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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVANSE LIVING AT OLATHE	101 W 151ST STREET OLATHE, KS 66061

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations 140991, 138106, 137930, 134082 at the above named assisted living facility conducted on 5-14-19, 5-15-19, 5-16-19, 5-20-19 and 5-21-19.	S 000		
S3028 SS=K	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101-(f)(1)(B) The facility reported a census of 48 residents (23 assisted living and 25 memory care). The sample included 3 residents, one focus review and 2 closed record reviews. Based on record review and interview for 1 (#700) of 3 sampled residents, 1 (#960) of 2 closed record reviews and 2 non-sampled residents (#961, #962), the administrator failed to ensure immediate measures taken to prevent further potential abuse while an investigation was in progress. Staff reported potential resident to resident sexual abuse involving Resident #960 and Resident #700 on 2-1-19 at approximately 9:30 pm. The administrator failed to put measures in place to prevent further potential abuse. This failure placed resident #960 in immediate jeopardy for harm or injury. Findings included: - Record review for resident #960 revealed admission on 11-23-18 with diagnoses Lewy Body Dementia, Anxiety, Anorexia, Left Humeral Fracture, Parkinson's Disease and Orthostatic Hypotension. The Functional Capacity Screen dated 11-24-18 recorded resident required physical assistance with bathing, dressing, toileting; supervision of eating; independent with transfers, walking/mobility; and unable to perform management of medications and treatments. Occasionally incontinent of bladder. Cognition: problems with short -term and long-term memory, memory/recall and decision-making. Communication: usually understandable and	S3028		

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S3028	Continued From page 2	S3028		

usually understands. Current problems/risks: falls/unsteadiness, wandering and decision-making.

The Negotiated Service Agreement/Health Care Service Plan dated 11-24-18 recorded the following services:
Bathing: physical assist twice a week. Offer bath if resistant to a shower.
Dressing: physical assist in the morning and evening.
Toileting: reminders and assistance with changing incontinent products.
Eating: Observation and supervision. Becomes agitated during meal time. Requires redirection. Staff to sit with resident and provide cueing or offer something he/she can walk and eat.
Medications: facility staff to administer in applesauce.

Nursing Progress Notes:
2-1-19 at 10:59 pm: "This nurse entered resident's apartment to administer medication, she was lying in her bed with a male resident (#700) partially clothed, wasn't upset or in distress. Asked male resident to leave, asked resident was she okay. Resident stated I am ok. I administered medication and did an assessment on resident." Signed by Licensed Staff F.
(Note: the entry lacked documentation of notification of resident's responsible party and physician.)

2-2-19 at 11:26 am: "CNA (Certified Nurse Aide) redirected male resident (#700) from resident's room twice this morning before breakfast. When resident's husband arrived, he noted that the door to resident's room was locked. Upon unlocking the door male resident (#700) was noted in resident's room. Resident (#700) was escorted

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from resident (#960)'s room and placed in area with staff to monitor him." Signed by Licensed Staff D.

2-2-19 at 11:32 am: "Around 9 am, this LPN (Licensed Practical Nurse) went with day charge nurse to resident's room to visit with resident's spouse. Resident noted to have reddened area around mouth and chin which concerned spouse. Per day charge (nurse), redness had been noted early in shift when medication given. Resident voices no complaint of pain or discomfort. Spouse anxious that male resident had been in room and concerned for (resident #960). He stated resident's brief had been laying on floor beside bed when he entered room. Resident was wearing a brief at this time. After further discussion, it was agreed that if resident #960 is in her room alone, the door will be closed and locked by staff. She will be able to get out simply by turning knob and opening door.
After talking on phone with (Administrative Staff B) and having read notes from previous night, returned to resident's room and spoke with spouse regarding event of last evening, that a male resident was in the bed with Resident #960 and that neither of the residents were wearing pants. Further explained that according to report received, Resident #960 had not appeared upset or angry or worried that male resident was in bed with her. (Spouse) requested to know what resident it was, this LPN responded that I am unable to share that information. (spouse) response was that he better be gone by tomorrow and began to wonder whether he should take Resident #960 home. Then stated it's probably better that I don't know who it was, because if I did...' (Spouse) visibly upset, then stated, I can't talk right now. Assured him that I will be available to talk if he need/wants to visit." Signed by

