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	N046056	A. BUILDING: _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE HEARTLAND ASSISTED LIVING	16207 MIDLAND DRIVE SHAWNEE, KS 66217

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey with complaint investigations #132079, #131995, #131760, #130280, #129273, #128715, #127871 at the above named assisted living facility conducted on 7-30-18, 8-2-18, 8-6-18, 8-7-18, 8-8-18 and 8-9-18.	S 000		
S3028 SS=J	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)(A)(B)(C) The facility reported a census of 44 residents. The sample included 4 residents and 3 closed record reviews. Based on record review and interview for 1 (#1) of 4 sampled residents, the operator failed to ensure each allegation of abuse was reported to the department within 24 hours; an investigation was started when the operator received notification of the alleged violation; and immediate measures were taken to prevent further potential abuse while the investigation was in progress. Staff reported potential sexual abuse involving resident #1 and #3 on 7-13-18. The facility failed to report the incident, investigate the alleged violation and take appropriate corrective action. Staff reported potential sexual abuse involving resident #1 and #2 on 7-24-18. The operator again failed to report within 24 hours, thoroughly investigate and put measures in place to prevent further potential abuse. These failures placed resident #1 in immediate jeopardy for harm or injury. Findings included: - Record review for Resident #1 revealed admission on 2-27-16 with diagnoses Frontal Temporal Dementia, Tremors, Hypertension, Depression, and Gastroesophageal Reflux Disease. The Functional Capacity Screen dated 4-19-18 recorded resident required physical assistance with dressing, and toileting; and independent with transfers, walking/mobility. Cognition: problems	S3028		

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S3028	Continued From page 2	S3028		

with short term memory, memory/recall and decision-making. Current problems included falls/unsteadiness, impaired vision and impaired decision-making. Resident uses a walker.

The Negotiated Service Agreement/Health Care Service Plan dated 4-19-18 recorded the following services:
Dressing - full body assistance at all times
Continence/Toileting - incontinent of bladder, uses incontinence products. Assistance required with toileting at all times.
Cognition - alert to self only. Frequency of impairment - at all times. Impairment of short term memory, decision-making and memory/recall (forgetfulness).
Special Monitoring - Dementia related issues and Diabetic Management checked off. (Note: no interventions documented.)
Mobility - Ambulates with walker at all times.
Safety - at risk for falls. (Note: No interventions documented.)

NSA/HCSP amended on 7-24-18: "Cognition: Due to reported incident of inappropriate touching with another resident, hourly checks." (No further instructions provided) Signed by Licensed Staff C.

Nurse's Notes
7-24-18 at 5:25 pm: "It was reported to this nurse that resident was involved in an incident of inappropriate touching with another resident on the morning of 7-23-18. Due to cognition, neither residents are aware of what had happened. Resident has been placed on hourly checks." Signed by Licensed Staff C.

7-26-18 at 2:00 pm: "No incidents of inappropriate touching have been observed since initiating hourly checks. Signed by Licensed Staff

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S3028	Continued From page 3 C." No further documentation in the record. Observation of Resident #1 during survey revealed resident remained in front common area most of the day. Ambulated with a walker. Alert, smiled when spoken to but unable to carry on a conversation. Staff provided assistance with toileting and reminders for meals. - Record review for Resident #2 revealed admission on 4-14-18 with diagnoses Dementia, Hypertension, Emphysema with Fibrosis, Overactive Bladder, Glucose Intolerance and Osteoarthritis. The Functional Capacity Screening dated 4-4-18 recorded resident independent with dressing, toileting, transfers, and walking/mobility. Cognition: problems with short term memory and decision-making. Problems/risks identified included impaired vision, impaired hearing, impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-13-18-18 recorded the following services: Cognition: Alert and oriented to self and place with impairment in short term memory, decision-making and memory/recall (forgetfulness) at all times. Special Monitoring: Wandering/Elopement and Dementia related issues. (Note no interventions documented.) Safety: Resident is a risk for falls. (Note: no interventions documented.) Nurse's Notes:	S3028		

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7-24-18 at 5:25 pm: "It was reported to this nurse that resident had been inappropriately touching another resident on the morning of 7-23-18. Due to resident's agitation and cognitive change as previously charted, resident has been placed on hourly checks for behaviors. Signed by Licensed Staff C.
(Note: Nurses notes 7-23-18 documented agitation and elopement attempts. The resident was sent to the emergency room for evaluation of agitation and returned with new orders).

7-26-18 at 1:45 pm: "Resident has had no agitation since 7-24-18. Appears calm, has not bothered other residents. No desire to leave and go to work have been observed." Signed by Licensed Staff C.

