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S 000	INITIAL COMMENTS The following citations represent the findings of abbreviated (complaint) survey #108961 at the above named facility on 2-21-17, 2-22-17, 2-23-17, 2-27-17, 2-28-17, 3-1-17, 3-2-17, 3-6-17, 3-7-17 and 3-8-17.	S 000		
S 105 SS=D	26-39-103 (b) Exercise of Resident Rights (b) Exercise of rights. (1) The administrator or operator shall ensure that each resident is afforded the right to exercise the resident ' s rights as a resident of the adult care home and as a citizen. (2) The administrator or operator shall ensure that each resident is afforded the right to be free from interference, coercion, discrimination, or reprisal from adult care home staff in exercising the resident's rights. (3) If a resident is adjudged incompetent under the laws of the state of Kansas, the resident ' s legal representative shall have the power to exercise rights on behalf of the resident. (4) In the case of a resident who has executed a durable power of attorney for health care decisions, the agent may exercise the rights of the resident to the extent provided by K.S.A. 58-625 et seq. and amendments thereto. This STANDARD is not met as evidenced by: KAR 26-39-103 (b)(2) The facility identified a census of 18 residents. The sample included 5 residents. Based on record review and interviewfor 1 (#2) of 5 residents sampled, the owner/operator failed to ensure each resident is afforded the right to be free from interference, coercion, discrimination,	S 105		

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

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S 105	Continued From page 1	S 105		

or reprisal from the adult care home staff in exercising the resident ' s rights.

- Record review for resident #2 revealed an admit date of 10-23-14 with diagnoses of schizophrenia, hypertension, and psychosis.

The FCS dated 1-6-17 recorded resident independent with dressing, toileting, transfer, walking/mobility, eating, communication, and experienced impaired decision making.

Interview on 2-21-17 at 12:30 p.m. with resident #2 stated he/she goes to store and gets snacks to keep in room and owner/operator wants us to eat all meals cooked in the facility. (The owner/operator) got onto him/her when he/she ordered a pizza and it was delivered to the facility about supper time. He/she was going to have it to snack on later in the evening. (The owner/operator) told resident #2 that he/she could not order a pizza at meal time and when he/she did order one it had to be delivered through the back door because all the residents then want pizza when they see it delivered through the front door and owner/operator wanted me to eat the dinner that was cooked for him/her.

Written statement from owner/operator dated 2-21-17 recorded, "I went to watch supper serve out and a pizza guy showed up at front door. I asked the guy why he was here and he stated that he had a pizza for (resident #2). After he said that I heard residents ask, 'are we getting pizza.' So I had to say no, that is for someone else. They said we want pizza. I asked (resident #2) to go back to room so we could talk. We went to his/her room and I asked him/her to have pizza delivered to back door because it makes

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S 105	Continued From page 2 other residents want pizza when they see it. He/She agreed and we are doing fine now. We have had no issues since this one." For resident #2, the owner/operator failed to ensure each resident is afforded the right to be free from interference, coercion, discrimination, or reprisal from the adult care home staff in exercising the resident ' s rights.	S 105		
S3026 SS=L	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)(A) The facility identified a census of 18 residents. The sample included 5 residents. Based on record review, interview and observations for all residents, the operator failed to ensure that no resident shall be subjected to verbal or mental abuse when staff members engaged in threatening and menacing conduct in the presence of residents. Findings included:	S3026		

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- Record review for resident #1 revealed admit date of 2-1-16 with diagnoses schizophrenia, epilepsy, mood disorder, depression and osteoporosis.

The annual Functional Capacity Screen (FCS) dated 1-30-17 recorded resident experienced impaired decision making and had no problems in short term memory, long term memory and memory recall.

Interview on 2-21-17 at 2:35 p.m. with resident #1 stated (office manager C) got into a fight with (licensed nurse A) at dinner time when everyone (all residents) was in the dining room for dinner. Office manager C was yelling at licensed nurse A and both were yelling and cursing at each other and asking residents questions about paperwork. Both of them were pushing each other and they eventually went outside. Not sure what happened after that. (Resident #1) further stated he/she was shook up after the incident and it was one of the reasons he/she wanted to move.

- Record review for resident #2 revealed admit date of 10-24-14 with diagnoses of schizophrenia, psychosis, and hypertension.