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S3028	Continued From page 4 Licensed Staff E 2-2-19 at 12:27 pm: "Short time after leaving resident's room, resident's spouse came looking for me. He stated wants to have her nightgown and brief checked out, and that he would like for her to be checked 'for rape, because if she was raped, I will be pressing charges'. Took him aside into private room with door closed, explained to him that we do not have training or rape kit or ability to assess that here and assured him that he can go to Emergency Room to be checked out and called Administrative Staff B and placed on speaker phone to determine how best to proceed. It was decided that he would take her to ER at (hospital) as this would bring less anxiety for resident and because resident does not physically need to be transported by ambulance. (Hospital) notified of events and that resident would be coming there accompanied by spouse..." Signed by Licensed Staff E 2-2-19 at 12:48 pm: Call placed to (physician) answering service, awaiting return call." Signed by Licensed Staff E. 2-2-19 at 3:28 pm: "(Physician) returned call, notified of situation, informed that resident at (hospital)." Signed by Licensed Staff E. Hospital record reveals resident was seen in the emergency room on 2-2-19 at 10:19 am. "Possible rape by a (resident) in his/her room last night. (Spouse) went into room and found both the patient and the other resident with their pants off, and he/she reports the patients face appeared red. Patient does have dementia." "Orientation: not oriented to place, not oriented to time, not oriented to situation. Affect Behavior/ appropriate, calm cooperative. Confused. Obeys	S3028		

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simple commands."

Forensic report dated 2-2-19 reported the following physical findings:
Cheek, nose, mouth chin with erythema (redness). Anus, vulva, perineum with erythema, swelling and ecchymosis (bruising). Erythema and swelling to genital area and vaginal opening. Right hip ecchymosis. Resident was prescribed Azithromycin 2 grams (antibiotic for Chlamydia) by mouth, Phenergan 25 milligrams (anti-nausea) by mouth and received an intramuscular injection of Garamycin 240 milligrams (antibiotic for Gonorrhea) in right and left hips.

- Record review for Resident #700 revealed admission on 7-3-18 with diagnoses Dementia, Hypertension, Hypothyroidism, Vitamin D Deficiency, Agitation, Polyuria and Dyslipidemia.

The Functional Capacity Screen dated 2-10-19 recorded resident independent with bathing, dressing, toileting, transfers, walking/mobility and eating; unable to perform management of medications/treatments. Cognition: problems with short- and long-term memory, memory/recall and decision-making. Communication: Sometimes understandable. Always understands. Note: The record lacked documentation of a prior FCS performed upon admission or otherwise.

The Negotiated Service Agreement with updated interventions on 2-12-19 and 3-31-19 recorded the following services:
Facility staff to administer and manage medications.
Status checks at regular intervals every day.
Please check on me at regular intervals to make

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sure that I am safe or not scared. Offer me something to do with structure so I don't get bored and want to leave.
Assistance of one staff with bathing twice a week (update 3-31-19).
Redirection for increased sexual behaviors (update 2-12-19): "I have recently had increase in sexually inappropriate behaviors, and currently have a 1:1 care giver with me at all times for redirection. I don't mean to offend anyone by my actions. I am not able to determine that these are not socially acceptable due to my disease process. Please help me by keeping me engaged in meaningful activities.

Neurology Letter dated 5-30-18: "This is to inform you that based on the most recent office evaluation and mental status exam for (Resident #700), it is our opinion that he requires a higher level of supervision during the day for safety reasons. His condition makes it very difficult for him to communicate as well as make sound decisions regarding his own safety. A level of care provided in an assisted living environment would allow additional opportunities for socialization, provide activities appropriate for mental and cognitive stimulation and provide closer supervision to ensure his/her environment is safe and secure..."

Nursing Progress Notes:
2-1-19 at 11:17 pm: "Resident was found in female resident (#960) apartment in bed partially clothed, it appeared to be consensual. Asked resident to leave. Director of nursing and unit manager notified." Signed by Licensed Staff F.

(Note: the record lacked documentation of notification of responsible parties, physician and interventions to address behavior)