Observation of Resident #2 during survey revealed resident to be ambulatory with no assistive devices. Alert and oriented to person and place. Spends time sitting in front common area visiting with other residents. Friendly and smiling.

On 7-30-18 at 4:50 pm, Licensed Staff C provided copies of resident's chart notes and documentation of hourly checks which began on 7-27-18 at 3:00 pm for Resident #2, on 7-27-18 at 6:00 am for Resident #1. On 8-6-18, Licensed staff C provided additional copies of documentation of hourly checks which began at 3:00 pm on 7-25-18 for Resident #1. Confirmed there were no interventions before 7-25-18 for monitoring of Resident #1, Resident #2 or Resident #3. Unable to provide documentation of hourly checks or monitoring for Resident #3.

Certified Staff F written statement: "It was 0545 am on Monday morning [7-23-18] when one or

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the residents, (Resident #8) came and got me because on his/her way down the hallway he/she saw Resident #2 kissing and feeling on Resident #1's body and was not able to keep them apart immediately. I headed towards there and found Resident #2's hands in Resident #1's pants as he/she was kissing him/her. I separated them and reminded Resident #1 he/she was married ...and what he/she was doing was not appropriate because Resident #1 really never talks or says anything. So I walked with Resident #1 and sat by him/her til my shift was over but I told my co-workers on that shift and the oncoming shift about what had happened so it does not happen again." Per interview with Certified Staff F, he/she failed to report the incident to Licensed Staff C or Administrative Staff A and B.

Written statement by Administrative Staff B received on 8-2-18 at 5:15 pm stated: "On Tuesday July 24th at approximately 11:00 am I was approached in the lobby by Resident #8. He/She reported to me that he/she witnessed a resident (Resident #2) fondling another resident, (Resident #1)..."

Interview and written statement on 8-2-18 at 4:50 pm with Licensed Staff C stated:
"On 7-24-18, it was mentioned to me that Resident #8 had reported seeing an inappropriate interaction between Resident #2 and Resident #1. Resident #8 had been speaking with Administrative Staff B also, so I waited for further instruction. I spoke with Resident #1's (family member) in the afternoon (around 2-3 pm) on 7-25-18 and (family member) and I agreed that hourly checks would be best while incident was investigated... "
Signed by Licensed Staff C.

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Licensed Staff C confirmed he/she failed to make changes to health care service plan for either Resident #2 or Resident #3 to monitor and manage specific inappropriate behaviors.

- Record review for Resident #3 revealed admission on 6-19-18 with diagnoses Bipolar Disorder, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Left Lower Extremity Muscle Weakness Related to Nerve Damage, and Essential Tremors.

The Functional Capacity Screen dated 6-20-18 recorded resident independent with dressing, toileting, transfers, and walking/mobility.
Cognition: problems with short term memory, memory/recall and decision-making.
Problems/risks identified included unsteadiness, impaired hearing, and socially inappropriate disruptive behavior. Resident uses cane and walker.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 6-19-18 recorded the following services:
Cognition: Alert and oriented times 4 with impairment of decision-making intermittently. "Staff to monitor for decision making impairment, especially during times of obsessive or disruptive behavior. Redirect as needed.
Special Monitoring: Inappropriate behavior. "Resident can become verbally disruptive at times and requires redirection.
Mobility: Ambulates. Assistance Required: Stand by assist, as needed. Uses walker. "Unsteady gait related to left lower extremity weakness - nerve damage."
Safety: Resident is a risk for falls. (Note: no interventions documented.)

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S3028	Continued From page 7 Nurse's Notes: 6-21-18 at 5:00 pm: "Staff notified this nurse that resident was on front patio exposing him/herself to another resident and his/her family. This nurse and (Administrative Staff B) spoke to resident and told him/her that this behavior was unacceptable. Resident verbalized understanding and apologized." Signed by Licensed Staff C. 6-26-18 at 1:55 pm: "Nurse Practitioner here to see resident this morning. Discussed resident's recent behaviors and resident's anxiety about moving to this building from a sister facility. New orders: 1. Stop alprazolam 0.25 mg (milligrams). 2. Start alprazolam 0.5 mg by mouth twice a day for 14 days, then as needed up to twice a day for increased anxiety. Order sent to pharmacy." Signed by Licensed Staff C. Observation of Resident #3 during survey revealed resident to be ambulatory throughout facility with walker. Alert and oriented to person, place, time and situation. Forgetful and would frequently repeat self. Resident primarily remained in front common area during the day and visited with staff and other residents. - Confidential Interview #3 stated: "I was sitting in the dining room when I saw Resident #3 put his/her arm around Resident #1 in the lobby. I watched a little longer and when I saw Resident #3's face get closer to Resident #1. I stood up to go intervene. When I stood up I had noticed that Resident #3 had unzipped his/her pants and put Resident #1's hand on his/her private part. I walked over there, removed Resident #1's hand and told Resident #3 that was inappropriate. (Another staff) saw some of the incident and	S3028		

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texted Administrative Staff B who was in a meeting with Licensed Staff C. When the meeting was over Licensed Staff C came and asked me to write a statement on what I saw. When I gave the statement to Licensed Staff C, he/she was in Administrative Staff B's office and Administrative Staff B watched me hand it to Licensed Staff C."

