STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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 an abbreviated survey for complaints #167509, #167464, #167347, #167354, #167364, #166761, #166422, and #165267 conducted on 12/02/21, 12/06/21, 12/07/21, 12/08/21, 12/13/21, 12/14/21, 12/15/21 and 12/16/21.	S 000		
S 185 SS=D	26-39-102 (d) Admission, Transfer, Discharge (d) The administrator or operator of each adult care home shall ensure that each resident is permitted to remain in the adult care home and is not transferred or discharged from the adult care home unless one of the following conditions is met: (1) The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the current adult care home. (2) The safety of other individuals in the adult care home is endangered. (3) The health of other individuals in the adult care home is endangered. (4) The resident has failed, after reasonable and appropriate notice, to pay the rates and charges imposed by the adult care home. (5) The adult care home ceases to operate. This REQUIREMENT is not met as evidenced by: K.A.R. 26-39-102 (d)(1)(2) The facility reported a census of 75 residents. The sample included 6 residents. Based on record review and interview the Administrator failed to have evidence which supported the facility could not meet the needs of resident #6 before issuing a 30-day discharge notice. The	S 185		

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
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

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S 185	Continued From page 1	S 185		

notice stated the facility could not met the needs of resident #6 and the safety of others is endangered in the facility due to a failure to respect rules regarding HIPAA (Health Insurance Portability and Accountability Act).

Findings included:

- Record review for resident #6 revealed an admission date of 04/09/20 with diagnoses of generalized anxiety disorder, major depressive disorder, hypertension, tachycardia, chronic pain, Crohn's disease, abdominal hernia with obstruction and ileostomy, generalized osteoarthritis, muscle weakness, muscular dystrophy, localized edema, and inflammatory polyarthropathy.

The Functional Capacity Screen (FCS) dated 02/21/21 (identified by Licensed Nurse B as the current and accurate FCS) identified the resident with intact cognition and able to communicate her needs and understand others. She required physical assistance with bathing, dressing, toileting, transfers, walking, mobility, management of medications and treatments. She experienced occasional bladder incontinence. Under item III Current or Recent Problems and Risks she was identified as a fall risk, had impaired vision and impaired decision making. She used assistive devices of a walker and wheelchair.

The Negotiated Service Agreement (NSA) dated 02/02/21 (identified by Licensed Nurse B as the current and accurate NSA) included the following services: physical assistance with bathing (no amount per week listed), physical assistance with dressing and undressing, staff to assist with toileting, incontinent care and ileostomy care. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

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S 185	Continued From page 2	S 185		

resident is independent with walker, staff to monitor during time of weakness and staff to assist with grooming. Meal preparation by the facility of a regular diet which she managed, and she needed assistance with cutting up meats. Housekeeping/Laundry services of weekly apartment cleaning, daily bed making, room tidy and trash pick-up with weekly personal and linens laundry. The facility would manage the resident's medications and treatments. The section for Behavioral Management was not marked and remained blank. Under the section of Health and Wellness Monitoring Licensed Nurse (LN) E marked impaired vision-wears glasses, impaired decision making with nothing further record and falls/unsteadiness-see HSP (Health Service Plan). Under the section for Outside Service Providers LN E listed a pharmacy, podiatrist, lab, X-ray, optometrist, and dentist. LN E did not mark Behavioral Management and the area was blank. The NSA indicated the resident believed herself capable of increased independence in at least some of her ADLs (activities of daily living) but tires noticeably most days. The NSA indicated the resident was her own responsible party for health care and financial matters.

The Health Care Services/Resident Health Service Plan (HSP) dated 02/21/21 directed staff to assist the resident with showering three times a week and PRN (as needed) for safety and to alert the nurse of skin issues. Staff to provide partial assistance PRN with dressing in the am/pm, assist with putting on and off TED (compression stockings) hose. Licensed or Certified staff to administer medications and perform simple treatments. Three meals a day provided in the dining room and resident may eat in her room independently. She is independent with a walker and staff to assist PRN during time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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 185	Continued From page 3	S 185		

of weakness. Staff to assist with the ileostomy PRN and resident provides the supplies. Under the section for Cognitive/Mood LN E marked alert, oriented and cooperative with notation to alert nurse to any behaviors and she was able to make her needs known to staff.

