| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N023017 | A. BUILDING: _____ B. WING _____ | C 06/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WINDSOR OF LAWRENCE | 3220 PETERSON RD LAWRENCE, KS 66049 |

| (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 |
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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of an abbreviated survey for complaints # 172267, 170473, 169834, 169841, 169332, 168577, 167868, 167874, 167498 and 166058 of the above named facility conducted on 6/6/2022 and 6/7/2022. | S 000 | | |
| S3028 SS=D | 26-41-101 (f) (3) Staff Treatment of Residents Reporting<br><br>(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:<br>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.<br>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.<br>(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.<br>(D) Appropriate corrective action shall be taken if the alleged violation is verified.<br>(E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.<br>(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<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101 (f)(3)<br><br>The facility reported a census of 37 residents. The sample included 5 residents (R). Based on record review and interview the operator failed to report to the department an allegation of abuse within 24 hours of being notified of the allegation of abuse that involved R1.<br><br>Findings included:<br><br>- Record review for R1 revealed an admission date of 11/30/21 with diagnoses of dementia - multiple infarction, without behavioral disturbances and stent in artery carotid stenosis.<br><br>Record review of the "Functional Capacity Screening" (FCS) Dated 12/29/21 revealed the resident was independent with bathing, dressing, transferring, walking, and eating. She required supervision with toileting and lacked the ability to manage her own medications. She had impaired short-term memory and decision making and used no walking mobility device.<br><br>Record review of the combined "Negotiated Service Agreement" (NSA) and "Health Care Service Plan" (HSP) identified/instructed staff to remind resident to shower twice weekly, she was independent with personal cares and toileting without reminders. Staff to observe and report changes to health care director. She did experience some leaking of urine and self applies a pad for incontinence.<br><br>Record review of the resident notes dated 11/30/2021 to 05/14/2022. The resident notes | S3028 | | |

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| S3028 | Continued From page 2 | S3028 | | |

lack documentation of resident having issues of incontinence or notification to the legal representative of the allegation of abuse involving R1.

Observation 06/06/22 at 01:30 PM revealed the resident to be walking around the community and sitting in the common area watching television with other residents. Her clothes were clean and dry.

Review email provided by Licensed Nurse A sent by Staffing Agency Representative C to Regional Licensed Nurse B revealed the following; the email was sent by staffing agency Certified Nurse Aide (CNA) D to Staffing Agency Representative C, she stated in the email that she witnessed facility CNA E physically and verbally abuse R1.

Review of undated investigation signed by Regional Licensed Nurse B revealed she fully investigated the alleged incident and had taken corrective action with an unsubstantiated outcome.

Interview on 06/06/22 at approximately 02:22 PM with Regional Licensed Nurse B confirmed she was made aware of the allegation at 02:26 PM on 06/03/22. She stated she investigated the incident and obtained witness statements. She confirmed she did not call the incident into the department. She stated she called her director and reported the incident per the facility policy.

Review of the facility Resident Abuse, Neglect and Exploitation Policy revised 4/30/2019 revealed the following:

"Findings shall be reported to the regional director of operations as soon as practical but not later

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| S3028 | Continued From page 3<br>than 24 hours after receiving the allegation"<br><br>"The residence director ...shall immediately act to rectify the problem and shall make a report of the incident and its correction to the department and/or governing state agency within the timeframe required by state regulations."<br><br>"The residence director ...shall notify the legal representative about the allegation within the timeframe ..."<br><br>"an employer shall report to the department / and or appropriate state ...any allegation of client or resident abuse ..."<br><br>"an employer shall report to the department by telephone within 24 hours after receiving the allegation and in writing within 5 working days after receiving an allegation."<br><br>Record review of email dated 06/06/22 provided by residence director F confirmed the allegation of abuse was not reported to the department on 06/03/22 by the facility or any representatives of the facility within 24 hours of receiving the allegation of abuse.<br><br>The operator failed to report to the department an allegation of abuse within 24 hours of being notified of the allegation of abuse that involved R1. | S3028 | | |