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 _____	02/14/2018

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
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations 121228, 126056 at the above named residential health care facility conducted on 2-6-18, 2-7-18, 2-12-18, 2-13-18 and 2-14-18.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and 1 focus review resident. Based on observation, record review and interview for 2 (#250, #420) of 3 sampled residents, the administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services. Resident #250 experienced 7 falls from 11-23-17 to 2-6-18 and the licensed nurse failed to implement interventions to address this resident's risk for falls. The falls on 10-30-17 and 1-24-18 resulted fractured ribs. Resident #420 experienced 22 falls from 10-30-17 to 1-27-18	S3155		

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

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 _____	02/14/2018

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
S3155	Continued From page 1 and the licensed nurse failed to implement interventions to address this cognitively impaired resident's risk for falls. Findings included: - Record review for resident #250 revealed admission on 10-30-17 with diagnoses Diabetes Mellitus, Congestive Heart Failure, Hypertension, Osteoporosis, Fibromyalgia, and Aortic Stenosis. The Functional Capacity Screen (FCS) dated 9-27-17 for admission recorded resident required physical assistance with bathing; supervision of walking/mobility. Current problems/risks included falls/unsteadiness. Uses walker. The FCS updated on 2-5-18 with change for supervision of toileting and transfers. Continued physical assistance with bathing and supervision of walking/mobility. Cognition: no problems. Current problems/risks included falls/unsteadiness. Uses walker. The initial Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 10-30-17 recorded the following services regarding walking/mobility: Mode of Locomotion: Staff to encourage resident to use walker with all ambulation with supervision as needed. Staff to report any unsteady gait to nurse. Nurse to notify (physician) of gait or balance problem. Falls: Staff to report unsteady gait to nurse. Nurse to notify (physician) of gait or balance problem. The NSA/HCSP for 10-30-17 lacked interventions to address the resident's fall risk as identified on the FCS.	S3155		

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 _____	02/14/2018

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
S3155	Continued From page 2 Nurse's Notes stated the following: 11-23-17 at 1:40 pm: "Reporting non-injury fall. Resident did bump head he/she said, 'only a little bit. I would have known if it was bad, I've had concussions before.' Said he/she was getting something out of the closet closest to the wall and started to fall. As he/she was falling, hit right hip on the arm of recliner and landed on right side..." Signed by Licensed Staff H. 11-25-17 at 6:25 am: "CMA (certified medication aide) alerted this nurse by phone that resident was found on floor in supine position beside recliner at 6:25 am. Resident stated 'I was getting up to go to bathroom and I stood up and my legs gave out.' Resident said he/she hit head slightly. Complained of no pain to extremities but complained of headache-like pain to head. Nurse assessed for injuries. Found no other injuries other than a bruise form previous fall on 11-23-17 to right lower back. Bruise measures 5.5 inches by 2.5 inches. No bumps or tenderness to head except feeling of headache...assisted to sitting position and resident complained of dizziness..." Signed by Licensed Staff G. 11(?)-29-17 at 9:00 pm: "1. CT scan of abdomen and pelvis to rule out fracture status post falls times 2, uncontrollable pain. 2. May transport by emergency medical services non-emergently if family unable to take for imaging. 3. reinforce not to take aspirin at this time due to large right flank hematoma. 4. Add 325 mg (milligrams) Tylenol every 6 hours as needed to give with percocet for improved pain management..." Signed by Licensed Staff G. 11-30-17 at 5:00 pm: "Returned from	S3155		

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 _____	02/14/2018

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
S3155	Continued From page 3	S3155		

(hospital)...resident reports has fracture of right 6th rib, continues to complain of pain..." Signed by Licensed Staff F.

1-13-18 at unknown time: "This nurse called to resident's room by CMA. Resident found lying on back next to recliner and closet. Resident states he/she hit head." Signed by Licensed Staff L.

1-15-18 at 8:45 am: "CMA called for nurse...upon arrival resident on floor in living area face down, feet outstretched. CMA with resident and resident states they heard a loud thud while walking past apartment...states tripped and fell while walking back from bathroom with walker. Complained of pain to right eye, blood noted on carpet, pressure being applied. 911 called by CMA immediately... This nurse observed golf ball size knot above right eye, blood coming from nose but controlled with pressure, bruising beginning under eye. Resident states he/she never lost consciousness." Signed by Licensed Staff E.

1-16-18 at 8:30 pm: "This nurse called to resident's room for assessment due to fall. When I arrived, resident stated he/she did not fall, he/she 'slid' off his/her chair because was not back far enough when he/she tried to sit down..." Signed by Licensed Staff J.

1-24-18 at 7:50 am: "Called to resident's room, resident on floor in bathroom lying on back beside toilet; stated 'I fell backwards.' Resident stated hit head and back and is having back pain..." Signed by Licensed Staff F.

1-24-18 at 7:53 am: "911 notified by CMA of need to transport to emergency room for evaluation..." Signed by Licensed Staff F.

