitive Loss / Dementia Care Area Assessment (CAA), dated 09/30/23, documented R1 triggered the CAA due to a BIMS score of less than 13 and disorganized thinking.</p> <p>The ADL Functional / Rehabilitation Potential CAA, dated 09/30/23, documented R1 had both self-care and mobility deficits. The CAA further documented R1 had problems with balance and cognition. The CAA documented nursing provided ADL, mobility, and transfer assistance for R1.</p> <p>R1's Care Plan with an initiated date of 10/25/21, documented R1 was at risk for impaired cognitive function, dementia, or impaired thought process related to psychotropic (alters mood or thought) drug use and dementia. An intervention dated 11/05/21 directed staff to monitor, document, and report to the physician (MD) any changes in cognitive function, specifically changes in decision-making ability, memory, recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. Interventions dated 10/28/21 documented R1 was independent with wheelchair propulsion and required assistance of one staff member for transfers. R1's plan of care did not address elopement potential.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's EMR recorded a Nursing note dated 09/11/24 at 10:00 AM that documented staff placed a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on R1's right wrist.</p> <p>A Social Services note dated 09/11/24 at 10:01 AM documented staff contacted R1's representative to discuss recent exit seeking behaviors. The director of nursing (DON) communicated a Wander Guard was placed on R1. The note documented R1's representative expressed that she had noticed increased a decline in R1's cognition in the last month. The note further documented staff discussed with R1's representative the possibility of exploring memory care facilities if R1's exit seeking behaviors continued.</p> <p>R1's EMR lacked any further documentation related to R1's elopement on 09/11/24.</p> <p>An investigation document provided by the facility titled [R1] Investigation dated 09/11/24 documented a timeline of events related to R1's elopement. The document recorded the following: On 09/11/24 at 07:15 AM to 07:20 AM Certified Nurse Aide (CNA) M entered R1's room and woke her up, ensured R1 had what she needed, and oversaw the transfer from R1's bed to her wheelchair. On 09/11/24 at 07:26 AM facility camera footage revealed R1 left her room and went straight to the northwest exit door, where R1 exited the building. On 09/11/24 at 07:32 AM R1 was seen at the back door with staff as they brought R1 back inside the building. On 09/11/24 at 07:33 AM staff contacted the Assistant Directors of Nursing (ADON) and made them aware. On 09/11/24 at 07:36 AM staff contacted Administrative Nurse D and made him aware. Administrative Nurse D requested a head-to-toe assessment on R1 and a head count of the entire unit. On 09/11/24 at 07:37 AM Administrative Nurse D called Administrative Staff A. The investigation document further recorded R1 did make it outside of the building for six minutes. The document recorded when R1 was at the northwest door, R1 did press on the door for 15 seconds before the door released. The door was checked by the Administrative Staff A, Administrative Nurse D, and the maintenance director. The documented further recorded the door alarm was working and functioned properly; however, they all felt as though the door alarm could have been louder to draw more attention to the door being opened.</p> <p>An electronic communication from Social Services X to Administrative Nurse D and Administrative Staff A dated 09/11/24 at 08:42 AM documented Social Services X reviewed camera footage for 09/11/24 from 07:00 AM to 07:45 AM. The documented recorded R1 wheeled herself to the northwest end of the hallway. R1 then pushed the door open on her own at 07:26 AM and wheeled herself outside. R1 was then brought back in at 07:32 AM via a therapist and nursing staff.</p> <p>An undated and unnotarized interview with CNA M conducted by Administrative Nurse D and titled [R1] Investigation documented CNA M got R1 up between 07:15 AM and 07:20 AM. CNA M informed R1 it was time for breakfast and supervised R1's transfer from her bed to her wheelchair. CNA M informed R1 she could go to the dining room when she was ready. CNA M then left R1's room between 07:25 AM and 07:30 AM to get the next resident up for the day. CNA M reported they were still helping another resident when they were made aware R1 had left the unit and it had been within five to ten minutes of leaving R1. CNA M reported that he was informed R1 was brought in from the parking lot.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An undated and unnotarized interview with Licensed Nurse (LN) G conducted by Administrative Nurse D and titled [R1] Investigation documented LN G was getting medications ready for residents at 07:33 AM when Consultant GG and Certified Medication Aide (CMA) R came up to LN G and stated they found R1 in the rear parking lot and brought her in. LN G reported they asked CNA M when he got R1 up and CNA M reported about 10 minutes before. LN G reported they contacted the ADONs at 07:36 AM and informed Administrative Nurse E that R1 got out of the building. LN G reported they did a head to toe assessment, R1's vitals were in normal limits and no new skin issues were found. LN G reported they checked the door alarm when they were on the phone with Administrative Nurse E and the alarm was working, but the alarm did not go off when R1 got out.