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S3028	Continued From page 7 2-2-19 at 10:57 am: "Resident was redirected out of resident (#960)'s room twice before breakfast this morning. After breakfast resident was found in same female's room with the door locked. Resident was redirected out and to activity room where he engaged in a group activity with staff present. (Administrative Staff B) notified and message left for (Licensed Staff C) to return call." Signed by Licensed Nurse D. 2-2-19 at 11:06 am: "Late Entry for 2-2-19 9:30 am: Administrative Staff B attempted to notify resident's (responsible party) at 9:30 am of my phone call and text of incident that happened last evening and this morning. Administrative Staff B unable to leave voicemail but did text (responsible party) to call as soon as possible. Attempted again at 10:00 am and phone went straight to voicemail. Will continue to try to contact." Signed by Administrative Staff B. 2-2-19 at 4:40 pm: "Resident approached this writer this afternoon and put his arm around this writer. Resident kissed this writer on the cheek and then attempted to turn this writers face to kiss this writer on the mouth. This writer stopped resident and reminded him that this is not appropriate behavior." Signed by Licensed Staff D. 2-3-19 at 10:12 am: "CNA (Certified Nurse Aide) walked to dining room and found resident kissing a female resident (#962) on the mouth. Resident was immediately removed from area. (Licensed Staff C) was notified and staff is keeping resident within sight at all times. Signed by Licensed Staff D. 2-3-19 at 10:18 am: "Licensed Staff C notifying	S3028		

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family and physician." Signed by Licensed Staff D.

2-3-19 at 3:11 pm: "Resident was started on 1:1 care immediately following incident this morning ...At this time, resident must have a 1:1 caregiver at all times until further notice ...(Agency) contacted and set up to begin 24 hour care this evening ..." Signed by Licensed Staff C.

Confidential Interview stated Resident #700 used to kiss Resident #961 then switched to Resident #960, "he/she was all over the place."

Confidential Interview on 5-15-19 at 12:39 pm stated Resident #700 requires assistance with showers, will dress self but staff have to remove old clothes or resident will put them back on. Resident ambulates independently and is "overly friendly". Did not feel Resident #960 would be able to give consent and possibly thought Resident #700 was her spouse.

Facility report to the department provided by Administrative Staff A stated:
"2-1-19: at approximately 9:30 pm, Resident #700 and Resident #960 were found partially clothed in Resident #960's apartment, lying in bed together. Both residents reside on the memory care, are independent with ambulation without an assistive device, able to verbally communicate if they are not okay with something, and able to make needs known. Neither resident appeared to be in distress...
2-2-19: At approximately 8:00 am, Resident #960's spouse arrive at the community. When he went to enter Resident #960's apartment, the door was locked. Licensed Staff D unlocked the door and let him in. Resident #700 was found inside Resident #960's apartment, standing and

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S3028	Continued From page 9 talking to her while Resident #960 was laying in her bed. Resident #700 was redirected out of the apartment. 2-3-19: Resident #700 was in the dining room, and kissed another resident, (non-sampled resident #962). Resident #700 was easily redirected. Resident #962 was in no distress and was smiling. Families and physicians were both notified. On 2-3-19, 1:1 companion 24 hours per day implemented with Resident #700..." The administrator failed to ensure immediate measures were taken to prevent further potential sexual abuse after Resident #700 was found with Resident #960 in bed on 2-1-19. The resident was again found in resident #960's room with the door locked on 2-2-19. On 2/3/19 resident #700 was found kissing resident #962 in the dining room. These failures placed resident #960, #962 and potentially all female residents in the memory care unit in immediate jeopardy for harm or injury. The Jeopardy was removed on 2-3-19 Resident #700 was started on 1:1 monitoring via companion provided by an outside agency.	S3028		
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:	S3101		

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S3101	Continued From page 10 KAR 26-41-202(h) The facility reported a census of 48 residents (23 assisted living and 25 memory care). The sample included 3 residents, one focus review and 2 closed record reviews. Based on record review and interview for 3 (#600, #700, #800) of 3 sampled residents, the administrator failed to ensure each individual involved in the development of the negotiated service agreement (NSA) signed the agreement. Findings included: - Record review for Resident #600 revealed admission on 12-9-18 with diagnoses Alzheimer's Disease, Dementia, Encephalopathy, Dissociative Disorder, Hypertension, Osteoarthritis, and Insomnia. The Functional Capacity Screen dated 12-10-18 recorded the resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 3-8-19 recorded services for 2 person physical assist with bathing, dressing, toileting and transfers. One staff to push in wheelchair. Facility staff to manage and adminsiter medications. Hospice staff to provide bathing twice weekly and hospice nurse to provide wound care as ordered by physician. With facility nurse to provide treatments to wound as needed. The NSA lacked documentation of signatures of resident or responsible party and licensed nurse responsible for the health care services. Interview on 5-16-19 at 11:30 am with Licensed	S3101		

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Staff C confirmed the NSA lacked signatures of the resident and/or resident's responsible party. Further confirmed he/she failed to sign the agreements as nurse responsible for the health care services plan.