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 _____	02/14/2018

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
S3155	Continued From page 4 2-6-18 at 12:10 pm: "(Resident) called for help about 11:45 am, (Certified Staff N) arrived and paged for nurse. (Resident) reported, 'my legs gave out and I just went backward.' Reported 9 out of 10 pain, constant in his/her head. (Resident) was laying on his/her back, legs straight through the bathroom door and head angled towards toilet. Bright red blood present related to back of head and baseball size, swollen area, midline center back of head. Eyes equal and fixed pinpoint. Called 911, (Resident) was transported via (emergency medical services) to (hospital)..." Signed by Licensed Staff I. (Note: resident returned to facility on 2-6-18 at 4:00 pm with no evidence of acute intracranial hemorrhage or mass) The resident experienced 7 falls from 11-23-17 to 2-6-18. The fall on 11-30-17 resulted in a fracture of the 6th rib. The fall on 1-24-18 resulted in fractures of the 11th and 12th ribs. Interview on 2-6-18 at 3:35 pm with Licensed Staff E stated resident lived in independent living prior to admission to facility and "it was told to us in the beginning falls were a problem." Confirmed the Functional Capacity Screen identified the resident to be at risk for falling and the NSA/HCSP lacked documentation of interventions to address the resident's fall risk. Further confirmed he/she failed to document a root cause analysis in an effort to address the cause of the resident's continued falls. For resident #250, the administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of this resident's risk for falls when the resident experienced 7 falls	S3155		

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 _____	02/14/2018

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
S3155	Continued From page 5	S3155		

from 10-30-17 to 2-6-18. The falls on 10-30-17 and 1-24-18 resulted fractured ribs with no interventions in place to address resident's fall risk.

- Record review for resident #420 revealed admission on 10-30-17 with diagnoses Diabetes Mellitus Type 2, Hypertension, Coronary Artery Disease, Neuropathy, Parkinson's Disease, Dementia and Seizures.

The Functional Capacity Screens (FCS) dated 10-19-17, 11-7-17 and 12-28-17 recorded resident required physical assistance with toileting, transfers and walking/mobility and identified the resident to be at risk for falls. Cognition: problems with short term memory and decision-making. Uses walker and wheelchair. The FCS dated 11-7-17 and 12-28-17 recorded resident to be frequently incontinent.

The Negotiated Service Agreement/Heath Care Service Plan dated 10-30-17 recorded the following services:
Mode of Locomotion: Staff to encourage resident to use wheelchair/scooter as needed. Scooter assessment will be performed to assure safe management. Staff to report any unsteady gait to nurse. Nurse to notify (physician) of gait or balance problem. Staff to assist with transfers/ambulation as needed.
Falls: Staff to report unsteady gait to nurse. Nurse to notify (physician) of gait or balance problem. Staff to assist (resident) with bilateral leg braces daily. 10-30-17: non-skid socks...

Medical Examination dated 10-22-17 and signed by physician stated, "fall risk, very unsafe gait." Ambulation: "unsteady". Gait: "very unsteady".

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 _____	02/14/2018

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
S3155	Continued From page 6 Nurse's Notes stated: 10-30-17 at 4:40 pm: "Resident on floor in bathroom in sitting position leaning against wall in front of toilet. When asked how fell, stated stepped off scooter to go to bathroom and lost balance and fell...incontinent of bowel and bladder...has 1 centimeter skin tear to first knuckle of right hand, and 1 centimeter skin tear to 5th knuckle of right hand and 1 centimeter skin tear to right inner elbow." Signed by Licensed Staff F. 10-31-17 at 2:00 am: "Went in to take vitals and resident was laying on the floor. Resident claims he/she slid out of chair and 'bounced on the floor.' Resident has some confusion as to whether or not he/she hit head. Skin tears to great toe bilaterally..." Signed by unknown licensed staff. 11-5-17 at 9:00 am: "Resident found on the floor by CMA (certified medication aide) around 8:45 am. Resident was on all fours near head of bed with scooter near by. Resident was too weak to help self up and needed 2 person assist. Resident stated had been sleeping and woke up on the floor with no recollection on how he/she got there or for how long, but later said had been there all night..." Signed by Licensed Staff H. 11-7-17 at 3:50 am: "At approximately 3:00 am this nurse was called...due to resident falling. Resident was on the floor in front of (apartment). When asked why he/she was roaming the halls he/she stated, 'was dropping something off to son's room.' Later when asked he/she would change story each time. Resident had complained of pain 9 out of 10 in left hip/knee and head and three skin tears to the right hand. Resident claimed he/she banged his/her head off	S3155		

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 _____	02/14/2018

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
S3155	Continued From page 7	S3155		

the floor when he/she fell..." Signed by Licensed Staff J.

11-7-17 at 6:25 pm: "...resident on floor in front of recliner in sitting position...when asked what happened he/she stated was trying to get into recliner and fell landing on right side and hitting head..." Signed by unknown licensed staff.

11-13-17 at 5:00 pm: "Resident found on floor by (staff) laying on floor on back in front of recliner... (spouse) present for fall and states that resident slip out of chair and did not sustain a head injury..." Signed by unknown licensed staff.

11-15-17 at 8:15 am: "Notified by housekeeper that resident was on floor. This nurse found resident sitting on bottom with legs out in front leaning against bed with scooter right beside him/her. Resident said he/she "slid out of chair and fell on his/her butt like he/she always does." Signed by Licensed Staff G.