The FCS dated 1-6-17 recorded resident experienced impaired decision making and had no problems in short term memory, long term memory and memory recall.

Interview on 2-21-17 at 12:30 p.m. with resident #2 stated a lot of staff talk loud here and (office manager C) and (licensed nurse A) did get into an

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S3026	Continued From page 4	S3026		

argument at dinner time in front of all of us. They were in each other ' s face yelling and accusing each other of things then asked some of us questions during the argument. They finally went outside and some of the residents called the owner/operator to let him/her know what was going on. "

- Record review for resident #4 revealed an admit date of 6-10-14 with diagnoses of insulin dependent diabetic, chronic renal disease, depression, gout, and chronic obstructive pulmonary disease.

The FCS dated 6-7-16 recorded resident had no problems with short term memory, long term memory, memory recall or decision making.

Interview on 2-27-17 at 11:40 a.m. with resident #4 stated he/she was in dining room when (office manager C) and (licensed nurse A) got into an argument yelling at each other in front of the residents at dinner time. They were yelling about paperwork not being done right.

During an interview on 2-23-17 at 11:00 a.m. licensed nurse A showed a video of self and office manager C involved in a loud verbal altercation. At one point office manager C walked into the dining room where residents were eating, saying " you want to ask all these people. . .he/she is blaming me and telling me it ' s my fault " , then speaking to a resident, office manager C said " (licensed nurse A) told me it was my fault because I put it in your ear, I told him/her, [blank] him/her, I did not put it in your ear " The office manager C was yelling and cursing while licensed nurse A was asking why office manager C wrote

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S3026	Continued From page 5	S3026		

orders on resident records and put them on his/her desk, why the negotiated service agreements had not been signed by the residents, and if the residents had been informed their monthly payment to facility was going up? Office manager C continued yelling and cursing at licensed nurse A and moved closer to licensed nurse A, pointing his/ her finger at licensed nurse A while licensed nurse A said, " you can back up, you can back up " . Licensed nurse A responded in a loud voice yelling and cursing as well. Office manager C and licensed nurse A asked residents questions about signatures and forms while yelling at the residents and each other. Office manager C tried to grab licensed nurse A ' s phone out of his/her hand when licensed nurse A told him/her it was recording the altercation. Residents can be heard in the background trying to get them to stop. Licensed nurse A confirmed this all happened in front of and involved the residents. Licensed nurse A provided a copy of the video recording.

Written statement from office manager on 2-27-17 recorded, " licensed nurse A had been gone the day before and asked me to come to his/her office. He/she asked why papers were on his/her desk. He/she began ranting about the desk being very messy and stated who had the right to put all this paper work on desk. I replied staff put it there to either make sure he/she saw it or that it needed attention. Licensed nurse A ' s response was that when he/she left on Friday the desk was clean. This was Tuesday and I tried to explain that the doctor was here the day before. I shut the door because did not want to get out of hand. Licensed nurse A started accusing me of writing and taking orders. I told him/her ok but it

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S3026	Continued From page 6	S3026		

was not me. . . he/she boldly called me a liar and said I played doctor and had done it before. He/she started to raise his/her voice and I tried to keep it together. I really don ' t get upset and when he/she is gone things continue to need attention. The owner/operator had asked the previous nurse (licensed nurse G) to come in and catch up orders and have them up to date. Licensed nurse A began saying negative things about all staff and I told him/her I have never been talked to the way she was calling me names (cursing) and I lied about his/her desk and thought I was better than him/her and I hated kids and that was why I was upset because he/she had been gone due to sick kids. I said he/she had been gone a lot in the short time he/she worked here and was called a liar several times. By now I was mad and I raised my voice, not to yelling, and said I had enough and who did he/she think he/she was to throw out wrong statements about facility. I walked out and he/she came too. He/she grabbed my shoulder and stopped me and said ' I knew you had been doing orders and (operator/owner) passed medications. ' I laughed and he/she went nuts. Called our facility names and was turning us over to state and he/she was recording and taking pictures on the phone. I kind of reached out pointing to phone and he/she said if you touch my phone or me I will call the police. I didn ' t respond and just walked away. It was now dinner time and a lot of residents were out here. He/she kept the slander coming louder and in front of residents. I said I was sorry he/she believed in his/her head any such things and walked out of dining room to my office and he/she followed and continued to degrade all staff of facility. The residents started calling the owner/operator, he/she had numerous calls. The owner/operator came and licensed nurse A was still yelling.

