STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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 complaint investigation #128471 and #128498.	S 000		
S3028 SS=D	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)(C)	S3028		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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
S3028	Continued From page 1 The facility reported a census of 82 residents with 12 residing on one of the Memory care units. The sample included 2 residents from the Memory care unit. Based on interview and record review the facility failed to ensure staff reported an allegation of abuse immediately to the Executive Director or supervisor on duty involving 2 of 2 sampled residents (#1 and #2). The executive Director failed to ensure nursing staff conducted a full body assessment to rule out injury for resident #2 and failed to start an investigation as soon as made aware of the allegation. Findings included: - Review of the record for resident #1 revealed an admission date of 1/10/16 with diagnoses of subdural hemorrhage, impulsiveness, hypertension, diabetes type 2, insomnia and anxiety. The significant change Functional Capacity Screen (FCS) dated 10/9/17 indicated the resident required physical assistance from staff for bathing, dressing and toileting. He/she had impaired cognition of short term memory, recall and decision making. He/she had impaired vision and hearing. Wandering or inappropriate behavior was not indicated. The Negotiated Services Agreement (NSA) dated 10/27/17 identified the resident needed extended service with transferring, morning and night time preparation, toileting and incontinence assistance. He/she wore hearing aids and glasses. He/she needed verbal reminding daily of time and place in the facility. He/she had behaviors of attitude, habits and emotional states which do not create unusual demands on others.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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
S3028	Continued From page 2 He/she had assaultive behavior, danger to self and wanders related to short term memory problems. He/she is easily worried/anxious, easily irritable/agitated. The resident is easily understood and understands others but judgment is frequently poor and needs supervision. The Health Service Plan (HSP) dated 1/9/18 indicated the resident needed physical assistance of 1-2 staff for transfers with a gait belt, toileting, bathing and dressing due to combative behavior. He/she used a wheelchair and needed physical assistance of 1 staff with verbal cueing and reminding. He/she was not marked for having socially inappropriate/disruptive behavior but did have impaired decision making with direction to staff to validate and redirect as appropriate. Review of the care notes between 1/3/18 and 4/10/18 revealed multiple attempts to self-transfer and fall with no evidence of socially inappropriate/disruptive or wandering behavior. On 4/7/18 at 10:15 PM licensed nurse C wrote a staff member had notified the nurse of an incident via a piece of paper alleging resident #1 was inappropriately touching resident #2 in the dining room area around 9:00 PM. The staff member reported to the nurse that he/she intervened and separated the residents. Licensed nurse C notified supervisory licensed nurse G by phone, the resident's durable power of attorney and sent a fax to the physician. The nurse initiated 15-minute checks on the resident's whereabouts for the next 24 hours and the resident currently laid in bed with eyes closed. The next enter dated 4/8/18 at 10:00 PM - resident without signs of agitation...no behaviors noted.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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
S3028	Continued From page 3 4/8/18 at 12:00AM (midnight) resident currently in bed with eyes closed...no signs of increased anxiety or behaviors at this time. The next entry was dated 4/8/18 at 9:59 PM - resident went to resident #2's room and was redirected. 4/9/18 (no time) no complaint at this time, resident sitting in wheelchair napping. 4/10/18 at 3:00 PM urinalysis sample obtained and sent to lab. (no further notes in the record at the time of review on 4/12/18 at 1:30 PM) Review of the FCS for resident #2 dated 10/30/17 revealed short/long term memory deficit, recall deficit and impaired decision making. He/she required physical assistance for bathing, dressing, toileting, transfers and mobility. Review of the care notes between 12/27/17 and 4/10/18 revealed an entry dated 4/7/18 at 10:15 PM of staff handing licensed nurse C a piece of paper about resident #2 being inappropriately touched by resident #1. Staff separated the residents as an intervention. At 10:40 PM licensed nurse C made an observation of resident #2 to be without signs of increased anxiety or behaviors. Resident currently lying in bed in his/her room with eyes closed. No signs of pain or discomfort observed, breathing even and unlabored with vital signs of BP 146/78, P - 64, R - 18, temperature 97.3 degrees Fahrenheit and oxygen saturation of 95%. The record lacked evidence of a head to toe assessment to rule out injuries related to the allegation. The next entry dated 4/8/18 at 6-10 PM no	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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
S3028	Continued From page 4	S3028		

behavior or agitation noted, resident quiet, family came to visit and took resident out for a walk in the wheelchair.

4/8/18 at 12:00 AM (midnight) resident currently lying in bed in his/her room with eyes closed. No signs of pain or discomfort, no signs of increased anxiety or behaviors noted...

4/8/18 at 9:59 PM resident #1 went to resident #2's bathroom, redirected and left room - family aware.

4/9/18 no time (licensed nurse H said he/she made entry around 9:00 AM) "STOP sign made and applied on resident #1's room-frame to get visitor inside."

4/10/18 (3 days after the allegation of inappropriate touching) at 11:15 AM licensed nurse H wrote - Head to toe completed. Resident alert and awake to follow directions with compliance. When this nurse tried to get clothes/pants off resident, resident yelled...resident moved all extremities with purpose. Bruise visible 2 x 2 cm (centimeters), red and not swelling (did not indicate where bruise was, interview with nurse H on 4/12/18 indicated was on a forearm but did not remember which). No pain voiced or shown at this time. No other bruises or open sores or redness visible. Genitals unremarkable, no bruises or redness visible.