Review of the progress notes in the resident's electronic record between 11/05/2020 and 12/15/21 revealed the following entries:

A "Social Services" note dated 01/21/21 at 04:58 PM indicated the resident was upset, yelling and cussing at staff because administration did not give a staff member a write up. Administrative staff F explained to the resident she addressed the situation, but the resident was still upset and planned to make a report to the state and the corporate office. Administrative staff F told her, "that is her right and if I could help with anything else please let me know".

A "Behavior Note" dated 01/22/21 at 09:54 AM which indicated the resident experienced mood changes, multiple reports of being easily upset if staff does not do everything she requests involving her husband. Her husband in the same apartment was in the dying process and on Hospice. ... LN E wrote the resident is very emotional at this time due to her husband's conditions and the lockdown protocols for COVID-19. Staff encourage to allow resident to vent her emotions, redirect her to the nurse and/or Administrator PRN.

A "Health status note" dated 01/27/21 at 11:11 AM, LN E spoke with an unnamed Hospice nurse regarding the resident's many complaints regarding husband's care. The Hospice nurse stated, this is her "controlling nature" and always

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

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S 185	Continued From page 4	S 185		

has been ... The nurse explained the resident appears "angry at the world" and this in understandable with her husband declining ...

A "Behavior note" dated 01/28/21 at 12:50 PM which indicated LN E heard yelling and derogatory comments from the resident directed at staff with threats to get the "staff fired, call the State Board and take you license". This incident was related to the resident asking for pain medication for her husband and feeling like staff were not listening ... the resident continued to yell for a while and directed her anger at staff, but other residents could hear which were in the dining room ... LN E was able to calm the residents done and explained resident #6 was upset and venting some anger ... LN G immediately went to residents' room to visit with her and assess her husband.

A "Health Status note" dated 01/28/21 at 02:55 PM indicated the resident was at the facility front door waiting for LN E. She presented herself in calm manner and stated, 'can you just explain to me why they cannot give the medications as ordered?' LN E asked for more details ... LN E provided an explanation ... The resident also discussed her behavior earlier and apologized but stated, she is on the 'edge' in this facility with everyone. LN E agreed with resident due to the many behaviors this nurse had witnessed since returning to routine visits in facility last week. Due to the unhappiness of resident with staff, facility, administration and verbalizing unhappiness with hospice this nurse requested a care plan meeting with the interdisciplinary team and work on options for resident ... Care Plan Meeting scheduled for Thursday February 04, 2021 at 01:00 PM ... (record review lacked any evidence of this meeting, outcomes or changes to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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 185	Continued From page 5	S 185		

NSA/HSP for her behaviors/moods). However, a "Health Status note" dated 02/04/21 at 05:58 PM indicated her medical care provider started her on an antidepressant with components of pain management.

No further entries about behaviors, incidents sign/symptoms of depression were recorded until a "Behavior Note" dated 03/02/21 at 04:42 PM by LN B "Resident is displaying intrusive behaviors at this time. She continues to go between resident's and spreading gossip amongst the staff". No specifics were included or how administrative or nursing staff addressed the situation.

A "Health Status note" dated 03/09/21 at 07:45 PM by LN E reflected the resident showing signs of increased depression since the passing of her husband. LN E recommended follow-up with her medical care provider and administrator to make arrangements to move resident to a new apartment to help with her with memories of her deceased husband in the current apartment.

No further notes about behaviors or moods until a "Behavior note" dated 04/01/21 at 08:36 AM by LN B regarding the resident attempting to get health information about another resident. LN B explained she could not discuss other resident's health information due to the HIPPA. LN B requested the resident "to mind her own business" all day. Later that day, the resident approached an employee who is the sister of the unnamed resident she was asking about and told her "sorry about the colon cancer", the employee did not know about this diagnosis. Now the unnamed resident is going around calling this resident a liar. This intrusive behavior is out of control ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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 185	Continued From page 6 There were no further notes to show what if anything was done to help the resident control her intrusive behavior, what if any education was given to staff on how to handle the resident's behavior, no changes to the NSA/HSP or any further follow-up about behaviors and depression with the medical care provider. A "Social Service note" dated 10/27/21 at 10:51 AM which indicated on the employees shift report a long list of maintenance concerns were added by resident #6 (resident council president) after the Resident Council meeting. She took it upon herself to write down the residents' maintenance needs. Administrative staff A talked with the resident about having the other residents write down their own needs in the maintenance log book. A folder with maintenance log sheets was added to the Credenza in the kitchen area so all residents can add needs. Another "Social Service note" dated 10/28/21 continued with the same concerns and resolutions agreed upon. A "Social Service note" dated 11/01/21 at 12:36 PM indicated Administrative staff A spoke with the resident concern a situation over the weekend with resident #7 and asking information about resident #7's health. Administrative staff A informed her staff could not talk to the resident about the health of other residents which would be a HIPPA violation. Informed her in the future she needed to refer other residents with health concerns to the paid staff who will address the situation according to the facility protocols. A "Social Services note" dated 11/02/21 at 01:29 PM read the shift report stated the resident was getting a petition to have another resident ... kicked out of the building. Administrative staff A	S 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

