STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046109	A. BUILDING: _____ B. WING _____	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CRESTONE SENIOR LIVING	21810 W. 119TH STREET OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of the inital survey with attached complaints #194559, #193321, #192814, #192183, #192101, and #191318 at the above named assisted living conducted on 04/30/25, 05/01/25, 05/05/25, 05/06/25.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 56 residents with three residents included in the sample and three focused reviews. Based on observation, interview, and record review the administrator failed to protect Resident (R) 3 from neglect by the failure to ensure staff responded timely to an alarm activation on 04/01/25 at 08:37 PM when cognitively impaired R3 exited the facility through an egress door to the outside. The local police department found R3 at approximately 10:00 PM (one hour and 23 minutes later) in the parking lot of a nearby school. This placed R3 in Immediate	S3026		

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

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S3026	Continued From page 1 Jeopardy. Findings included: - Record review for R3 revealed an admission date of 04/01/25 with a diagnosis of Alzheimer's Disease. The 04/01/25 "Functional Capacity Screen" (FCS) documented R3 as independent with transfers and walking mobility and was at risk for falls and wandering. The 04/01/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R3 encouragement to take breaks, sit often to prevent injury from falls, and checked her wandering monitor device each shift for placement and functioning. The 04/01/25 at 03:37 PM "Progress Note" documented R3 moved into the memory care unit of the facility. She ambulated independently without any assistive devices. The 04/01/25 at 11:48 PM "Progress Note" documented at approximately 09:47 PM facility staff reported they could not find R3 in the memory care unit. R3 was thankful to the police for assisting her back to the facility. She exhibited no signs of injury or adverse reactions to the incident. Her daughter assisted R3 to bed and stayed until R3 fell asleep. The 04/01/25 and 04/02/25 "15 Minute Checks" form documented facility staff visually checked R3 every 15 minutes from 04/02/25 at 12:30 AM to 04/02/25 at 11:45 PM.	S3026		

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S3026	Continued From page 2 The 04/09/25 facility "Investigation Report" to the department reported the following: On 04/01/25 at 08:37 PM - an alarm in the memory care unit activated while Certified Nurse Aide (CNA) D and CNA E were busy providing care to other residents in their apartments. 08:51 PM - (14 minutes after the alarm activated) CNA D acknowledged the alarm. 09:05 PM - R3 knocked on an independent living resident's patio door. 09:08 PM - R3 exited out the front door of the building. 09:25 PM - (34 minutes after the alarm activated) CNA D reported R3 was missing. The nurse instructed CNA D and CNA E to begin an immediate search of the memory care unit. They failed to find R3. 09:40 PM - (one hour and three minutes after the alarm activated) Licensed Nurse C notified Administrative Staff F R3 was missing and the search for R3 expanded to other areas of the building. 09:45 PM - facility staff notified Administrative Staff A R3 was missing. Administrative Staff A notified the local police department. 10:00 PM- (one hour and 23 minutes after the alarm activated) - The police found R3 in a parking lot of a school west of the facility. The 04/02/25 "Training and In-Service Agenda" documented facility staff participated in an elopement training in-service. Review of facility records revealed facility staff participated in missing resident drills on 10/11/24, 12/26/24, 01/27/25, and 03/26/25. The last drill was six days before R3 successfully	S3026		

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S3026	Continued From page 3 exited the building without staff knowledge. The facility's "Resident Monitoring Systems" logbook report from 05/11/24 to 04/26/25 documented operation of door monitors and patient wandering system in the main building was checked weekly by maintenance staff. Observation on 05/01/25 at approximately 12:15 PM revealed the memory care unit exit doors were alarmed and secured with a keypad to enter a code or a scanning device near the door that required a key fob to open the door. All doors also had a wander monitoring system that alarmed when a resident wearing a monitoring device was near the door. An egress door on the southeast corner of the unit was secured like the other doors with the addition of a sign that informed readers to push against the door until it opened for emergencies. On 05/01/25 at approximately 12:15 PM Administrative Staff A stated there were two staff present in the memory care at the time R3 exited the facility. One staff was present in the front common area of the memory care where she last saw R3. The other staff assisted a resident in their room. Another resident required immediate care and the staff member in the common area went into the resident's room to assist. It was during that time R3 left the common area, walked to the egress door, and unsuccessfully attempted to enter a code. R3 held the door handle down until the door opened, alarmed, and R3 walked out. R3 walked across the courtyard and knocked on an independent living resident's patio door, went through the resident's apartment to the front entrance of the building and walked	S3026		