11-16-17 at 11:00 pm: "This nurse called to resident's room to assess him/her post fall. Resident and (spouse) stated he/she was trying to sit in recliner when it slid backward causing him/her to slide down onto bottom. Resident was sitting in front of recliner. recliner was pushed back farther than normal...this nurse recommends a non-skid mat for under chair..." Signed by unknown licensed staff.

11-19-17 at 2:15 am: "...Resident found sitting on floor with legs out in front of recliner. Resident said he/she fell out of recliner on way to bathroom. Resident said he/she fell on butt then fell back and hit head..." Signed by Licensed Staff G.

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 _____	02/14/2018

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
S3155	Continued From page 8	S3155		

11-21-17 at 4:00 am: "Resident was attempting to sit down in recliner and slid out of it onto the floor. Resident and (spouse) claim he/she went down onto bottom and did not hit head..." Signed by unknown licensed staff.

11-27-17 at 12:00 pm: "Resident found on floor in bathroom sitting up with feet in front of toilet. Resident states he/she slid off of toilet while trying to transfer self onto toilet..." Signed by unknown licensed staff.

11-30-17 at 10:50 am: "This nurse heard call...for help. Upon arrival CMA was with resident who was on his/her knees in a praying position...enforced 30 minute checks for resident from here on out due to high fall risk." Signed by Licensed Staff H.

12-2-17 at 7:30 am: "This nurse called to resident's bedroom by (staff) that resident was found on the floor. Resident was found sitting on the floor next to his/her bed by the bathroom. Stated he/she fell out of bed..." Signed by Licensed Staff I.

12-11-17 at 9:00 pm: "This nurse was called to resident's room by reception who received a call from resident's (family member) stating he/she had fallen. Upon arrival resident was found laying on the floor between bed and the windows. Resident stated he/she was trying to rollover and slid out or bed..." Signed by unknown licensed staff.

12-16-17 at 6:40 am: "Called by CMA to room...found resident sitting in front of recliner with legs out in front and back up to recliner with wheelchair in front of him/her. Resident stated he/she 'slid out of wheelchair.' Resident said

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 _____	02/14/2018

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
S3155	Continued From page 9	S3155		

he/she was getting ready for the day...resident said he/she 'bonked' head..." Signed by Licensed Staff G.

12-19-17 at 10:20 am: "Resident found on floor by therapy staff in bathroom. Resident defecated on floor.." Signed by Licensed Staff H.

12-20-17 at 12:35 pm: "...resident on floor, complained of hitting head, also complained of left knee pain. Resident will not straighten out left leg. Resident states "seat tipped over on scooter' and he/she fell. Stated 'I thought it was going to fall on me.'..." Signed by Licensed Staff F.

12-21-17 at 11:00 pm: "Resident and (spouse) were attempting to transfer from wheelchair to bed when (staff) walked in and resident was face down on bed sideways...noticed skin tear on the left elbow..." Signed by unknown licensed staff.

Note: Resident in hospital from 12-22-17 to 12-28-17 for respiratory issues.

1-10-18 at 10:40 am: "Report received that resident had slid out of chair..." Signed by Licensed Staff F.

1-19-18 at 7:30 am: "Had non-injury fall at 5:00 am. Resident rolled out of bed trying to readjust..." Signed by unknown licensed staff.

1-23-18 at 2:50 pm: "Called to resident's room, resident on floor leaning against wall beside bedroom door with pillow beside him/her. Stated 'I rolled out of bed.'..." Signed by Licensed Staff F.

1-27-18 at 12:00 pm: "This nurse called to resident's room by (staff). Resident found sitting on bottom at entrance to bathroom in room.

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 _____	02/14/2018

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
S3155	Continued From page 10 Resident has small skin tear to right wrist. States he/she was getting up and fell..." Signed by Licensed Staff L. The resident experienced 22 falls from 10-30-17 to 1-27-18. Observation on 2-7-18 at 2:10 pm revealed resident to be mobile per wheelchair, wearing socks with no shoes or leg braces on. Room with lots of clutter along walls in narrow entryway and on furniture. Required physical assistance times one to transfer from wheelchair to toilet and back and then from wheelchair to recliner. Interview on 2-7-18 at 1:15 pm with Licensed Staff E confirmed the Functional Capacity Screen identified the resident to be at risk for falling (resident was admitted with a history of falling) and the NSA/HCSP lacked interventions to address the resident's fall risk. Stated resident was receiving physical and occupational therapy but confirmed the HCSP lacked instructions to the certified staff to address resident's fall risk. Further confirmed he/she failed to document a root cause analysis in an effort to address the cause of the resident's continued falls. For resident #420, the administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of this resident's ongoing risk for falls when the resident experienced 22 falls from 10-30-17 to 1-27-18.	S3155		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services	S3165		

