STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046098	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF LENEXA	22000 PRAIRIE STAR PARKWAY LENEXA, KS 66220

(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 an abbreviated survey for complaints #'s 184172, 184067, 184041, 183878, and 183392 of the above named facility conducted on 11/28/23 and 11/29/23.	S 000		
S3026 SS=G	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: K.A.R. 26-41-101(f) (1) (A) The facility reported a census of 70 residents. The sample included one "Resident" (R)1, and two closed record reviews (R's 2 and 3). Based on observation, interview, and record review the administrator failed to protect R1 from physical abuse when "Certified Nurse Aide" (CNA) A was observed on video striking him on his bare rear right thigh, while cursing at him. The administrator further failed to protect R2 from abuse from CNA B who was unnecessarily rough with R2 during her physically assisted transfer, gave her a shower using cold water, and intentionally sprayed cold water in R2's face	S3026		

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

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S3026	Continued From page 1 twice. Findings included: - Record review for R1 revealed an admission date of 04/14/22, with diagnoses of hypertension, sensorineural hearing loss of both ears, late onset Alzheimer's disease with behavioral disturbances, obstructive sleep apnea, depression, chronic pain, and depression/anxiety. R1's "Functional Capacity Screen" (FCS) dated 09/11/23 revealed R1 was unable to perform the tasks of bathing, dressing and toileting. He required physical assistance with eating. He was independent with walking and mobility. He lacked the ability to manage his own medications and was incontinent of his bladder. He had impaired short-term memory, impaired long-term memory, impaired memory recall and impaired decision making. He was sometimes able to make himself understood and he usually understood others. He was marked with impaired hearing, wandering, and impaired decision making. He used no mobility device. R1's "Negotiated Service Agreement" (NSA) dated 09/11/23 identified the facility would have one staff member provide full assistance with bathing, dressing, toileting, and placing/removing his hearing aids. He required no assistance with ambulation, transfers or eating. Facility staff were to provide reassurance/redirection as needed. R1's "Individual Service Plan" (ISP) dated 09/11/23 instructed facility staff to wash R1's	S3026		

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S3026	Continued From page 2	S3026		

body and encourage R1 to assist. Staff to provide assistance with dressing/undressing, and assist with toileting, changing his brief if it was soiled. Staff to assist with the placement and removal of his hearing aids and assist R1 with calming when he was agitated. Staff were to allow him to vent himself using his word salad, and when staff providing information to him, allow adequate time for R1 to process the information.

Review of R1's "Observation Notes" dated 11/02/23 revealed the following entry:
At 02:35 PM "Daily Communication Log" note; R1 had left the community to go to a geriatric psychiatric hospital.

- Observation of the untimed and undated 14 second video provided to the facility from R1's wife revealed R1 laid in bed on his back with CNA A standing on the right side of the bed. R1 wore only a pair of white socks that came above the ankle. His knees were bent, and his feet were raised off the mattress. It was not clear in the video to see CNA A's left hand; her right hand was across R1's right knee and she held the outside of R1's lower left knee. R1 could be heard speaking, and CNA A responded, "Get your pants on", "We have to get your pants on". While CNA A spoke to R1 she continued to hold the lower outside of R1's left knee. R1 rolled from his back to his left side in the fetal position, CNA A let go of his left knee, bent over the top of the bed with the bottom of her right forearm resting on the outside of R1's right leg. R1 pulled his right leg forward and CNA A stood up and raised her right arm up, with hand closed towards the

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right side of her head and she rapidly lowered her hand in a downward position. The video revealed CNA A's hand make contact with R1's bare right hip and she stated "Dammit". CNA A walked to the right side of the bed and continued to say R1's name. R1 remained on his left side in the fetal position. CNA A continued to try and move R1's right leg. The 14 second video stopped at this time.

Review of the facility provided text message communication, from R1's wife, revealed an undated and untimed message to CMA F which stated "I realize you are extremely busy, but would you please report back to me later? Also, I have a very disturbing/painful video clip from last night" of CNA A and R1 "I want someone to ask her if she's ready to report her actions". CMA F responded that she would ask CNA A what she did.