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S3026	Continued From page 7 (Licensed nurse A) stated he/she should quit so I said, 'ok quit.' The owner/operator was here and tried to get him/her outside and finally went out and left without passing medications." Interview and written statement on 2-27-17 at 5:30 p.m. with owner/operator recorded, " I was feeding horses and do not have phone reception while there, as soon as I got a signal my phone rang and (licensed nurse A) stated he/she was leaving. I asked him/her to wait until I got to facility to talk about what happened. As I pulled up to facility I could hear licensed nurse A yelling at office manager and got between them and asked licensed nurse A to sit in my truck to calm down and talk to me about what happened. Licensed nurse A left. I talked to residents as it happened at supper time in front of residents. I was never asked to look at a video . . . " (Note: phone text message copies provided by licensed nurse A document that he/she attempted to send video and owner/operator was made aware that he/she had a video recording of the incident on 11-8-16.) For all residents, the operator failed to ensure that no resident was subjected to verbal or mental abuse when staff members engaged in threatening and menacing conduct in the presence of residents. This failure placed all residents in immediate jeopardy for harm including fear and emotional distress. The jeopardy was corrected on 2-23-17 when office manager C left the facility and was placed on leave.	S3026		

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S3028	Continued From page 8	S3028		
S3028 SS=L	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(B)(C)(F) The facility identified a census of 18 residents. The sample included 5 residents. Based on	S3028		

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S3028	Continued From page 9	S3028		

record review, and interview for all residents, the operator failed to ensure each allegation of abuse was reported to the department, immediate measures were taken to prevent further potential abuse, allegations of abuse were thoroughly investigated and a written record of the investigation was maintained. Two staff members engaged in a verbal altercation with threatening and menacing conduct in front of and involving residents on 11-8-16. The owner/operator failed to investigate and implement immediate measures to prevent further abuse. Residents reported additional incidents of verbal threats.

Findings included:

During an interview on 2-23-17 at 11:00 a.m. licensed nurse A showed a video of self and office manager C involved in a loud verbal altercation. At one point the office manager C walked into the dining room where residents were eating saying " you want to ask all these people. . .(licensed nurse A) is blaming me and telling me it ' s my fault " , then speaking to a resident said " (licensed nurse A) told me it was my fault because I put it in your ear, I told him/her, (blank) him/her, I did not put it in your ear " . Office manager C was yelling and cursing while licensed nurse A was asking why office manager C wrote orders on resident records and put them on his/her desk, why the negotiated service agreements had not been signed by the residents, and if the residents had been informed their monthly payment to facility was going up? Office manager C continued yelling and cursing at licensed nurse A and moved closer to him/her, pointing his/ her finger at licensed nurse A while licensed nurse A said " you can back up, you can back up " . Licensed nurse A responded in a loud

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S3028	Continued From page 10	S3028		

voice yelling and cursing as well. Office manager C and licensed nurse A asked residents questions about signatures and forms while yelling at the residents and each other. Office manager C tried to grab licensed nurse A ' s phone out of his/her hand when licensed nurse A told him/her it was recording the altercation. Residents can be heard in the background trying to get them to stop. Licensed nurse A confirmed this all happened in front of and involved the residents. Licensed nurse A provided a copy of the video recording.

Written statement from office manager C on 2-27-17 recorded, " licensed nurse A had been gone the day before and asked me to come to his/her office. He/she asked why papers were on his/her desk. He/she began ranting about the desk being very messy and stated who had the right to put all this paper work on desk. I replied staff put it there to either make sure he/she saw it or that it needed attention. Licensed nurse A response was that when he/she left on Friday the desk was clean. This was Tuesday and I tried to explain that the doctor was here the day before. I shut the door because did not want to get out of hand. Licensed nurse A started accusing me of writing and taking orders. I told him/her ok but it was not me. . . he/she boldly called me a liar and said I played doctor and had done it before. He/she started to raise his/her voice and I tried to keep it together. I really don ' t get upset and when he/she is gone things continue to need attention. The owner/operator had asked the previous nurse (licensed nurse G) to come in and catch up orders and have them up to date. Licensed nurse A began saying negative things about all staff and I told him/her I have never been talked to the way she was calling me names (cursing) and I lied about his/her desk and