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 _____	02/14/2018

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
S3165	Continued From page 11 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) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and 1 focus review resident. For all residents the administrator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan as evidenced by record review and interview for 3 (#250, #325, #420) of 3 sampled residents and 1 (#550) of 1 focus review resident. Findings included: - Record review for Resident #250 revealed admission on 10-30-17 with diagnoses Congestive Heart Failure, Diabetes Mellitus, Hypertension, Hyperlipidemia, Osteoporosis, Insomnia, Depression, Fibromyalgia and Aortic Stenosis. The Functional Capacity Screens dated 9-27-17 and 2-5-8 recorded resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 10-30-17 recorded services for facility staff to provide standby assistance with bathing; assist with dressing as needed; nurse to provide blood glucose monitoring as needed and staff to encourage use of walker and supervise mobility	S3165		

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 _____	02/14/2018

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
S3165	Continued From page 12 as needed. The NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of health care services. - Record review for Resident #325 revealed admission on 7-31-16 with diagnoses Severe Rheumatoid Arthritis, Hypertension, Diabetes Mellitus Type 2, Osteoporosis, and Neuropathic Pain. The Functional Capacity Screen dated 3-7-17 recorded resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 3-13-17 recorded services for staff assistance with bathing as needed; assistance with dressing and transfers. The NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of health care services. - Record review for Resident #420 revealed admission on 10-30-17 with diagnoses Type 2 Diabetes Mellitus, Hypertension, Coronary Artery Disease, Neuropathy, Obstructive Sleep Apnea with CPAP, Parkinson's Disease, Dementia and Seizures. The Functional Capacity Screens dated 10-19-17, 11-7-17 and 12-28-17 recorded resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 10-30-17 recorded resident to receive physical assistance for bathing, dressing, toileting, transfers, walking/mobility, and eating. Facility staff to	S3165		

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 _____	02/14/2018

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
S3165	Continued From page 13 administer medications and provide blood glucose monitoring. The NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of health care services. - Record review for Resident #550 revealed admission on 5-27-17 with diagnoses Dementia, Congestive Heart Failure, Mitral Valve Regurgitation, Gastroesophageal Reflux Disease, Hypertension, Falls, Coronary Artery Disease, Cardiomyopathy and Weakness. The Functional Capacity Screens dated 5-27-17, and 1-8-18 recorded resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 1-9-18 recorded resident to receive physical assistance with bathing, dressing, toileting, transfers, walking/mobility and eating. Facility staff to administer medications. The NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of health care services. Interview on 2-7-18 at 1:26 pm with Licensed Staff E confirmed all Negotiated Service Agreements failed to designate the name of the nurse responsible for the health care service plans. For all residents, the administrator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health care services plan.	S3165		

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 _____	02/14/2018

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
S3200	Continued From page 14	S3200		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1(#420) of 3 sampled residents, the administrator failed to ensure all medications and biologicals are administered to the resident in accordance with a medical care provider's written order and professional standards of practice when the resident failed to receive medications as ordered by the physician.	S3200		

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 _____	02/14/2018

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
S3200	Continued From page 15 Findings included: - Record review for resident #420 revealed admission on 10-30-17 with diagnoses Diabetes Mellitus Type 2, Hypertension, Coronary Artery Disease, Neuropathy, Parkinson's Disease, Dementia and Seizures. The Functional Capacity Screens (FCS) dated 10-19-17, 11-7-17 and 12-28-17 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Heath Care Service Plan dated 10-30-17 recorded services for Medication Management: Nurse/CMA (certified medication aide) will administer medications. Nurse/CMA will order medications from pharmacy or notify (family member) of need for refill from (mail-order) pharmacy. Review of Medication Administration Record (MAR) for January 2018 revealed the following medications lacked documentation of administration: Finasteride 5 mg (milligrams) tablet for benign prostatic hypertrophy. Take 1 tab by mouth once daily. Circled as not administered on 1-1-18, 1-2-18, 1-3-18, 1-4-18, 1-6-18. Multivitamin 1 tablet by mouth once daily. Circled as not administered on 1-1-18, 1-2-18, 1-3-18 and 1-4-18. Atorvastatin 40 mg. Take 1 tablet by mouth at bedtime for Hyperlipidemia. Circled as not administered from 1-2-18 through 1-19-18. Back of MAR contained documentation that the above medications "not available - nurse notified". MAR for February 2018 revealed the following	S3200		

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 _____	02/14/2018

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
S3200	Continued From page 16 medications lacked documentation of administration: Primidone 50 mg tablet for tremors. Take 1 tablet by mouth every evening. Circled as not administered on 2-1-18, 2-2-18, 2-3-18 and 2-4-18. Atorvastatin 40 mg tablet. Take 1 tablet by mouth at bedtime. Circled as not administered on 2-2-18 and 2-4-18. On 2-1-18 and 2-3-18 the MAR was left blank. Aripiprazole 5 mg tablet for psychosis. Take 1/2 tablet by mouth once daily. Circled as not administered from 2-1-18 through 2-5-18. Back of MAR contained documentation of the above medications "unavailable - not given." Interview on 2-7-18 at 2:00 pm with Licensed Staff E reviewed the MARs and confirmed the above medications lacked documentation of administration. Stated the resident uses an outside pharmacy for some medications. Confirmed the record lacked documentation of communication with the family regarding requests for medications to be ordered and further lacked documentation that the physician was notified the resident failed to receive medications as ordered. For Resident #420, the administrator failed to ensure all medications and biologicals were administered to the resident in accordance with a medical care provider's written order and professional standards of practice when the resident failed to receive medications as ordered by the physician.	S3200		
S3248 SS=D	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff	S3248		