- Confidential Interview #4 stated: He/she was in the dining room cleaning up after lunch on "Friday the 13th" (in July). He/she observed Resident #3"in the lobby" with Resident #1 and Resident #3 had placed Resident #1's hand inside he/her pants. Stated he/she did not write a statement regarding the incident, but verbally reported it to Administrative Staff B.

Interview and written statement on 8-2-18 at 4:50 pm with Licensed Staff C stated:
"...On an unknown day, (a staff member) had reported to Administrative Staff B and myself that Resident #3 was holding Resident #1's hand over his/her pants. I spoke with Resident #3 and he/she denied this behavior. To manage Resident #3's behaviors, he/she is usually taken out of the facility once a day with Administrative Staff B. I did not report this incident to the state because I believed that I needed to go through my direct supervisor to do so." Signed by Licensed Staff C.

For Residents #1, #2, #3, the operator failed to ensure all allegations of sexual abuse were reported to the department within 24 hours, investigations started and documented when the operator received notification of an alleged violations and failed to ensure immediate measures were taken to prevent further potential abuse while the investigations were in progress and ongoing. These failures placed resident #1 in

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S3028	Continued From page 9 immediate jeopardy for harm or injury. The jeopardy was removed on 8-2-18 at 5:15 pm when Administrative Staff B provided the following written plan: "We will continue to monitor Resident #1 with one-hour checks. When Resident #3 is out of his/her room, his/her normal pattern is to not go past the laundry room, located next to Administrative Staff A's office, the lobby and his/her room on the (opposite) hall. His/her pattern also consists of going back to his/her apartment as soon as dinner is over and does not come out until 7:30 am. Staff will also be conducting 15-minute checks on his/her whereabouts and also staff will be instructed to be aware of him/her not sitting by or in close proximity to Resident #1 at any time. If any inappropriate touching is noticed by these or any residents it will be reported to the hotline within 24 hours, an investigation will be completed and sent, corrective action will be taken to correct issue, and we will begin monitoring said residents immediately."	S3028		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11)	S3261		

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S3261	Continued From page 10 The facility reported a census of 44 residents. The sample included 4 residents and 3 closed record reviews. Based on record review and interview for 2 (Residents #5, #6) of 3 closed records, the operator failed to ensure documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #5 revealed admission on 1-4-17 with diagnoses Hypertension, Hypothyroidism, Anxiety, Glaucoma, Depressive Disorder, Insomnia, Gastroesophageal Reflux Disease and Deep Vein Thrombosis. The Functional Capacity Screen dated 1-4-18 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; supervision with eating and independent with management of medications and treatments. No problems with cognition. The Negotiated Service Agreement/Health Care Service Plan dated 1-4-18 recorded services: Bathing - full body assistance at all times. "Staff to assist with washing resident's back and lower legs during showers." Dressing - lower body assistance at all times. "Staff to assist with pulling up undergarments and pants while dressing and undressing." Continence - incontinent of bladder. Assistance required at all times. "Staff to assist with pulling up and down undergarments during toileting. Cognition - Alert and oriented times three (self, place and time/situation).	S3261		

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S3261	Continued From page 11 Medication Management - Family to provide medications and pre-fill medication box. Transfers - assistance required. Assistive device used: electric wheelchair. Staff to assist transferring resident in and out of electric wheelchair at all times. Safety - Resident is a risk for falls. (Note: no interventions documented). Nurse's Notes: 4-13-18 at 11:02 am: "Resident has skin tear on right upper arm. Resident reported he/she obtained skin tear when he/she hit arm against the wall while driving electric wheelchair. This nurse cleaned skin tear, applied triple antibiotic ointment, applied non-adherent dressing and wrapped with gauze. Will change as needed." Signed by Licensed Staff C.\ The record lacked further documentation. Interview on 8-6-18 around 4:30 pm with Licensed Staff C stated the resident discharged from the facility on a Saturday which he/she believed was 5-21-18. Stated the resident required increased assistance and family wanted 1:1 staffing. Confirmed the he/she failed to document an assessment, date/time resident left the facility and disposition of resident's medications. For Resident #5, the licensed nurse failed to document date/time of discharge including an assessment and disposition of medications. - Record review for Resident #6 revealed admission on 11-20-17 with diagnoses Chronic Pain, Constipation, Type II Diabetes Mellitus, Difficulty Walking, Hypertension, Muscle	S3261		