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S3028	Continued From page 11	S3028		

thought I was better than him/her and I hated kids and that was why I was upset because he/she had been gone due to sick kids. I said he/she had been gone a lot in the short time he/she worked here and was called a liar several times. By now I was mad and I raised my voice, not to yelling, and said I had enough and who did he/she think he/she was to throw out wrong statements about facility. I walked out and he/she came too. He/she grabbed my shoulder and stopped me and said I knew you had been doing orders and (operator/owner) passed medications. I laughed and he/she went nuts. Called our facility names and was turning us over to state and he/she was recording and taking pictures on the phone. I kind of reached out pointing to phone and he/she said if you touch my phone or me I will call the police. I didn ' t respond and just walked away. It was now dinner time and a lot of residents were out here. He/she kept the slander coming louder and in front of residents. I said I was sorry he/she believed in his/her head any such things and walked out of dining room to my office and he/she followed and continued to degrade all staff of facility. The residents started calling the owner/operator, he/she had numerous calls. The owner/operator came and licensed nurse A was still yelling. (Licensed nurse A) stated he/she should quit so I said ok quit. The owner/operator was here and tried to get him/her outside and finally went out and left without passing medications.

Interview and written statement on 2-27-17 at 5:30 p.m. with owner/operator recorded, " I was feeding horses and do not have phone reception while there, as soon as I got signal my phone rang and (licensed nurse A) stated he/she was leaving. I asked him/her to wait until I got to facility to talk about what happened. As I pulled

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S3028	Continued From page 12	S3028		

up to facility I could hear licensed nurse A yelling at office manager C and got between them and asked licensed nurse A to sit in my truck to calm down and talk to me about what happened. Licensed nurse A left. The following morning I call (Regional Manager at Topeka) and he/she instructed me to call the Board of Nursing and tell them what happened. I called them and reported the incident. I found out that office manager C was trying to separate self from licensed nurse A and he/she would follow him/her and I thought he/she was going to hit office manager C. Later that day, licensed nurse A brought me a two week notice and I accepted it. Licensed nurse A returned to work and you could feel the tension in the facility. I talked to residents as it happened at supper time in front of residents. I was never asked to look at a video nor notified the department. I did not have anything in writing for review. " (Note: phone text message copies provided document that licensed nurse A attempted to send video and owner/operator was made aware that he/she had a video recording of the incident on 11-8-16)

Interview with Regional Manager on 3-2-17 at 7:30 a.m. recorded owner/operator contacted him/her on November 9, 2017 with questions about how to handle a situation with the nurse walking out. The owner/operator reported that office manager C and licensed nurse A had an altercation and licensed nurse A walked out, leaving no one to pass medication and no other nurse to take over resident care issues. Owner/operator was informed that if the nurse left without giving time to find a replacement it could be considered patient abandonment and may be reportable to the board of nursing. The owner/operator did not report that the altercation took place in front of or involved residents.

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S3028	Continued From page 13 Interviews with residents regarding the incident revealed the following: Interview on 2-21-17 at 2:35 p.m. with resident #1 stated (office manager C) got into a fight with (licensed nurse A) at dinner time when everyone (residents) was in the dining room for dinner. Office manager C was yelling at licensed nurse A and both were yelling and cursing at each other and asking residents questions about paperwork. Both of them pushing each other and they eventually went outside. Not sure what happened after that. (Resident #1) stated he/she was shook up after the incident and it was one of the reasons he/she wanted to move. Interview on 2-21-17 at 12:30 p.m. with resident #2 stated had lived her over a year and a half. Resident #2 stated " A lot of staff talk loud here and (office manager C) and (licensed nurse A) did get into an argument at dinner time in front of all of us. They was in each other ' s face yelling and accusing each other of things then asked some of us questions during the argument. They finally went outside and some of the residents called the owner/operator to let him/her know what was going on. " Interview on 2-27-17 at 11:40 a.m. with resident #4 stated he/she was in dining room when (office manager C) and (licensed nurse A) got into an argument yelling at each other in front of the residents at dinner time. They were yelling about paperwork not being done right.	S3028		