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S3026	Continued From page 4	S3026		

out. The staff first heard the alarm when they exited the residents' rooms where they had been assisting with cares. Facility staff moved the sign on the door to a higher position and installed a louder alarm. Administrative Staff A stated one of the staff working was an agency CNA and the other staff worked only as needed. They did not provide witness statements, and she was unable to reach them for interview.

On 05/01/25 at approximately 12:15 PM Administrative Staff F stated the door alarm/wander monitoring system alerted staff on their work phones with a "chime."

Observation on 05/01/25 at 12:22 PM revealed the egress door alarm was not audible in all resident bathrooms with the sink water running.

On 05/01/25 at approximately 12:22 PM Administrative Staff A confirmed the egress door alarm was not audible when staff were in some resident bathrooms, with sink water running.

Observation on 05/01/25 at approximately 12:40 PM revealed a four-lane street in front of the facility on the south with a sidewalk. Between the front parking lot and the street was an area landscaped with large rocks surrounding two covered drains. It was downhill from the facility entrance to the sidewalk and street. Across the street from the facility entrance was a small pond. Behind the facility was a high metal fence. West of the facility (the direction police found R3) was another four-lane street with a sidewalk. A long-curved driveway led to the school parking lot where police found R3. The area was open and grassy with no large trees or buildings

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S3026	Continued From page 5 blocking the view. On 05/05/25 at 12:06 PM Administrative Staff A stated the maintenance department installed a new louder alarm on the egress in the memory care unit. Observation on 05/05/25 at 12:16 PM revealed the egress door newly installed on 05/02/25 alarm was not audible when in a resident's room in the bathroom with sink water running at full blast in the room farthest from the egress door. Administrative Staff A turned the water down and the door alarm was faintly audible when listening for it. On 05/05/25 at 02:06 PM CNA G stated there were two phones assigned to the unit. When one of them charged, there was only one phone available to use. CNA G stated she did not currently have a phone but obtained a phone from another staff and attempted to demonstrate the alert staff heard on their phones if the door alarm/wander monitoring system activated. CNA G could not sign into the app on the phone and received an error message. She stated the facility's Wi-Fi system was down, and the phones had not worked all day. Staff had reported the problem to Administrative Staff F. On 05/05/25 at 02:12 PM Administrative Nurse B stated the facility phone alerted staff via a monitoring application (app), but they had to sign into the app to receive notifications. She was unsure if agency staff received access and training for the app so they could receive alerts on their phones.	S3026		

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S3026	Continued From page 6 On 05/05/25 at 02:18 PM CNA H stated her phone had not worked all day. On 05/05/25 at 02:30 PM Licensed Nurse C stated she was present in the facility the evening R3 went missing. She gave report and handed off the phone to the agency night nurse while she stayed late to catch up on charting. She verbally informed staff at hand-off how to sign in to the app to receive notifications. She did not know if an alert went to the phone carried by the agency nurse when R3 activated the alarm. Licensed Nurse C stated she became aware R3 was missing when one of the CNAs informed her. On 05/05/25 at approximately 02:51 PM Administrative Staff A stated she was unsure if agency staff received a log-in to the phone app. The weather on 04/01/25 according to Wunderground.com was 61 degrees Fahrenheit with a wind speed of 16 mph at 08:53 AM near the time R3 exited the facility. It was dark at 10:00 PM when police found her. The facility's 05/31/23 "Elopement Protocol" policy documented an immediate systematic search of the property and surrounding neighborhood would take place. Facility staff would notify law enforcement within 30 minutes if a resident was still missing. The administrator failed to protect R3 from neglect by the failure to ensure staff responded timely to an alarm on 04/01/25 at 08:37 PM when cognitively impaired R3 exited the facility through an egress door to the outside. The local police department found R3 at approximately 10:00 PM	S3026		