</p> <p>Consultant GG's untitled and undated statement, provided by the facility, documented R1 was found in the parking lot around 07:30 AM when Consultant GG pulled into the parking lot that morning. The statement documented R1 appeared okay and reported she had used the back door to get out. Consultant GG documented she took R1 inside.</p> <p>CNA M's untitled statement dated 09/11/24, provided by the facility, documented CNA M woke R1 up and waited for her to sit in her wheelchair at 07:15 AM. CNA M documented he went to assist another resident and staff found R1 outside with Consultant GG.</p> <p>LN G's untitled statement dated 09/11/24, provided by the facility, documented Consultant GG and CMA R approached her with R1. The statement documented Consultant GG stated R1 was found in the back parking lot. CNA M came over and stated that he had gotten R1 up and dressed for the day 10 minutes prior. LN G documented they contacted the ADON and then assessed R1's skin and took R1's vital signs. LN G documented R1 had no new skin issues and R1's vital signs were within normal limits. LN G documented staff performed a head count of residents on the west side.</p> <p>On 09/16/24 at 01:38 PM observation of the facility rear parking lot, and surrounding area, revealed the northwest door opened to a sidewalk with one on and off ramp on the east side of the sidewalk. The area surrounding the sidewalk had a tall curb that connected to the parking lot. The sidewalk near the northwest door was close to the facility's dumpsters. The edges of the rear parking lot had tall curbs that surrounded the entire perimeter. The east side of the parking lot had one entrance and exit for vehicles and connected to a road that ran north and south and had a posted speed limit of 10 miles per hour (mph). The road on the east side of the building connected to a busy road toward the front of the building with two lanes of traffic that ran each direction and posted speeds of 45 miles per hour.</p> <p>On 09/16/24 at 02:22 PM R1 sat in her wheelchair, in her room. R1 had a WanderGuard bracelet to her right wrist .</p> <p>On 09/16/24 at 01:43 PM CNA M stated he got R1 up six to seven minutes prior to R1 being found outside. CNA M stated R1 got out of the back door and he wasn't sure how she got through the door. CNA M stated he thought perhaps staff had taken the trash outside and the door may not have shut all the way, and she may have been able to get out because of that. CNA M stated he heard the door beep one time when R1 went out. CNA M stated he did not hear a door alarm, only the single beep. CNA M stated he believed R1 had only been outside for about 10 minutes at the longest and had no distress when she was brought inside. CNA M stated staff placed a Wander Guard on R1 and checked it daily.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/16/24 at 01:26 PM Consultant GG stated she found R1 around 07:30 AM when she pulled into the parking lot. Consultant GG stated she was not sure of the exact date when she found R1 outside, but stated it was recent and within the last week. Consultant GG stated she asked R1 how she got outside and felt R1's skin and hands to see if R1 was cold. Consultant GG stated R1's hands and skin felt okay and R1 was not cold. Consultant GG stated she took R1 to the back door, knocked on it, and staff opened it to let them inside. Consultant GG stated she reported to the nurse what had happened, and the nurse took R1 and assessed her. Consultant GG stated R1 did not appear to be in distress at the time. On 09/16/24 at 01:38 PM Consultant GG walked out to the rear parking lot and pointed out the area R1 was found in. Consultant GG stated R1 was found in a section of the rear parking lot, on the northwest side of the building, near the facility's dumpsters. Consultant GG stated R1 had made it down from the sidewalk and into the actual parking lot when she found R1.</p> <p>On 09/17/24 at 01:25 PM CNA N stated staff can hear the door alarms on either end of the hallway even if they are on the opposite end of the hallway. CNA N stated all staff are supposed to respond to the doors when the alarms are going off. CNA N stated the facility recently provided door alarm and elopement education for staff.</p> <p>On 09/17/24 at 01:18 PM LN H stated there were no issues with the door alarms that she was aware of. LN H stated the door alarms could be heard at either end of the hallway, even if staff stood at the end of the opposite hall from where the alarm was sounding. LN H stated if a resident exhibited exit seeking behavior staff would notify the DON and the resident's doctor about the behavior and request a WanderGuard from maintenance. LN H stated she would have documented a note if she witnessed exit seeking behaviors, and who was notified, in the resident's progress notes or under risk assessments. LN H stated the facility provided elopement education, what to do and who to contact as well as education on door alarms after R1's elopement.</p> <p>On 09/17/24 at 01:34 PM Maintenance U stated they check the door alarms weekly and then perform a more extensive inspection monthly. Maintenance U stated there were no issues with the door R1 went out on 09/1/24 and that everything was working as intended. Maintenance U further stated the facility placed a louder alarm on the door because they felt it could be louder.