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S3028	Continued From page 14 Review of department records failed to show owner/operator reported of allegation of verbal abuse. Licensed nurse A continued to work during two week notice period and office manager C continued to be employed. Interviews with residents documented additional incidents of verbal threats by the office manager C. - Record review for resident #1 revealed admit date of 2-1-16 with diagnoses schizophrenia, epilepsy, mood disorder, depression and osteoporosis. The annual Functional Capacity Screen (FCS) dated 1-30-17 recorded resident experienced impaired decision making and had no problems in short term memory, long term memory and memory recall. Interview on 2-21-17 at 2:35 p.m. with resident #1 stated (office manager C) got onto him/her for drinking more than one cup of coffee and told him/her if he/she continued to drink more than two cups of coffee a day he/she would take away all residents coffee pots from their rooms and make sure no one drank more than two cups of coffee a day. Interview on 2-21-17 at 4:00 p.m. with office manager C stated he/she told resident #1 that he/she could not have caffeine due to seizures and doctors ' orders. He/she stated did not tell him/her he/she would take all coffee pots from residents rooms if he/she drank coffee.	S3028		

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S3028	Continued From page 15 - Record review for resident #3 revealed an admit date of 3-1-12 with diagnoses of chronic obstructive pulmonary disease, coronary artery disease, hypertension, bipolar, and anxiety. The FCS dated 9-9-16 recorded resident had impaired decision making and had no problems in short term memory, long term memory and memory recall. Interview on 2-21-17 at 5:10 p.m. with resident #3 stated office manager C told him/her he/she was going to take his/her coffee away from him/her if did not decrease coffee intake. "(Office manager C) told me he/she would have me out of here real fast; (office manager C) wants to be in control of everything. I have to buy instant coffee and ask staff to heat up hot water in the afternoon when I want coffee. " For all residents of the facility, the owner/operator failed to ensure each allegation of abuse was reported to the department, immediate measures were taken to prevent further potential abuse, allegations of abuse were thoroughly investigated and a written record of the investigation was maintained. Two staff members engaged in a verbal altercation with threatening and menacing conduct in front of and involving residents on 11/8/16. The owner/operator failed to investigate and implement immediate measures to prevent further abuse. Residents reported additional incidents of verbal threats. This failure placed all residents in immediate jeopardy for harm including fear and emotional or mental distress.	S3028		

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S3028	Continued From page 16 The jeopardy was corrected on 2-23-17 when office manager C left the facility and was placed on leave.	S3028		
S3155 SS=D	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 identified a census of 18 residents. The sample included 5 residents. Based on record review and interview for 1 (#1) of 5 residents sampled, the owner/operator failed to ensure a licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) that meet the needs of each resident and are in accordance with the Functional Capacity Screen (FCS) and the Negotiated Service Agreement (NSA). Findings included: - Record review for resident #1 revealed admit date of 2-1-16 with diagnoses schizophrenia, epilepsy, mood disorder, depression and	S3155		

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S3155	Continued From page 17 osteoporosis. The admission FCS dated 2-1-16 and significant change FCS dated 1-30-17 recorded resident independent with dressing, toileting, transfer walking/mobility, eating, required physical assistance with bathing and management of medications/treatments and had impaired decision making. Current or recent problems included falls/unsteadiness . The admission NSA/HCSP dated 2-1-16 and amended NSA/HCSP dated 1-16-17 recorded physical assistance for shower two times a week and independent with ambulation and transfer. The NSA/HCSP lacked interventions to address seizures, impaired decision making, inappropriate behaviors and falls/unsteadiness. The nurses notes recorded first recorded seizures on the 2-17-16. Additional seizures were recorded on the following dates - 4-4-16 seen by medical care provider as resident continued with daily seizures including today. - 7-13-16 seizure and hit head, sent to emergency room by ambulance. Had 4 Centimeter (CM) laceration to back of head. Returned from hospital with 10 staples in back of scalp. - 8-8-16 resident continues to have seizures once a day or every other day. - 9-3-16 seizure at approximately 12:30 a.m. - 9-9-16 continues with seizure activity.	S3155		