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S3026	Continued From page 7 (one hour and 23 minutes later) in the parking lot of a nearby school. The Immediate Jeopardy was removed on 04/02/25 at 12:30 AM, prior to the surveyor entering the building on 04/30/25, when the following actions were documented by the facility in their "Abatement Plan" and it was accepted by the department on 05/05/25 at 04:47 PM. 1. Facility staff initiated 15-minute visual checks of R3 on 04/02/25 at 12:30 AM 2. Administrative Staff F provided one-to-one care for R3 until 04/02/25 at 07:00 AM 3. The facility provided one-to-one 24-hour observation on 04/02/25 through 04/04/25. 4. R3's family provided one-to-one 24-hour observation on 04/05/25 and 04/06/25. 5. R3 moved out of the facility on 04/06/25. 6. Staff training regarding missing resident completed on 04/03/25. 7. Geri-Psych Nurse Practitioner visited R3 and modified her medications on 04/03/25. 8. Elopement drill completed on 04/09/25. 9. Egress door sign was moved to the top of the door on 04/11/25. 10. A black rug was placed in front of the egress door on 04/15/25. 11. A louder door alarm was installed on 05/02/25.	S3026		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual '	S3080		

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S3080	Continued From page 8 s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 56 residents with three residents included in the sample and three focused reviews. Based on interview and record review the administrator failed to ensure designated staff recorded all findings of functional capacity on the screening forms for Resident (R) 7 and R8. Findings included: - Record review for R7 revealed an admission date of 08/15/24 with diagnoses of dementia, weakness, repeated falls, and dysphagia. The 11/20/24 "FCS" identified R7 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications; she was rarely or never understandable and rarely or never understood others during communication; and was at risk for falls and impaired vision.	S3080		

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S3080	Continued From page 9 The 11/20/24 "FCS" cognition section was blank. The 11/25/24 "NSA" identified R7 received complete assistance for bathing, dressing, and toileting; two-persons assisted with transfers; someone propelled her wheelchair to and from meal, around the community, and to activities for walking/mobility; she received set-up assistance for eating and her husband routinely fed her. Facility staff managed R7's medications. R7 received complete assistance to change briefs every two hours for bladder incontinence, physical therapy and/or occupational therapy and was on a toileting schedule to prevent injury from falls; and she managed her impaired vision independently. On 05/06/25 at 02:17 PM Administrative Staff A confirmed R7's "FCS" failed to document all findings of her functional capacity. - Record review for R8 revealed an admission date of 03/31/25 with diagnoses of dementia, type 2 diabetes mellitus, and muscle weakness. The 03/27/25 "FCS" identified R8 required physical assistance with bathing and dressing, she was occasionally incontinent of bladder, she was rarely or understandable and always understood others during communication; and was at risk for falls, impaired vision, and impaired hearing. The 03/27/25 "FCS" management of medications and treatments and cognition sections were blank. The undated "NSA" identified R8 received management of medications by facility staff and	S3080		

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S3080	Continued From page 10 checking her mobility device for appropriate height, adequate condition, and her ability to use it safely. The "NSA" failed to describe services R8 received for bathing, dressing, bladder incontinence, cognitive difficulties, communication, impaired vision and impaired hearing. On 05/06/25 at 02:21 PM Administrative Staff A confirmed R8's "FCS" failed to document all findings of her functional capacity. On 11/13/24 at approximately 10:34 AM Administrative Staff A confirmed R8's "NSA" failed to document the findings of her functional capacity for management of treatments. The administrator failed to ensure designated staff recorded all findings of R7 and R8's functional capacity on a screening form.	S3080		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service;	S3085		