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/17/24 at 12:09 PM in a joint interview with Administrative Staff A and Administrative Nurse D, Administrative Staff A and Administrative Nurse D stated they were not aware of any exit seeking behaviors prior to R1's elopement. They reported R1 had some confusion but was at baseline. Administrative Nurse D stated R1 started out in the assisted living (AL) and he was not aware of any exit seeking behaviors while there. Administrative Staff A and Administrative Nurse D stated R1 had never left or attempted to leave the facility, and never vocalized that she wanted to leave the facility that they were aware of. Administrative Staff A and Administrative Nurse D stated they expected staff to document if they witnessed exit seeking behaviors from any of the residents. They expected nurses to document a skin assessment, complete vitals, and have the social worker notify family in this incident. Administrative Nurse D stated because there was no fall, or medical related issues, there was no expectation for nurses to document anything other than the assessment and a statement for their soft file. Administrative Nurse D stated the notification for the family was documented by the social worker as there was no injury or medical related issues resulting from the elopement. Administrative Nurse D stated he expected staff to notify family and facility leadership. Administrative Nurse D stated they reviewed the camera footage, interviewed staff and created a timeline of events related to the incident. Administrative Nurse D stated CNA M helped R1 out of bed, R1 was seen in the hallway while CNA M went into another resident room to assist them. He stated R1 then went to the right down the hall, pressed the door for 15 seconds, the door opened, and R1 went outside. Administrative Nurse D stated there were no other staff in the hallway within camera view at the time, and staff were either in the dining room or in other resident rooms. Administrative Nurse D stated the door alarms were working, and staff reported they could hear them, but the facility felt the door alarms were not as loud as they could be. Administrative Nurse D stated maintenance installed new speakers so the alarm could be louder. Administrative Nurse D and Administrative Staff A stated they believe staff may have been complacent in responding to the alarm, and that perhaps they thought someone else would get the alarm, as they were busy helping other residents. Administrative Nurse D stated staff were educated that everyone will respond to a door alarm regardless moving forward. Administrative Nurse D and Administrative Staff A stated the facility have conducted door alarm drills to test staff after education was provided and will have an all staff Inservice over elopements tomorrow. Administrative Nurse D stated R1's care plan was updated to reflect the new behavior, a WanderGuard was placed, and R1's representative was notified. Administrative Nurse D stated if R1's exit seeking behaviors worsen, the facility may look at locked unit placement for R1 and this was discussed with the family. Administrative Nurse D stated for now, the interventions were working, and it hasn't come to that. Administrative Nurse D stated he felt staff responded well in notifying leadership and getting the resident back inside the building.</p> <p>The facility's Elopement/Unsafe Wandering policy with an original date of 06/2018 documented it is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. The facility will notify the appropriate State Agency in accordance with state requirements: [SPECIFY REQUIREMENTS HERE]. Notification to the appropriate State Agency will be made within twenty-four (24) hours of the serious accident/incident. A narrative summary of each incident/accident will be forwarded to the appropriate State Agency within five (5) days.</p> <p>On 9/17/24 at 03:31 PM, the facility received the Immediate Jeopardy [IJ] Template and was informed that the facility failure to respond to door alarms in order to prevent cognitively impaired R1 from exiting the facility without staff supervision or knowledge and entering an unsafe location placed R1 in IJ.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/17/2024
NAME OF PROVIDER OR SUPPLIER  The Healthcare Resort of Olathe		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility submitted an acceptable plan of corrective actions for removal on 09/17/24. The plan included the following actions: R1's Care Plan was updated to include the current status of R1's exit seeking. Staff placed a Wander Guard on R1. A full in-service was given to [nursing] staff to discuss R1 and the procedure for answering door alarms. The maintenance director assessed the door, door alarms, and added a louder door alarm for the northwest door. Nursing staff were educated on answering alarms immediately. Any resident suspected of exit seeking would be assessed by the interdisciplinary team (IDT) and protective action taken immediately. An all-staff in-service on elopement prevention and response to door alarms was scheduled for 09/18/24.</p> <p>Implementation of the corrective actions and removal of the immediacy was verified during the onsite survey on 09/17/24 at 04:14 PM. The deficient practice remained at a scope and severity of D.</p>		