- Record review for Resident #700 revealed admission on 7-3-18 with diagnoses Dementia, Hypertension, Hypothyroidism, Vitamin D Deficiency, Agitation, Polyuria and Dyslipidemia.

The Functional Capacity Screen dated 2-10-19 recorded resident required health care services.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) with updated interventions on 2-12-19 and 3-31-19 recorded the following services:
Facility staff to administer and manage medications.
Status checks at regular intervals every day. Please check on me at regular intervals to make sure that I am safe or not scared. Offer me something to do with structure so I don't get bored and want to leave.
Assistance of one staff with bathing twice a week (update 3-31-19).
Redirection for increased sexual behaviors (update 2-12-19): "I have recently had increase in sexually inappropriate behaviors, and currently have a 1:1 care giver with me at all times for redirection. I don't mean to offend anyone by my actions. I am not able to determine that these are not socially acceptable due to my disease process. Please help me by keeping me engaged in meaningful activities.

The NSA lacked documentation of signatures of resident or responsible party and licensed nurse

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responsible for the health care services.

Interview on 5-15-19 at 2:32 pm with Licensed Staff C confirmed the NSA lacked signatures of the resident and/or resident's responsible party. Further confirmed he/she failed to sign the agreements as nurse responsible for the health care services plan.

- Record review for Resident #800 revealed admission on 4-18-19 with diagnoses Dementia.

The Functional Capacity Screen dated 4-1-19 recorded resident required health care services.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-20-19 recorded the following services:
Bathing: one staff twice a week to supervise resident. Resident able to shower independently but wants someone with him/her.
Mobility: ambulates with four-wheeled walker. Needs reminders to use walker.
Facility staff to manage and administer medications.

Interview on 5-15-19 at 4:13 pm with Licensed Staff C confirmed the NSA lacked signatures of the resident and/or resident's responsible party. Further confirmed he/she failed to sign the agreements as nurse responsible for the health care services plan.

Facility policy for "Resident Assessment and Negotiated Service Agreement" stated: 9. The NSA is to include service types for all areas addressed on the Resident Assessment and is to individualized based on the resident' needs and preferences. The family, resident, and any other

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVANSE LIVING AT OLATHE	101 W 151ST 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
S3101	Continued From page 13 significant individuals are included in the development of the NSA. 10. The Resident Assessment and Resident NSA are to be printed and signed and dated by the Community representative and the resident and/or his or her responsible party as indicated or required by state regulations. A copy is given to the family/responsible party." The facility failed to follow its policy. For Residents #600, #700, and #800, the administrator failed to ensure each individual involved in the development of the NSA signed the agreement.	S3101		
S3310 SS=E	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)	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046090	A. BUILDING: _____ B. WING _____	C 05/21/2019

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S3310	Continued From page 14 The facility reported a census of 48 residents (23 assisted living and 25 memory care). The sample included 3 residents, one focus review and 2 closed record reviews. Based on record review and interview for 3 (#M, #N, #O) of 5 sampled employee records, the administrator failed to 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. Findings included: - Personnel record review on 5-15-19 at 11:20 am with Administrative Staff A and Licensed Staff C revealed the following: Certified Staff M with date of hire 3-12-19: The record contained a TB (tuberculosis) symptom screen dated 5-14-19. The record lacked documentation of TB skin testing and a TB symptom screen completed upon hire. Certified Staff N with date of hire 3-27-19: The record contained a TB symptom screen dated 3-27-19. The record lacked documentation of TB skin testing. Non-certified Staff O with date of hire 9-17-18: The record contained a TB symptom screen dated 10-10-18 and a TB skin test dated 10-10-18. The record lacked documentation of a two-step TB skin test upon hire and a symptom screen completed upon hire. The facility policy for "Infection Control - Tuberculosis - Caregivers" stated: All caregivers shall be screened and tested for tuberculosis (TB) infection and disease per the	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3310	Continued From page 15 guidelines contained in this policy. Procedure: New Employee Initial Tuberculosis System Screen and TB Infection Testing: 1. Each new employee shall have an initial TB symptom screen that includes the components of the TB symptom screen questionnaire within 7 days of employment... TB Infection Testing: 1. Each new employee shall receive a two-step TB Skin Test or IGRA for Mycobacterium within 7 days of employment..." The facility failed to follow it's policy. Interview on 5-15-19 at 12:12 pm with Licensed Staff C confirmed the above records lacked documentation of a two step TB skin test and/or the TB symptom screen completed upon hire or within 7 days. For Staff #M, #N, #O the administrator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		