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 _____	02/14/2018

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
S3248	Continued From page 17 records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(2) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and 1 focus review resident. The facility identified 30 employees hired since last resurvey, with 2 non-certified staff, 1 certified staff and 2 licensed staff reviewed. Based on record review and interview for 2 (Dietary Staff D, Licensed Staff F) of 5 staff reviewed, the administrator failed to	S3248		

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 _____	02/14/2018

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
S3248	Continued From page 18 ensure the employee records contained evidence of licensure for the employee performing a function that required specialized education or training; and supporting documentation for a criminal background check pursuant to K.S.A 39-970 and amendments thereto. Findings included: - Record review on 2-7-18 around 11:56 am of employee records revealed the following: Dietary Staff D (date of hire 9-5-17): lacked documentation of criminal background check. Licensed Staff F (date of hire 2-28-17): lacked evidence of licensure verification. Interview on 2-7-18 at 11:56 am with Administrative Staff A confirmed the personnel record for Dietary Staff D lacked documentation of a criminal background check and the record for Licensed Staff F lacked evidence of licensure verification on or before date of hire. For Dietary Staff D and Licensed Staff F, the administrator failed to ensure the employee records contained supporting documentation for a criminal background check and licensure verification, respectively.	S3248		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action	S3261		

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 _____	02/14/2018

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
S3261	Continued From page 19 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and 1 focus review resident. Based on record review and interview for 2 (#325, #420) of 3 sampled residents, the administrator failed to ensure documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the action. Findings included: - Record review for Resident #325 revealed admission on 7-31-16 with diagnoses Severe Rheumatoid Arthritis, Hypertension, Diabetes Mellitus Type 2, Osteoporosis, and Neuropathic Pain. The Functional Capacity Screen dated 3-7-17 recorded resident required physical assistance with bathing, dressing and transfers; independent with toileting, walking/mobility,and management of medications and treatments. Continent of bladder. No problems with cognition or communication. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 3-13-17 recorded services for staff assistance with bathing as needed; assistance with dressing and transfers. Observation of resident on 2-7-18 at 4:00 pm	S3261		

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 _____	02/14/2018

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
S3261	Continued From page 20	S3261		

revealed resident in bed with right leg elevated on pillow. Gauze dressing intact around right lower leg.

Nurse's Notes revealed the following:

8-30-17 at 9:30 pm: "Resident verbalized to this nurse that an outside provider at (physician) appointment today started him/her on Doxycycline twice a day for 7 days for an unknown infection to right lower leg. Swabs were collected at said physician's office..." Signed by Licensed Staff G. The entry lacked documentation of assessment of area on leg which was infected.

8-31-17 at 5:00 am: "Resident on Doxycycline for rash/cellulitis right lower leg...still has red patch to right lower shin area above ankle." Signed by Licensed Staff F.

9-13-17 at 4:00 am: "Resident called this nurse to look at his/her leg. He/She stated the wound has opened since (physician) appointment on 9-11-17. He/She has requested us to obtain wound care orders to assist in dressing changes....also expressed an interest in going to the wound care clinic for evaluation." Signed by unknown licensed staff.

9-13-17 at 10:12 pm: "Called on-call provider...to receive wound care orders. Resident is dressing his/her right lower leg his/herself and applying Vaseline, sometimes hydrocortisone cream with gauze and triple antibiotic ointment as needed..." Signed by Licensed Staff G.

9-15-17 at 8:00 pm: "Received new orders from on-call (physician) 1. Vaseline only to wound on right leg..." Signed by Licensed Staff G.

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 _____	02/14/2018

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
S3261	Continued From page 21 10-4-17 at 8:00 pm: "Received new orders for wound care. Right lower leg cleanse with normal saline, apply honey alginate, ABD pad and roll with gauze. Change every 4 days." Signed by Licensed Staff G. 12-21-17 at 5:05 pm: "(Resident) asked for help communicating to wound care team. I called (physician) at 4:50 pm and left voicemail regarding "new" yellow drainage noted in past 24 hours. Doctor and nurse are aware per visit on 12-20-17. Called (home health) nurse who works on wound...at 4:55 pm. Discussed would possible to culture in order to give the best care and quality of life..." The entry lacked signature. (Note: The record lacked any further entries regarding right lower leg wound after this date.) The record lacked documentation of ongoing assessments of right leg cellulitis which evolved into an open right leg wound including appearance with measurements, amount and description of any drainage and results of treatments. Interview on 2-6-18 at 1:15 pm with Licensed Staff E and Administrative Staff Q stated resident #325 had a "hematoma that had opened up" on "right calf". Stated wound had required a "wound vac" for drainage which was cared for by home health. Interview on 2-12-18 at 12:12 pm with Licensed Staff I and Administrative Staff O confirmed the record lacked documentation of ongoing assessments of right lower extremity cellulitis and wound including response to treatments. For Resident #325, the administrator failed to	S3261		

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 _____	02/14/2018

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
S3261	Continued From page 22	S3261		

ensure documentation of ongoing assessments of cellulitis of the resident's right lower leg which evolved into an open wound. The record lacked documentation of wound measurements, amount of and description of any drainage and response to treatments (results of actions taken).