On 4/12/18 at 3:22 PM Administrative staff F and administrative nurse E provided copies of statements he/she obtained during the facility investigation. Later that day, at 5:10 PM during a discussion about the statements not being dated when signed or notarized administrative staff F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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
S3028	Continued From page 5	S3028		

said the statements were obtained on 4/10/18 (3 days post allegation). Statements as follows:

Undated handwritten statement by Certified medication aid (CMA) D wrote he/she came out of a resident's room during medication pass and observed resident #1 feeling all over resident #2's groin area and chest. He/she immediately separated the residents and said to resident #1 that resident #2 is not his/her spouse...one of the staff came out of a room and he/she told the staff to tell the nurse and that staff walked over to resident #2 and wheeled him/her to the TV area... The statement lacked evidence of ever reporting the incident to the nurse on duty and the Executive director.

Undated written statement by direct care staff M revealed being told by CMA D of resident #1 grabbing resident #2's chest and groin area. The statement lacked evidence of reporting the allegation to the nurse on duty and Executive Director.

Undated written statement by licensed nurse H revealed he/she was on the unit and when he/she came out of another resident's room he/she saw CMA D making movements with arms up and down his/her uniform/body, pointed to resident #1 as nurse H was going out of the unit he/she heard "tell him/her" so nurse H looked up and said, "yes he/she had moved resident #1 to the table". Direct care staff L went back into another resident's room and said, "I don't know". Licensed nurse H indicated he/she left the unit because he/she did not know what CMA D was saying or doing.

Undated written statement by licensed nurse C revealed he/she was passed a note on 4/7/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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
S3028	Continued From page 6 10:15 PM from (unidentified) staff that resident #1 was inappropriately touching resident #2 in the dining room around 9:00 PM. Staff stated he/she had separated the 2 residents. Licensed nurse C immediately notified administrative nurse G by phone. A notarized statement obtained on 4/12/18 from licensed nurse H indicated he/she was leaving the unit and already out the door when he/she saw CMA D waving his/her arms up and down and to the side over his/her uniform and the pointed over to resident #1. Nurse H then saw direct care staff L coming out of a room and CMA D said, "tell him/her" and nurse H looked up and said yes he/she had moved resident #1 to the table, direct care staff L went back into the room he/she came out of and said "I don't know ... nurse H left the unit...CMA D never followed him/her or approached him/her to tell him/her about the incident. Nurse H gave report to night shift nurse C and clocked out approximately 10:05 PM and while driving home he/she received a phone call from nurse C and was told about the incident. Nurse C told him/her that he/she had asked CMA D if he/she reported the incident to nurse H and CMA D said no I have not... Interview on 4/12/18 at 4:03 PM with direct care staff L revealed on Saturday 4/7/18 the resident was his/her normal self as far as activities of daily living and mood/behaviors. The resident was in his/her wheelchair by the medication cart with CMA D giving him/her the medications. Later he/she came out of another resident's room to throw away trash or something when CMA D pointed to resident #1, did a dance like move with his/her hands going up and down his/her body then pointed towards resident #2. He/she did not know what CMA D was trying to tell him/her so	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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
S3028	Continued From page 7	S3028		

he/she went to CMA D and was told at that time resident #1 was touching up on resident #2 and he/she told CMA D to tell nurse H, then went back into the room where he/she was providing cares. He/she said at one time during all of this exchange he/she moved resident #2 across the unit to the TV area.

Interview on 4/12/18 at 5:50 PM with licensed nurse C revealed he/she came on duty about 9:30 PM and while in the office area preparing for his/her shift at about 10:15 PM CMA D slipped him/her a piece of paper. He/she asked CMA D "what's this" and said CMA D replied something that happened so he/she had written it down to give to a nurse. Nurse C asked CMA D if he/she had told anyone and he/she reported having tried to get the attention of the 2-10PM nurse. Asked if he/she called out to the nurse or approached the nurse and CMA D shrugged his/her shoulders and said I tried to get the nurse's attention. Licensed nurse C confirmed he/she had not made visual assessment of resident #2's body at the time of notification because the resident was already asleep. He/she had the staff get vital signs and asked them if they saw anything on resident #2 skin when they put him/her to bed. He/she reported the resident wore a 2-piece pajama set.

Interview with administrative staff F and administrative nurse E on 4/12/18 at 5:10 PM revealed he/she was still conducting the investigation and putting the report together for the State Agency. Administrative staff F reported he/she received notification of the allegation of inappropriate touching on 4/7/18 at about 10:15 PM. Administrative staff F confirmed the interviews and statements of staff were obtained on 4/10/18. Administrative nurse E confirmed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(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
S3028	Continued From page 8 record lacked evidence of a head to toe body assessment of resident #2 at the time of the report of inappropriate touching to rule out injury. The facility's policy titled Abuse, Neglect or Exploitation dated 9/2017 directed any team member or contractor who witnesses or becomes aware of alleged abuse, neglect or exploitation must immediately report such incident to the Executive Director or supervisor on duty... The director or designee is to start an investigation as soon as made aware of the allegation... The director or designee is to interview all team members that have knowledge of the event or were on duty at the time of the event. Documentation of the interview must be done and signed/dated by the interviewed team members. The facility failed to ensure staff reported an allegation of abuse immediately to the Executive Director or supervisor on duty involving 2 of 2 sampled residents (#1 and #2). The executive Director failed to ensure nursing staff conducted a full body assessment to rule out injury for resident #2 and failed to start an investigation as soon as made aware of the allegation.	S3028		