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S3085	Continued From page 11 and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(2) The facility reported a census of 56 residents with three residents included in the sample and three focused reviews. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Resident (R) 7 identified the provider of each service. Findings included: - Record review for R7 revealed an admission date of 08/15/24 with diagnoses of dementia, weakness, repeated falls, and dysphagia. The 11/20/24 "FCS" identified R7 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications; she was rarely or never understandable and rarely or never understood others during communication; and was at risk for falls and impaired vision. The cognition section of the "FCS" was blank. The 11/25/24 "NSA" identified R7 received complete assistance for bathing, dressing, and toileting; two-persons assisted with transfers; someone propelled her wheelchair to and from meal, around the community, and to activities for	S3085		

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S3085	Continued From page 12 walking/mobility; she received set-up assistance for eating and her husband routinely fed her. Facility staff managed R7's medications. R7 recieved complete assistance to change briefs every two hours for bladder incontinence, physical therapy and/or occupational therapy and was on a toileting schedule to prevent injury from falls; and she managed her impaired vision independently. The "NSA" failed to identify the provider of services for bathing, dressing, toileting, transfers, walking/mobility, and bladder incontinence. On 05/06/25 at approximately 01:02 PM Administrative Staff A stated the "NSA" was also the "Service Plan." On 05/06/25 at 02:10 PM Administrative Staff A confirmed R7's "NSA" failed to identify the provider of services for bathing, dressing, toileting, transfers, walking/mobility, and bladder incontinence. The 05/31/23 facility's "Individualized Service Plan (ISP)" policy documented an "ISP" would be maintained for each resident. The administrator failed to ensure the "NSA" for R7 identified the provider of each service.	S3085		
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	S3101		

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S3101	Continued From page 13 the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 56 residents with three residents included in the sample and three focused reviews. Based on interview and record review the administrator failed to ensure designated staff ensured each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R) 3, R4, R6, R7, and R8. Findings included: - Record review for R3 revealed an admission date of 04/01/25 with a diagnosis of Alzheimer's Disease. The 04/01/25 "FCS" identified R3 required physical assistance with bathing; was unable to perform management of medications and treatments; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was at risk for falls, impaired vision, impaired hearing, impaired decision-making, wandering, and inappropriate behavior. The 04/01/25 "NSA" identified R3 received assistance by facility staff for bathing, management of medications, encouragement to take breaks and sit often to prevent injury from	S3101		

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THE CRESTONE SENIOR LIVING	21810 W. 119TH STREET OLATHE, KS 66061

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S3101	Continued From page 14	S3101		

falls, and checking her wander monitoring device for placement and function each shift. R3 was independent with impaired vision and impaired hearing. She had a power of attorney (POA) for impaired decision-making. Services R3 received for management of treatments, cognitive difficulties, and inappropriate behavior were not described on the "NSA."

The 04/01/25 "NSA" lacked signatures.

On 05/05/25 at 12:42 PM Administrative Staff A confirmed R3's "NSA" lacked signatures.

- Record review for R4 revealed an admission date of 09/05/24 with diagnoses of dementia and paraplegia.

The 10/31/24 "FCS" identified R4 was unable to perform management of medications and was occasionally incontinent of bladder.

The 12/13/24 "NSA" identified R4 received management of medications by facility staff and she was independent with incontinence care.

The 04/01/25 "NSA" lacked signatures.

On 05/05/25 at approximately 01:39 PM Administrative Staff A confirmed R4's "NSA" lacked signatures.

- Record review for R6 revealed an admission date of 09/27/24 with diagnoses of dementia, wandering, and Alzheimer's Disease.

The 12/10/24 "FCS" identified R6 was unable to perform management of medications, was

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S3101	Continued From page 15 occasionally incontinent of bladder, and was at risk for wandering. The 02/26/25 "NSA" identified R6 received management of medications by facility staff, reminders from staff for bladder incontinence, and assistance to minimize elopement risk. The "NSA" failed to describe services provided for wandering. The 02/26/25 "NSA" lacked signatures. On 05/06/25 at 02:06 PM Administrative Staff A confirmed R6's "NSA" lacked signatures. - Record review for R7 revealed an admission date of 08/15/24 with diagnoses of dementia, weakness, repeated falls, and dysphagia. The 11/20/24 "FCS" identified R7 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications; she was rarely or never understandable and rarely or never understood others during communication; and was at risk for falls and impaired vision. The cognition section of the "FCS" was blank. The 11/25/24 "NSA" identified R7 received complete assistance for bathing, dressing, and toileting; two-persons assisted with transfers; someone propelled her wheelchair to and from meal, around the community, and to activities for walking/mobility; she received set-up assistance for eating and her husband routinely fed her. Facility staff managed R7's medications. R7 recieved complete assistance to change briefs every two hours for bladder incontinence,	S3101		

