Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021007	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ABILENE MEMORY CARE	1100 N VINE STREET ABILENE, KS 67410

(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 the licensure resurvey with attached complaints (194049 and 191114) at the above named facility conducted on 04/15/25.	S 000		
S3028 SS=F	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (3) The facility reported a census of 23 residents. The sample included 1 closed record review resident. Based on record review and interview for 1 closed record review Resident (R)4, Certified Nurse Aide (CNA) C failed to ensure each allegation of abuse was reported to Administrator A as soon she was made aware of the allegation. Findings included: - Review of R4's medical record revealed he admitted to the facility on 01/26/23 with diagnoses of hypertension, hypothyroidism, major depressive disorder and cerebrovascular disease. R4's "FCS/NSA" (Functional Capacity Screen/ Negotiated Service Agreement) dated 08/13/24 recorded the resident as independent with toileting and eating, required supervision with transfer and required physical assistance with bathing, dressing, walk/ mobility and management of medications and treatments. R4 had short-term memory impairment, impaired decision making and was understandable/ understood communication. Reports indicated R4 was allegedly abused on 10/04/24 by Certified Medication Aide (CMA) D. R4 informed CNA C on 10/04/25 of allegation. CNA C failed to report allegation to Administrator	S3028		

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S3028	Continued From page 2 A. Reports indicated R4 informed an outside source on 10/07/24, who informed Administrator A. CNA C's signed facility obtained statement dated 10/07/24 recorded, "About 11:30 PM (no date), [R4] came out of his room. I went to talk to him and help him back to his room. He stated he needed to clean up his arm. I asked him what happened, and he stated that he got into it with that man. I helped him to his room and got the med aide [CMA D] to dress his skin tear. After he left [R4] stated he is the one who did it to my arm ..." Review of CNA C's record revealed training on reporting last completed on 01/29/24. Interview on 04/15/25 at approximately 03:00 PM with Administrator A confirmed CNA C did not report the allegation of abuse to Administrator A and further confirmed CNA C was expected to report all allegations of abuse to the Administrator immediately. Facility's Abuse, Neglect and Exploitation Policy was requested on 04/16/25 and Administrator A stated the facility did not have a policy, they follow state regulations. CNA C failed to ensure each allegation of abuse was reported to Administrator A as soon she was made aware of the allegation.	S3028		
S3299 SS=E	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions.	S3299		

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S3299	Continued From page 3 (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 census equaled 23 residents. Based on record review and interview for all residents receiving meal services, Administrator A failed to ensure the facility staff stored all food under safe and sanitary conditions. Findings included: - Observation during the initial tour on 04/15/25 at 11:30 AM of the facility kitchen revealed a refrigerator and freezer containing food. The freezer contained one plastic bag of chocolate chip cookies, which was not sealed. The refrigerator contained two clear bottles containing liquid, which were not dated or labeled. Administrator A identified one bottle as containing Italian dressing and one bottle as containing French dressing. Interview on 04/15/25 at approximately 11:30 AM with Administrator A confirmed the plastic bag containing chocolate chip cookies was not sealed in the freezer and further confirmed the two clear bottles containing liquid were not dated or labeled in the refrigerator. Interview on 04/15/25 at approximately 04:45 PM	S3299		

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S3299	Continued From page 4 with Administrator A confirmed all residents eat at the facility. Facility food storage policy requested on 04/16/25 and Administrator A stated they follow state regulations and did not have a facility policy. For all residents of the facility, Administrator A failed to ensure the facility staff stored all food under safe and sanitary conditions.	S3299		