- Record review for resident #420 revealed admission on 10-30-17 with diagnoses Diabetes Mellitus Type 2, Hypertension, Coronary Artery Disease, Neuropathy, Parkinson's Disease, Dementia and Seizures.

The Functional Capacity Screens (FCS) dated 10-19-17, 11-7-17 and 12-28-17 recorded resident required physical assistance with toileting, transfers and walking/mobility and identified the resident to be at risk for falls. Cognition: problems with short term memory and decision-making. Uses walker and wheelchair. The FCS dated 11-7-17 and 12-28-17 recorded resident to be frequently incontinent.

The Negotiated Service Agreement/Heath Care Service Plan dated 10-30-17 recorded the following services:
Physical assistance with bathing, dressing, toileting, transfers.
Nurse/CMA (certified medication aide) will administer medications. Nurse will provide blood glucose monitoring.
Skin Condition: Nurse will monitor skin condition and notify physician of any issues needing to be addressed. Wellness staff will notify nurse of skin tears, bruises or other injuries noted.
Staff to assist (resident) with bilateral leg braces daily. 10-30-17: non-skid socks...

Observation on 2-7-18 at 2:10 pm revealed

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 _____	02/14/2018

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
S3261	Continued From page 23	S3261		

resident to be mobile per wheelchair, wearing socks with no shoes or leg braces on. Required physical assistance times one to transfer from wheelchair to toilet and back and then from wheelchair to recliner. While on toilet, observed resident's right inner thigh with two open areas. One area with dried skin peeling off, scant amount of serous drainage; measured approximately 6 cm (centimeters) long and 1 cm wide. The second area approximately 4 cm long and 0.5 cm wide with no drainage noted. Left upper thigh no open areas observed (possibly due to positioning). Resident denied pain or discomfort. Certified Staff R stated he/she had not been told about the burns to resident's upper thigh.

Nurse's notes stated:
1-20-18 at 10:00 am: "resident had spilled coffee on him/herself. Resident was found sitting in his/her recliner and states he/she spilled coffee on his/her lap. Resident has large reddened area to bilateral upper thighs and states when touching the area it hurts. No blisters or open areas noted. Ice place to thighs. (physician) notified and new order given for Silvadene cream twice a day for 5 days..." Signed by Licensed Staff L.

The record lacked further documentation of assessment of burned areas or response to treatment with Silvadene cream.

Physician's Progress Note dated 1-23-18 stated, "Nursing request evaluation of burns. (Resident) spilled hot coffee on his/her thighs. Has burns to bilateral inner thighs - painful. Physical exam: Burns secondary. Bilateral inner thighs reddened areas with peeling skin. Discussed treatment with nursing - apply Silvadene cream to burns."

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 _____	02/14/2018

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
S3261	Continued From page 24 Interview on 2-7-18 at 1:51 pm with Licensed Staff E confirmed the record lacked documentation of ongoing assessment of burned areas on residents bilateral upper thighs. For Resident #420, the administrator failed to ensure documentation of assessment of burned areas to resident's bilateral upper thighs.	S3261		
S3280 SS=E	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) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and	S3280		

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 _____	02/14/2018

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
S3280	Continued From page 25 1 focus review resident. Based on record review and interview for all residents and staff, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with all residents and all staff. Findings included: - Review of the facility emergency management plan on 2-6-18 at 2:58 pm with Administrative Staff B who provided documentation of quarterly review of the emergency management plan with staff and residents. Documentation revealed the following: Residents reviewed emergency management plan during resident council meetings in assisted living as follows: 2-22-17 with 9 residents 5-17-17 with 4 residents 8-23-17 with 4 residents 11-29-17 with 10 residents The plan failed to provide documentation of review with memory care residents and any assisted living residents who did not attend the resident council meetings. Staff reviewed the emergency management plan during staff meetings as follows: 3-24-17 with 6 staff 6-26-17 with 15 staff 9-25-17 with 23 staff 12-29-17 with 11 staff The plan failed to provide documentation of review with all employees of the facility and all regular agency staff who worked at the facility.	S3280		

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 _____	02/14/2018

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
S3280	Continued From page 26 Interview on 2-6-18 at 2:58 pm with Administrative Staff B confirmed the facility lacked documentation of quarterly review of the emergency management plan with all residents (including memory care residents) and all staff (including regular agency staff). Stated staff meetings had not been mandatory. The facility failed to provide a policy and procedure for quarterly review of the entire emergency management plan with all residents and all staff. The administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with all residents and all staff.	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 required to meet federal, state, and local laws	S3298		