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physical therapy and/or occupational therapy and was on a toileting schedule to prevent injury from falls; and she managed her impaired vision independently.

The 11/25/24 "NSA" lacked signatures.

On 05/06/25 at approximately 01:02 PM Administrative Staff A confirmed R7's "NSA" lacked signatures.

- Record review for R8 revealed an admission date of 03/31/25 with diagnoses of dementia, type 2 diabetes mellitus, and muscle weakness.

The 03/27/25 "FCS" identified R8 required physical assistance with bathing and dressing, she was ocassionally incontinent of bladder, she was rarely or understandable and always understood others during communication; and was at risk for falls, impaired vision, and impaired hearing. The management of medications and treatments and cognition sections were blank.

The undated "NSA" identified R8 received management of medications by facility staff and checking her mobilty device for appropriate height, adequate condition, and her ability to use it safely. The "NSA" failed to describe services R8 received for bathing, dressing, bladder incontinence, cognitive difficulties, communication, impaired vision and impaired hearing.

The undated "NSA" lacked signatures.

On 05/06/25 at 02:21 PM Administrative Staff A confirmed R8's "NSA" lacked signatures.

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S3101	Continued From page 17 On 05/06/25 at approximately 01:02 PM Administrative Staff A stated the "NSA" for all residents was also their "Service Plan." The 05/31/23 facility's "Individualized Service Plan (ISP)" policy documented an "ISP" would be maintained for each resident and must be signed by the resident or responsible party. The administrator failed to ensure designated staff ensured each individual involved in the development of the "NSA" signed the agreement for R3, R4, R6, R7, and R8.	S3101		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3)	S3211		

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S3211	Continued From page 18 The facility reported a census of 56 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of six over-the-counter (OTC) medications. Findings included: - Observation on 04/30/25 at 01:56 PM revealed Certified Medication Aide (CMA) J unlocked and opened assisted living medication cart #2. The following OTC medications lacked residents' full names: One bottle of acetaminophen 500 milligrams (mg), 100 caplets One bottle of Zyrtec 10 mg, 25 liqui-gels On 04/30/25 at approximately 01:56 PM CMA J confirmed two OTC medications in medication cart #2 lacked residents' full names. On 04/30/25 at 02:02 PM revealed CMA J unlocked and opened assisted living medication cart #1. The following OTC medications lacked residents' full names: Two bottles of Macular Health 60 softgels One bottle of Robitussin DM, eight ounces (oz) On 04/30/25 at approximately 02:02 PM CMA J confirmed three OTC medications in medication cart #1 lacked residents' full names. On 04/30/25 at 02:12 Licensed Nurse C unlocked and opened the memory care	S3211		

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S3211	Continued From page 19 medication cart. The following OTC medications lacked residents' full names: One bottle of Restore Eye Health, 60 softgels On 04/30/25 at approximately 02:12 Licensed Nurse C confirmed one OTC medication in memory care medication cart lacked residents' full names. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of six OTC medications.	S3211		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(b)(6)(8)	S3270		

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S3270	Continued From page 20 The facility reported a census of 56 residents. Based on interview and record review the administrator failed to ensure the written emergency management plan included how to manage a potential emergency during a natural gas leak or if a resident went missing from the facility. Findings included: - Review of the facility's emergency management preparedness plan lacked evidence of detailed written plans to manage a natural gas leak emergency and missing resident emergency. On 05/06/25 at approximately at 02:55 PM Administrative Staff A confirmed the emergency management plan lacked evidence of detailed written plans to manage a natural gas leak emergency and missing resident emergency. The facility's 05/01/25 "Elopement Policy" documented elopement drills were completed monthly. On 05/06/25 at approximately 05:05 PM Administrative Staff wrote in an email the facility was currently working on a policy to address natural gas leaks. The administrator failed to ensure the written emergency management plan included how to manage a potential emergency during a natural gas leak or if a resident went missing from the facility.	S3270		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness	S3280		