Interview on 11/29/23 at 12:49 PM with CMA F, she confirmed the date of the text message was on 11/02/23 at 10:00 AM. She stated CMA F worked the overnight shift and the incident happened on 11/01/23 during the night shift. CMA F stated that R1 was admitted to the geriatric psychiatric unit on 11/02/23 and that she did not speak to R1's wife again until 11/03/23.

Review of the facility provided text message communications on Friday 11/03/23 at 04:32 PM from Administrator D to R1's wife, revealed Administrator A requested the video clip from R1's wife and reported to her that CNA A was suspended. R1's wife responded she had tried unsuccessfully to send the clip to CMA F and she would come to the facility on the following

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Monday morning for assistance in transferring the video to the facility. Administrator A responded with a request for what R1's wife saw/heard so she could make the department report.

Review of the facility provided text message communications on Friday 11/03/23 at 03:07 PM from Administrator A to CNA A, told her that she was on administrative leave, she could not come back to the building at this time, and that she would need to write a statement. CNA A's response was she would do whatever was asked of her, and she really liked her job and hoped she did not do anything to make her lose it, and to please give her another chance she would do a better job.

Interview on 11/29/23 at 04:12 PM with Administrator D, confirmed she suspended CNA A as soon as she was made aware of the incident. She confirmed CNA A did abuse R1 on 11/01/23 and worked her next shift on 11/02/23, and when the wife made the video available on 11/03/23 CNA A was suspended then terminated. Administrator A confirmed CNA A refused to provide a written statement. Administrator A included in her statement R1 was sent to a geriatric psychiatric unit on 11/02/23.

The administrator failed to protect R1 from physical abuse when CNA A was observed, on video, striking him on his bare rear right thigh, while cursing at him.

- Record review for R2 revealed an admission date of 06/28/23, with diagnoses of late onset

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S3026	Continued From page 5 Alzheimer's disease, dementia with behaviors/delirium, paroxysmal atrial fibrillation, major depressive disorder, hypertension, chronic diastolic congestive heart failure, anxiety, presence of a pacemaker, nonrheumatic aortic valve stenosis, depression, and chronic pain. R2's FCS dated 09/21/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, mobility, and eating. She lacked the ability to manage her own medications, she was incontinent of her bladder, and had impaired short-term memory, impaired long-term memory, impaired memory recall and impaired decision making. She was sometimes able to make herself understood and she sometimes understood others. She was marked with falls, socially inappropriate disruptive behavior, and impaired decision making. She used a walker and a wheelchair mobility device. R2's NSA dated 09/21/23 identified the facility would have staff assist with bathing, dressing, toileting opportunities every two to three hours, and when transferring out of bed R2 would have two staff members. All other transfers required one staff member for assistance. One staff member would assist R2 with meals. R2's ISP dated 09/21/23 instructed facility staff to provide total assistance with bathing. Staff were to give R2 "a washcloth and encourage" her to wash herself. Staff were to provide "hands on assistance for all dressing and undressing" R2 did not participate in this task. Facility staff were to provide toileting opportunities every two to three hours. R2 required two staff members transferring her from her bed, and only one staff	S3026		

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member was required for all other transfers.

Review of R2's "Observation Notes" dated 07/19/23 to 10/25/23 revealed the following entries:

On 07/19/23 at 09:34 PM a "Nurse Note" for R2 monthly summary. It stated R2 required full assistance with all "Activities of Daily Living" (ADL)'s and R2 would often scream out calling for her "Mommy".

On 07/20/23 at 02:55 PM a "Nurse Note" stated that R2 continued to have daily behaviors and was scheduled to see the "Nurse Practitioner" (NP).

On 07/31/23 at 02:50 PM a "Nurse Note" stated R2 had no behaviors on this day. She did refuse to allow a male care giver to provide her care and did allow a female caregiver to provide care.

On 08/30/23 at 03:37 PM a "Daily Communication Log" note revealed R2 received a shower and she "screamed" and called staff "bad names".