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 _____	02/14/2018

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
S3298	Continued From page 27 and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and 1 focus review resident. The administrator failed to ensure food shall be prepared using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature as evidenced by observation and interview and affecting all residents. Findings included: - Observation during entrance tour on 2-6-18 from 10:23 am to 11:10 am of main kitchen revealed a steam table for food service. Large gas stove with light brown liquid in pot sitting on burner with no fire underneath; and a large pot of red liquid sitting on burner with no fire underneath. Dietary Staff D identified the brown substance as "gravy for lunch" and the red substance as "soup for tomorrow." Temperature of the gravy and soup were 202 degrees F (Fahrenheit) and 205 degrees F respectively. Surveyor requested food temperature logs. Interview on 2-6-18 around 11:00 am of Dietary Staff D stated "We do not have those...". Confirmed no documentation of monitoring of food temperatures. Administrative Staff B provided logs found in office dating from 12-17-17 to 12-31-17. The logs	S3298		

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 _____	02/14/2018

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
S3298	Continued From page 28 were blank except for lunch on 12-23-17, 12-25-17, 12-28-17, 12-29-17. Holding/Service Guidelines stated Proper Hot Holding: minimum 135 degrees F. If temperature below, rapidly reheat to a holding temperature of 165 degrees F for a minimum of 15 seconds. Record action taken in the temperature log. Proper Cold Holding: Maximum 41 degrees F. If products rise above set temperature place product in shallow pan and place inside freezer until temperature drops. Record action taken in the temperature log. For all residents, the administrator failed to ensure food shall be 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)(1) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and 1 focus review resident. The administrator failed to ensure facility staff shall store all food under safe and sanitary conditions; and containers of	S3299		

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 _____	02/14/2018

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
S3299	Continued From page 29 poisonous compounds and cleaning supplies were not stored in the areas used for food storage, preparation or serving as evidenced by observation, record review and interview and affecting all residents. Findings included: - Observations during entrance tour on 2-6-18 from 9:30 am to 1:10 pm accompanied by Administrative Staff B included the following: Facility community room with a residential style refrigerator/freezer. The refrigerator contained the following items which all lacked a label and date of preparation: medium sized plastic container of leftovers; a small clear plastic cup covered with plastic wrap which contained what appeared to be chocolate pudding with cookie crumbles on top; a ziplock bag of what appeared to be frosting and 2 individual containers of sauces. The refrigerator further contained a 16 ounce carton of 100% egg whites with use by date of 1-14-18; a bottle of Miracle Whip salad dressing with use by date 11-28-17; Masterpiece BBQ sauce with use by date 10-13-17; Parmesan Cheese with use by date 10-8-17 and Olive Garden Italian Salad dressing with use by date 10-4-17. The freezer contained the following items which lacked a label and date of preparation: 1 ziplock bag of a red substance, 1 ziplock bag of blue berries, 1 ziplock bag with 2 donuts, 1 ziplock bag of a green substance in a plastic tray, 1 ziplock bag with half of a pie in an aluminum pie pan, and a gallon ziplock bag of a light colored fruit. The freezer also contained 3 ziplock bags of a brown substance with date 10-8 which lacked a label.	S3299		

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 _____	02/14/2018

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
S3299	Continued From page 30 All of the above items confirmed by Administrative Staff B and removed. A storage room adjacent to the community room contained open metal shelving with 2 bottles of chocolate syrup next to a can of stainless steel cleaner. Interview on 2-6-18 at 10:10 am with Administrative Staff M stated he/she used the refrigerator/freezer in the community room and some of the items in the refrigerator belonged to residents or were used for activities. Confirmed he/she did not keep track of dates on the condiments. Further confirmed he/she utilized the storage room for activity storage and confirmed the chocolate syrup had been placed next to the stainless steel cleaner. - Observations of main kitchen on 2-6-18 beginning at 10:23 am revealed the following: A four door pass-through refrigerator off the main kitchen contained 2 carts with multiple trays. The parchment paper on the trays on one side was soiled with spillage and food debris. Trays contained an uncovered glass of orange juice, an uncovered pan of Jello and an uncovered carafe of tea. These items lacked label/date. A plastic container of mandarin oranges lacked a label and date. An uncovered metal container of fruit salad with a serving spoon in it lacked a label and date. Stainless steel beverage/coffee bar with water spillage on shelf underneath and on floor. Stainless steel salad bar/cooler with broken internal thermometer. Raw chicken, raw pork	S3299		

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 _____	02/14/2018

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
S3299	Continued From page 31	S3299		

and raw ground beef patties in uncovered containers on salad bar. Various shredded cheeses uncovered on salad bar.

Cooler underneath salad bar contained the following items which lacked labels and dates:
plastic containers of beets and olives
2 uncovered containers of batter, one with a scoop in it
container of sauce (honey mustard?)
plastic container of sliced ham
uncovered pan of brown meat with a red center
uncovered green plastic bowl of sauce

Interview on 2-6-18 around 10:35 am with Dietary Staff D confirmed all above items and removed. Stated the batters were french toast batter and pancake batter. Stated he/she did not know what the brown meat was or when it had been put in the cooler. Confirmed the thermometer was broken. Unable to provide temperature logs for the cooler.

Observed two plastic cups on the counter next to the salad bar containing food substances, one with a spoon in it and one with a fork in it. Dietary Staff D stated these cups contained oatmeal and cream of wheat.