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S3280	Continued From page 21 (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)(4) The facility reported a census of 56 residents. Based on interview and record review the administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents every quarter. Findings included: - Review of the facility's emergency management plan from opening revealed designated staff failed to conduct quarterly reviews of the plan with residents in the assisted living and memory care units.	S3280		

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S3280	Continued From page 22 On 04/30/25 at 04:12 PM Administrative Staff A confirmed facility records lacked evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents every quarter. The administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents every quarter.	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 and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d)	S3298		

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S3298	Continued From page 23 The facility reported a census of 56 residents. The facility had a main kitchen where dietary staff stored, prepared, and served food and one satellite kitchen where staff stored and served food. Based on interview and record review, the administrator failed to ensure dietary staff served food at the proper temperature to avoid bacterial growth. Findings included: - On 04/30/25 at approximately 02:30 PM food temperature logs for the main kitchen and satellite kitchen was requested which the facility failed to provide. On 04/30/25 at approximately 02:30 PM Administrative Staff I confirmed the facility lacked a food temperature log. The facility's 2015 "Culinary Policies and Procedures" documented the temperatures of foods would be checked prior to serving and documented on a form. The Kansas Department of Agriculture's "Focus on Food Safety" booklet documented "minimum hot holding temperature is 135 degrees Fahrenheit (F)." and "maximum cold holding temperature is 41 degrees F. The administrator failed to ensure dietary staff served food at the proper temperature to avoid bacterial growth.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage	S3299		

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S3299	Continued From page 24 (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 56 residents. The facility had a main kitchen where dietary staff stored, prepared, and served food, one satellite kitchen where staff stored and served food, and one service station where staff stored and served food. Based on observation and interview the administrator failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation on 04/30/25 at approximately 02:17 PM of the memory care kitchen revealed two refrigerators. The following items in refrigerator #1 contained the following food items for the residents that lacked date labels when they were opened or prepared: One five-pound container of Daisy sour cream Four 11.5-ounce (oz) bottles of mayonnaise One plastic gallon carton of milk One metal pan of shredded cheese covered with plastic wrap The following items in refrigerator #2 lacked date	S3299		

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labels when they were opened or prepared:

One 11.5 oz bottle of mayonnaise
One 64 oz bottle of cranberry/grape juice
One 56 oz bottle of Sunny D beverage
One plastic square container with a white semi-liquid substance covered with a plastic lid. The container lacked a label identifying what was inside.

On 04/30/25 at approximately 02:17 PM Administrative Staff F stated the white substance was most likely house made ranch dressing.

Observation on 04/30/25 at approximately 02:29 PM of the main kitchen revealed the following:
1. Inside the freezer was plastic bag of what appeared to some kind meat patties. The bag was open and one patty laid by itself on a shelf.
2. Inside the refrigerator was a plastic bag of what appeared to be prepared biscuits. The bag was open with biscuits falling out of the bag. There were also two plastic containers covered in plastic wrap that contained what appeared to be salad with meat. The containers lacked date labels when they were prepared.
3. In the corner of the kitchen were shelves containing paper goods. On one of the shelves was an opened container of minced garlic and one 32 oz bottle of opened lemon juice with a label that read "Refrigerate after opening."
4. The dry goods pantry had a clear, rectangular, plastic container that stored dry rice. The top of the container had two side-by-side lids that did not fit, leaving an approximate two-inch opening.