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S3155	Continued From page 18 The nurses notes provided on 2-21-17 at 2:55 p.m. lacked documentation of inappropriate behaviors. On 2-21-17 licensed nurse D back dated nurses notes for 2-20-17 that stated, " during the three months I have been here, resident has thrown medications at staff stating he/she did not want to take them, shaken his/her cane at staff as is he/she was going to hit them and stated ' Satan is in the room, get out of here Satan. ' God told him/her he/she was no longer an epileptic. " A written statement from licensed nurse D on 2-22-17 recorded, "On 2-21-17 I added nurses notes into chart for 2-20-17 about (resident's) behavior because the mental health hospital need additional documentation of resident's behavior on 2-20-17." A written statement from owner/operator on 2-21-17 at 12:45 p.m. recorded during the last thirty to forty-five days noticed resident was more agitated and had nurse set up appointment with mental health care facility to see what they thought they could do to help. They did an adjustment for a couple of weeks. There was little improvement so went back to mental health facility. They talked to him/her and not sure if they did any medication changes but still no improvement. . ." The NSA/HCSP lacked interventions for inappropriate behaviors. For resident #1, the owner/operator failed to ensure a licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) for seizures, falls, and inappropriate behaviors.	S3155		

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S3171	Continued From page 19	S3171		
S3171 SS=F	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility identified a census of 18 residents. The sample included 5 residents. Based on record review, interview, and observations for 3 (#1, #2, #5) of 5 residents, the operator failed to ensure all Health Care Services (HCSP) provided to residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for resident #1 revealed admit date of 2-1-16 with diagnoses schizophrenia, epilepsy, mood disorder, depression and osteoporosis. The annual Functional Capacity Screen (FCS) dated 1-30-17 recorded resident independent with walking, mobility, transfer, and experienced impaired decision making. The amended Negotiated Service Agreement (NSA)/HCSP dated 1-16-17 recorded resident independent with walking, mobility, and transfer. The NSA/HCSP recorded following for transportation: Staff to transport resident to local appointments; Medicaid cab with staff escort.	S3171		

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S3171	Continued From page 20 Staff not responsible for transportation to alcoholics anonymous (AA) meetings. Interview on 2-21-17 at 12:20 p.m. with licensed nurse D stated cancelled a scheduled neurologist appointment on 1-10-17 because the operator/owner told me to cancel the appointment due to no ride available to take resident. Interview on 2-21-17 at 2:35 p.m. with resident #1 stated (office manager C) got onto him/her for drinking more than one cup of coffee and told him/her if he/she continued to drink more than two cups of coffee a day he/she would take away all residents coffee pots from their rooms and make sure no one drank more than two cups of coffee a day. Interview on 2/21-17 with office manager C stated he/she told resident #1 that he/she could not have caffeine due to seizures and doctors' orders. He/she stated did not tell resident #1 he/she would tak all coffee pots from resident rooms if he/she drank coffee. Regional manager reported a voice mail message received on 2-22-17 at 6:56 p.m. from Resident #1 stating that he/she was being told he/she could not go to his/her AA meeting. Interview on 2-27-17 at 4:30 p.m. with office manager C stated he/she told resident #1 that he/she could not go to AA due to a seizure earlier in the day. He/she stated did not call nurse or operator to check if resident could go to AA meeting. "I am on call and if the staff cannot get a hold of operator they are to call me." Office manager C stated he/she did not call the registered nurse.	S3171		

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S3171	Continued From page 21 Review of resident ' s record lacked documentation of a seizure on 2-22-17. For resident #1, the operator failed to ensure all Health Care Services (HCSP) provided to residents by qualified staff in accordance with acceptable standards of practice when the office manager C failed to have registered nurse assess resident to determine if resident could have more coffee to drink or if resident was capable of going to his/her AA meeting per resident request. - Record review for resident #2 revealed admit date of 10-24-14 with diagnoses of schizophrenia, psychosis, and hypertension. The FCS dated 1-6-17 recorded resident experienced poor decision making, impaired decision making, resident unable to manage medications and required physical assistance with management of treatments. The NSA/HCSP dated 1-6-17 recorded facility staff to administer medications and manage treatments. The nurses notes recorded the following: 9-23-16 at 7:40 p.m. "(Office manager C) called and informed me resident (#2) was having paranoid delusions reporting people from the town was going to get (him/her) and stating, 'that man is not my husband, my husband passed away.' Resident's spouse is still alive. Resident reported to certified staff that new medication was causing dizziness, even though medication is same medication just at a lower dose. Reported he/she did not want to take medication. (Medical	S3171		

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S3171	Continued From page 22	S3171		

care provider) informed and received new order to change medication back to quetiapine 50 milligrams (for schizophrenia)." Signed licensed nurse A.

The record lacked evidence of resident being physically assessed by a licensed nurse.