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S3261	Continued From page 12 Weakness and Urinary Retention. The Functional Capacity Screen dated 11-20-17 recorded resident required physical assistance with bathing, supervision with dressing, toileting, transfers, walking/mobility; independent with eating and management of treatments and unable to perform management of medications. Occasionally incontinent of bladder. Cognition: problems with short term memory and memory/recall. No problems with communication. Current problems included fall/unsteadiness and impaired hearing. The Negotiated Service Agreement/Health Care Service Plan dated 11-20-17 recorded services: Bathing - Full Body Assistance required at all times. "Staff will assist getting in/out of shower. staff will assist with putting on lotion as requested by resident. Staff to monitor and alert nurse of any skin issues." Dressing - Supervision/prompts at all times. Toileting - no assistance required. Cognition - Alert and oriented to self and place at all times Medication Management - facility staff to administer all medications. Special Monitoring - Diabetic Management (Note: no documentation of interventions such as who performs blood sugar monitoring, prepares and dials insulin pen,and who injects insulin.) Mobility - assistance required - uses walker at all times. Safety - Resident is a risk for falls. (Note: no interventions to address fall risk.) Nurse's Notes: (Note: Prior to this, date of last entry was 5-17-18) 7-24-18 at 1:49 pm: "Resident not feeling well the	S3261		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE HEARTLAND ASSISTED LIVING	16207 MIDLAND DRIVE SHAWNEE, KS 66217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 13	S3261		

past few days. Has been refusing to come to meals. Will not answer when asked questions. Assessed resident and attempted to ask resident yes or no questions to determine symptoms. Resident would only occasionally nod head in response. Had staff take vitals and blood sugar. All within normal range for resident. Instructed staff to obtain urine sample and put resident on list to be seen by nurse practitioner." Signed by Licensed Staff C.
7-25-18 at 9:33 am: "Resident seen by nurse practitioner on 7-24-18. Nurse Practitioner instructed to continue to encourage fluids and send out if condition worsens. Staff contacted this nurse around 6:38 pm to notify that resident's condition had worsened and this nurse instructed staff to notify (family member) and send resident out to emergency room for evaluation and treatment." Signed by Licensed Staff C.
7-25-18 2:30 pm: "Spoke to nurse at (hospital) who stated that resident had suffered heart attack." Signed by Licensed Staff C.
7-27-18 at 9:57 am: "Resident passed away at hospital." Signed by Licensed Staff C.

The record lacked documentation of the results of a timely physical assessment conducted by the licensed nurse when symptoms of illness were first reported by the staff a "few days" ago.

Progress Note per Nurse Practitioner dated 7-24-18:
History of present illness: "...pleasant, frail (resident) presents in room with 2 other residents supporting and talking to him/her. Staff report resident just has not been eating very well at all the past few days and is not able to explain what is wrong. Today's confusion persists, resident makes eye contact but does not answer questions, no wincing or grimacing with exam.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046056	A. BUILDING: _____ B. WING _____	C 08/09/2018

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S3261	Continued From page 14 Resident is calm and cooperative. Appears weak." Lethargy: "Discussed with nursing administration the need for resident to be assessed, malaise and lethargy continue. Nursing director to talk to the power of attorney tomorrow and discuss. Labs to be drawn next lab draw if resident does not send out. Resident is not dehydrated at present but worried could happen due to his/her poor intake." Nurse practitioner ordered a urinalysis, gave order to only give insulin if blood sugars are high; with oral antidiabetic medicine to continue. Interview on 8-6-18 at 4:21 pm with Licensed Staff C stated he/she had assessed the resident, confirmed he/she failed to document the results of his/her assessment in the record. Stated he/she did not assess resident earlier than Tuesday 7-24-18 because "it was the weekend and it wasn't reported to me until Tuesday" did not remember being told on Monday. Also stated, "I checked the blood sugar on Friday and it was normal (low 100's). Resident had stated he/she felt like his/her blood sugar was high because he/she was "light-headed" I gave him/her an orange. Further stated the nurse practitioner thought "it was something viral". Confirmed he/she failed to document this conversation with nurse practitioner. Also stated Resident #6 was normally talkative and able to make her needs known. For Resident #6, the operator failed to ensure documentation of all symptoms and other indications of illness including date, time of occurrence, action taken and results of the action when the resident became ill.	S3261		