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S 185	Continued From page 7	S 185		

spoke with the resident as she denied this. Staff reported they heard resident #t talking about it with another resident, but they could not remember who it was. Administrative staff A informed resident #6 that every resident here deserved quality and dignity of life and it is staff's obligation to take care of them each according to their individual care plan and that is not something that can be shared with her due to HIPPA.

A "Social Service note" dated 11/04/21 at 01:33 PM indicated resident #6 cancelled the food committee meeting due to her inability to be present. Administrative staff A explained to the resident the meeting should not have been cancelled due to her inability to be present because as the Resident Council President it is not her responsibility to be present at the food meeting.

A "Social Service note" dated 12/08/21 at 01:11 PM included the resident's concern about her medication delivery. A meeting with certified medication aide (CMA) H, the resident, and Administrative staff A occurred today. The following is the solution outcome: Morning medications are due at 9:00am. The medication will be delivered to the resident's room if she doesn't come down to the medication cart. The CMA who goes to resident's room will enter and watch her take the medications. CMA H is afraid of the resident's cat so she will have another CMA deliver medications to her room if needed.

A "Behavior note" dated 12/11/21 at 12:00 PM by LN B an unnamed staff member reported to LN B resident #6 told her LN B's job is going to be replaced. This resident is constantly "maliciously gossiping with staff and residents about writer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

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S 185	Continued From page 8	S 185		

(LN B)". Grievance written and given to the Administrative Staff A at this time.

A Late entry "Behavior note" dated 12/11/21 at 02:44 PM by LN B indicated resident #6 arrived at the nursing office to report that another resident had a low blood sugar on 12/10/2021. Educated resident could not talk to LN B about another resident's information. This is a continuous conversation that has been explained to the resident. This resident was again educated on HIPPA.

The last entry was a "Health Status note" dated 12/13/21 at 04:23 PM by LN B which indicated Administrative staff A notified LN B resident #6 was evicted for intrusive behaviors and harassing the staff. Her date to be moved is recorded as 01/21/2022.

An electronic request to Administrative staff A on 12/15/21 at 09:46 AM to review the discharge notice and documentation the notice is based upon resulted in the following information: The notice listed the reason as intimidating staff/residents in order to get her way, verbal abuse including racial slurs towards staff members resulting in ADL care/medication administration impediments. The notice also was marked "safety of other is endangered in the adult care home due to failure to respect rules regarding HIPPA" There were 6 handwritten statements from staff member only which detailed staff being subjected to racial slurs and some where it was hearsay. Some talked about the resident being in control and calling EMS for another resident with a low BS (this was a valid call per the resident involved, resident #3). None of the statements indicated the resident's care needs could not be met or that any other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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 185	Continued From page 9	S 185		

residents were in danger.

Review of the documentation "Care Log" for resident #6 between 11/07/21 and 12/11/21 indicated she received the allotted minutes for the care assistance she needed. Her care needs are paid for by an insurance company who assesses care needs and sets a budgeted time the facility can bill for those minutes of care. Staff recorded they provided all or almost all of the budgeted minutes for care with bathing, grooming, dressing, walking/mobility, eating, laundry/housekeeping, meal preparation, medication management and PRN meds, monitoring of vital signs, ostomy care, and reporting functions or conditions.

Review of the November and December 2021 Medication Administration Record for the resident revealed all medications including PRN given as order with one time in November of no staff initials and no reason indicated and three times in December without staff initials and no reason indicated.