On 10/11/23 at 03:09 PM a "Nurse Note" stated an allegation of abuse. "Resident service director and Executive Director" were completing the investigation. The local police, family, and NP were notified. "Resident was in good spirits, confused per her baseline, and had no recollection of the incident". "Accused staff member was immediately suspended and escorted from the building pending completed investigation".

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S3026	Continued From page 7 On 10/12/23 at 07:18 AM a "Daily Communication Log" note stated R2 was very emotional on 10/10/23. "Resident was going through a mix of emotions". Review of the facility provided investigation of the allegation of abuse revealed on 10/10/23 between 08:30 and 09:00 PM CNA C was assisting CNA B with providing a shower for R2. CNA C reported to Administrator D that she witnessed CNA B spray R2 in the face with cold water twice, and when CNA C tried to adjust the water temperature CNA B pushed her hand away. Administrator D was notified on 10/10/23 at approximately 09:45 PM of the abuse. CNA B was immediately suspended and then terminated. Review of the facility provided notarized witness statement dated 10/12/23 from CNA C, she wrote she entered the memory care unit to see if CNA B needed any assistance and, heard R2 screaming. She proceeded to R2's room to check on her and observed R2 sitting on the toilet with CNA B in front of R2 removing her clothing in preparation for R2's shower. CNA C observed CNA B "Abruptly" transfer R2 to her wheelchair and wheeled her to the shower. CNA C "told him to be careful because it appeared he was rough when he initially transferred her". CNA C wrote "he proceeded to repeat the same roughness to the shower chair". She observed CNA B turn on the water and "sprayed" R2 from "top to bottom" with the water, and he did not check the water temperature prior to spraying R2 with the water. She was holding the washcloth and it was "cold". "After he grabbed the washcloth from me, and put soap on the washcloth, he turned the water	S3026		

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S3026	Continued From page 8 off". "He then turned the water back on", R2 "said it was cold and asked for something to dry her face". CNA C turned around to get a towel and CNA B sprayed R2 in the face with the water. CNA C and R2 requested that CNA B not spray her in the face and CNA B started laughing and sprayed R2 in the face a second time. Interview on 11/29/23 at 09:00 AM with Administrator D and "Resident Service Director" (RSD) /" "Licensed Nurse" (LN) E, they stated R2 would scream out with all cares provided. She stated CNA B had completed required CNA training in English. Administrator B stated that she had caught CNA B providing incorrect information at times related to his clock in and out times and would state he had provided resident cares when he had not. Interview on 11/30/23 at approximately 02:00 PM with Administrator D, she confirmed the ISP was the "Health Service Plan" (HSP). The administrator failed to protect R2 from abuse when CNA B was observed by facility staff transfer R2 in a rough manner, shower R2 with cold water and intentionally spray cold water in R2's face.	S3026		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each	S3248		

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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:
K.A.R. 26-41-102 (d) (2)

The facility reported a census of 70 residents. The sample included 1 resident, 2 closed record reviews and 2 newly hired "Certified Nurse Aides'" (CNA's A and B). Based on record review and interview the Administrator failed to ensure CNA's A and B had supporting documentation of a criminal background check pursuant to K.S.A. 39-970 being performed at the time of hire.

Findings included:

- Record review for CNA A revealed she began

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S3248	Continued From page 10 employment on 04/17/23. Her record lacked documentation of a criminal background check pursuant to K.S.A. 39-970. Interview on 11/29/23 at 10:17 AM with Administrator D, she confirmed CNA A employee file lacked the criminal background check pursuant to K.S.A 39-970. - Record review for CNA B revealed he began employment on 07/25/23. His record lacked documentation of a criminal background check pursuant to K.S.A. 39-970. Interview on 11/29/23 at 10:17 AM with Administrator D, she confirmed CNA A employee file lacked the criminal background check pursuant to K.S.A 39-970. The Administrator failed to ensure CNA's A and B had supporting documentation of a criminal background check pursuant to K.S.A. 39-970 being performed at the time of hire.	S3248		