Interview on 2-27-17 at 4:25 p.m. with office manager C stated and confirmed he/she stated resident #2 was having paranoid delusions and notified licensed nurse A to inform of the paranoid delusions and medication change.

For resident #2, the operator failed to ensure all Health Care Services (HCSP) provided to residents by qualified staff in accordance with acceptable standards of practice when non-medical personnel made an assessment of the resident, notified the licensed nurse and the licensed nurse reported that assessment to the medical care provider without personally assessing the resident.

- Record review for resident #5 revealed an admit date of 3-21-12 with diagnoses of depression, atrial fibrillation, dementia, hypertension, debility, and anxiety.

The FCS dated 1-10-17 recorded resident required supervision with transfer, physical assistance with bathing, dressing, toileting, bladder incontinence, unable to managed medications/treatments, experienced short term memory loss, memory recall, long term memory loss, impaired decision making, falls/unsteadiness, and wandering.

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S3171	Continued From page 23 Unable to locate a NSA/HCSP for 1-10-17. The HCSP dated 3-28-16 recorded certified medication aides, and licensed nurses are responsible for all medications and treatments to be administered. A written order dated 10-17-16 recorded: 1) kayexalate (to treat elevated potassium)15 grams now, 2) Stat lab on 10-19-16 for Basic Metabolic Panel (BMP), 3) then start kayexelate 30 grams on Tuesday and 15 grams on Thursday. The laboratory report dated 10-20-16 (run date) recorded potassium 5.7 ' ABNORMAL ' H (HIGH), (range 3.5 - 5.2.) The nurses notes recorded the following on 10-17-16 at 7:55 p.m. " received new lab orders from (medical care provider). " Signed licensed nurse A. No further notes documented in nurses notes until 11-1-16 that recorded left lower extremity healed. Interview on 2-23-16 at 9:20 a.m. with licensed nurse A stated " (resident #5's) potassium was elevated and I got order from medical care provider for kayexalate and recheck lab on 10-19-16 stat. I informed owner/operator of the stat lab ordered and resident would need to go to hospital as lab does not come to facility on that date. The owner/operator asked me to call the medical care provider and attempt to get the order changed. I informed him/her it was important and the medical care provider ordered it on that date stat. On 10-19-16 it was past 6:00 p.m. and owner/operator stated the lab is probably closed now. I called the hospital and	S3171		

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S3171	Continued From page 24 they said the lab was open twenty four hours seven days a week. The owner/operator then call the medical care provider to get order changed for lab day on Thursday. I went to hospital on 10-20-16 and got items needed to do a lab for potassium and took blood to the hospital. " Confidential interview stated he/she listened in on phone call and heard owner/operator talking to a (medical care provider) and asking to get lab dates changed. Written statement on 2-27-17 at 5:30 p.m. with owner/operator recorded, "I have never called to have a date changed as I don't deal with medical stuff." Written statement on 2-28-17 at 11:30 a.m. with owner/operator recorded, "No, I did not change the date for (resident #5). Interview on 2-27-17 at 4:45 p.m. with resident #5 unable to recall any lab or blood drawn. Resident is confused at this time. For resident #5, the operator failed to ensure all Health Care Services (HCSP) provided to residents by qualified staff in accordance with acceptable standards of practice when the stat lab ordered on resident #5 for 10-19-16 was not obtained until 10-20-16. For residents #1, #2, and #5, the owner/operator failed to ensure all HCS provided to residents by qualified staff in accordance with acceptable standards of practice.	S3171		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records	S3248		

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S3248	Continued From page 25 (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 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)(2) The facility identified a census of 18 residents. The sample included 5 residents. Based on record review and interview for 2 (#K and #L) of 2 personnel (certified staff) records reviewed, the owner/operator failed to ensure the records contained supporting documentation for criminal background checks of facility staff pursuant to	S3248		

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S3248	Continued From page 26 K.S.A. 39-970. Findings included: - Review of personnel records on 2-21-17 at 2:15 p.m. revealed certified staff K hired on 9-5-16 and certified staff L hired on 11-1-16 lacked evidence of a criminal background check. Interview on 2-21-17 at 3:30 with office manager C stated and confirmed unable to provide evidence that indicated criminal background check conducted for (certified staff K and L). For certified staff K and L, the owner/operator failed to ensure the records contained supporting documentation for criminal background checks of facility staff pursuant to K.S.A. 39-970.	S3248		