Observation on 04/30/25 at 02:49 PM of the

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S3299	Continued From page 26 service station revealed a refrigerator with a temperature log attached the front. The log lacked documentation of refrigerator temperatures from 04/01/25 to 04/30/25. Inside the refrigerator were the following items that lacked date labels when they were opened or prepared: One 11.5 oz bottle of mayonnaise One plastic gallon carton of milk One metal pitcher was uncovered and contained what appeared to be a red substance. The Pitcher lacked a label of what was inside. On 04/30/25 at approximately 02:49 PM Administrative Staff I stated the red substance appeared to be V-8 juice. She confirmed the items in refrigerator lacked date labels. The 2015 facility's "Culinary Policies and Procedures" did not address food storage. The Kansas Department of Agriculture's 2024 "Focus on Food Safety" booklet documented food items must be date marked if they were time or temperature controlled for safety, ready-to-eat, prepared on-site, original container was opened, or held under refrigeration. Cold foods must be maintained at an internal temp of 41 degrees Fahrenheit or below and foods must be covered. The administrator failed to ensure designated staff stored food items under safe conditions.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe,	S3305		

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S3305	Continued From page 27 sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(b)(4)	S3305		

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S3305	Continued From page 28 The facility reported a census of 56 residents. Based on observation and interview the administrator failed to ensure designated staff maintained sanitary conditions for food service. Findings included: - Review of the facility's culinary cleaning log revealed it was blank. Observation on 04/30/25 at approximately 02:30 PM of the main kitchen revealed a food preparation counter with three fresh bell peppers and a wireless ear bud. An unidentified dietary staff stated the ear bud was his and removed it. On a shelf near the same food preparation counter was a plastic uncovered box with clean food service utensils inside. The outside of the box closest to the food preparation area appeared visibly soiled with what appeared to be dried spots of splashed liquids. The doors and handles of the refrigerator and upright freezer were visibly soiled and felt sticky to touch. On 05/01/25 at approximately 11:25 AM Administrative Staff A confirmed the cleaning was blank. She looked in the kitchen and could not find one that staff filled out. The facility's 2015 "Culinary Policies and Procedures" documented a sanitary environment to protect residents, staff, and visitors from food-borne illness.	S3305		

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THE CRESTONE SENIOR LIVING	21810 W. 119TH STREET OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3305	Continued From page 29 The administrator failed to ensure designated staff maintained sanitary conditions for food service.	S3305		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 56 residents with three residents included in the sample. Based on interview and record review for 3 Residents (R) 4 R6 and R8, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for three residents.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046109	A. BUILDING: _____ B. WING _____	05/06/2025

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S3310	Continued From page 30 Findings included: - Record review for R4 revealed an admission date of 09/05/24 with diagnoses of dementia and paraplegia. The 10/18/24 first step of a two-step TB skin test was negative which was 43 days after admission. The second step on 10/30/24 was also negative. R4's record lacked evidence of documentation designated staff provided a TB symptom screen questionnaire and a TB skin test within seven days of admission. - Record review for R6 revealed an admission date of 09/27/24 with diagnoses of dementia, wandering, and Alzheimer's Disease. The 10/18/24 first step of a two-step TB skin test was negative which was 21 days after admission. The second step on 11/01/24 was also negative. R6's record lacked evidence of documentation designated staff provided a TB symptom screen questionnaire and a TB skin test within seven days of admission. On 05/06/25 at 01:10 PM Administrative Staff A confirmed R4 and R6's records lacked evidence of documentation designated staff provided a TB symptom screen questionnaire and a TB skin test within seven days of admission. - Record review for R8 revealed an admission date of 03/31/25 with diagnoses of dementia, type 2 diabetes mellitus, and muscle weakness. The 03/31/25 first step of a two-step TB skin test was administered to R8. Her record lacked	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 31 evidence of documentation designated staff read results of the first-step TB skin test, provided a second step of the test and provided a TB symptom screen questionnaire. On 05/06/25 at 02:00 PM Administrative Staff A confirmed R8's record lacked evidence of documentation designated staff read results of the first-step TB skin test, provided a second step of the test and provided a TB symptom screen questionnaire. The 05/13/23 facility's "TB Tracking: Residents" policy documented a licensed nurse would administer the first step of a two-step TB skin test at move in or on the date of the pre-assessment. The second step must be administered no less than seven days after the initial step results were read. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of admission. The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		