In prep area of kitchen observed a metal rolling cart with slots for trays. Dietary Staff D was placing trays of cookies on the cart. A tray on the cart contained some clean pans and utensils. Another tray on the cart contained a large metal bowl of bread crumbs covered with plastic wrap which lacked label/date. On top of this bowl was 1/2 of a pecan pie covered with plastic wrap which also lacked label/date. Metal pan of muffins covered with plastic wrap was on the floor underneath the cart which lacked label/date.

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 _____	02/14/2018

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
S3299	Continued From page 32 Dietary Staff D confirmed all items and stated the pan of muffins has "been there for a while." Administrative Staff B discarded the pie, bread crumbs and muffins. Large bin of flour contained a measuring cup. Administrative Staff B confirmed and removed the cup. The main kitchen had a walk-in cooler with 5 boxes of meat observed on the floor of the cooler with two pork roasts on top of one of the boxes. The following items lacked a label/date: pan of cooked meat, plastic containers of spaghetti, red sauce, strawberries, metal pan of meat, metal pan of leftovers, plastic containers of soup, plastic containers of shredded cheese, container of a brown substance, uncovered pan of Jello and a cooking pot covered with plastic wrap contained an unknown brown substance. The walk-in freezer with temperature of 22 to 26 degrees F (Fahrenheit) contained a cart with trays. Three trays in the upper slots contained raw uncovered chicken parts. Below these trays were a variety of frozen meats in ziplock bags and several ziplock bags of a brown substance which was thawing. This brown substance (sauce/gravy?) was dripping down onto the trays beneath, one tray onto which it dripped also contained a ziplock bag of fish and egg salad (which lacked a label/date). The ziplock bag of fish was covered with the brown sauce. A ziplock bag labeled as muffin batter was dated 3-30 (lacked the year). A bag of chicken pieces on a lower shelf was unsecured and open to air. Administrative Staff B confirmed all the above items and confirmed the temperature of the freezer. Stated it was in a "defrost mode."	S3299		

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 _____	02/14/2018

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
S3299	Continued From page 33 Dietary Staff D, again, unable to provide temperature logs for monitoring of coolers and freezers. Administrative Staff B located a "Daily Checklist" from 12-17-17 to 12-30-17 for opening and closing checks of Refrigeration, Ware-washing and Dishwasher temperatures. Logs lacked documentation for checking of closing temperatures and lacked documentation for checking of opening temperatures on 12-17-17, 12-19-17, 12-22-17, 12-23-17, 12-26-17 and 12-30-17. A stainless steel counter in the main kitchen contained a bottom shelf. The bottom shelf contained a spray bottle of a chemical with unreadable labeling. Several bottles of hand soap for the automatic dispensers sitting next to a box of 6 cans of PAM cooking spray and a box of 6 spray bottles of grid conditioner (prevents sticking and buildup on waffle irons). Administrative Staff B removed the hand soap and discarded the spray bottle of chemical, stating, "they don't belong there." Dietary Consulting Report dated January 24, 2018 recorded sanitation issues with the kitchen, dishroom, pot sink and question regarding posting of a cleaning schedule and included recommendation for "a deep cleaning frenzy". Facility failed to provide policies and procedures for food storage including monitoring and recording of refrigeration temperatures. On 2-12-18, Administrative Staff O confirmed there are no facility policies and procedures for chemical storage in the facility. Interviews conducted with Administrative Staff B and Dietary Staff D throughout tour of main kitchen confirmed all above items and where	S3299		

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 _____	02/14/2018

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
S3299	Continued From page 34 applicable, discarded the items. Surveyor did not witness discarding of exposed chicken parts in freezer or clean up of spilled gravy/sauce. For all residents, the administrator failed to ensure facility staff stored all food under safe and sanitary conditions; and containers of poisonous compounds and cleaning supplies were not stored in the areas used for food storage, preparation or serving.	S3299		
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) The facility reported a census of 45 residents (20 assisted living residents and 25 memory care residents). The sample included 3 residents and 1 focus review resident. Based on record review	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 _____	02/14/2018

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
S3310	Continued From page 35 and interview for 2 (Non-Certified Staff S and Certified Staff N) of 5 sampled staff and 1 (#550) of 1 focus review resident, the administrator failed to ensure the home's compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Personnel record review on 2-6-18 at 11:56 am with Administrative Staff A revealed the following: Non-Certified Staff S with date of hire 5-12-17: The record lacked documentation of a 2-step TB skin test. Certified Staff N with date of hire 8-8-17: TB skin test performed 8-8-17. The record lacked documentation of a second step. Interview on 2-6-18 at 11:56 am with Administrative Staff A confirmed the above records lacked documentation of TB skin testing or chest x-ray in accordance with the department's tuberculosis guidelines. - Resident record review for Resident #550 revealed admission on 5-27-17. The record contained a TB skin test on 5-28-17. The record lacked documentation of a second TB skin test. Interview on 2-12-18 at 12:03 pm Licensed Staff E confirmed the record lacked documentation of a 2-step TB skin test or chest x-ray to rule out TB. For Certified Staff N, Non-Certified Staff S, and Resident #550, the administrator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes	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 _____	02/14/2018

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
S3310	Continued From page 36 adopted by reference in K.A.R. 26-39-105.	S3310		