Phone interview with the resident's case manager for her insurance on 12/15/21 at 10:35 AM revealed she had not been contacted recently about any problems with the resident's behaviors or the discharge notice. She did report the resident had told her she wasn't getting the care on the care logs like staff was making her sign, but she did not know of any specifics. She called the surveyor back after talking with the resident about the discharge notice and the resident refused to talk with the surveyor stating she felt the facility was retaliating against her for talking with surveyor about other issues.

Review of the facility's policy for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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 185	Continued From page 10 Admission/Transfer/Discharge revealed the same verbiage as the regulatory requirements. The Administrator failed to have evidence which supported the facility could not meet the needs of resident #6 before issuing a 30-day discharge notice which stated the facility could not met the needs of resident #6 and for safety of others is endangered in the facility due to a failure to respect rules regarding HIPPAA (Health Insurance Portability and Accountability Act).	S 185		
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	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 11 exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f)(3)(A)(B) The facility reported a census of 75 residents with 6 included in the sample. Based on record review and interview the Administrator failed to take immediate measures to prevent further potential abuse and start an investigation when the Administrator became aware on 11/30/21 of an allegation regarding sexual abuse by Resident (R)1, when he purchased alcohol for R2 on multiple occasions and she was found excessively intoxicated and naked in her room. This failure placed all female residents of the facility in immediate jeopardy. Findings included: - Review of R2's Electronic Medical Record lacked evidence R2 consumed alcoholic beverages regularly prior to November 2021 when R1 purchased and provided the beverages to her. The "Health Status Note" dated 11/09/21 at 08:00 AM revealed an unidentified Certified Medication Aide (CMA) was notified R2 was drinking excessively and not providing her own cares at this time. The "Social Services Note" dated 11/09/21 at 12:58 PM revealed R2's representative noted the resident had a bottle of alcohol and asked the	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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 12	S3028		

facility for R1 to stop bringing alcohol to R2. Administrative Staff A returned the bottle of alcohol and asked R1 not to bring R2 any additional alcohol at this time.

The "Health Status Note" dated 11/10/21 at 03:30 PM revealed the facility notified the R2's representative that the resident was "intoxicated again in her room with [the] other resident present".

The "Social Services Note" dated 11/11/21 at 01:01 PM revealed R2 was found naked and intoxicated in her room. Facility staff had to re-dress the resident. The resident's family confronted R1 about bringing R2 alcohol and stated he had been "bringing [it] to the resident's room". R1 stated he did not remember the family's request not to take alcohol to the resident's room.

The "Health Status Note" dated 11/15/21 at 03:20 PM revealed an unidentified CMA reported R2 was in her room drinking alcohol with another resident. R2 denied drinking the alcohol, although the other resident admitted to the behavior.

On 11/30/21 at 04:00 PM Administrator A made a report to the State Agency stating the facility needed to report an allegation of sexual abuse. R2's representative reported her family suspected she had been a victim of sexual abuse and made a report to Adult Protective Services (APS) regarding another resident of the facility.

Interview with R2 on 12/02/21 at 03:40 PM revealed she did not drink regularly until she became friends with R1. The resident stated she was just friends with R1, but they did hug and kiss on occasion. R2 did not remember ever

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 13 being extremely intoxicated and without her clothing. Interview with R1 on 12/02/21 at 02:44 PM revealed he was friends with R2. He reported he bought the alcohol and would have drinks with R2, but not often and not to the point of intoxication. R1 admitted to consensual hugging, kissing, and fondling. R1 stated R2 was in her "right mind and wanted to". On 12/02/21 at 11:55 AM Administrator A confirmed she made a report to the State Agency regarding an allegation of sexual abuse of R2 and named an alleged perpetrator as R1. When asked to review the facility's investigation she said she had not started interviewing residents or staff yet. When asked what measures were put into place to protect other residents in the facility while the investigation was being completed, she could not name any specific interventions and said she reported the allegation to Licensed nurse (LN) B. She was not aware of any interventions LN B put into place. Interview on 12/02/21 at 12:10 PM with LN B revealed she did not know of an allegation regarding sexual abuse by R1 towards R2. She said she received a group message through the work phone from the attached Skilled Nursing Facility's Social Service Staff C on 11/30/21 at 01:47 PM. The message read: "FYI [R2's name] sister called APS on [R1] over there [at the Assisted Living], she's in my office now and just made a comment so wanted to make sure you were all aware". LN B said a short time later and as part of the conversation thread she received a message from Administrator A which read: "she just shared that info with me about [R1]". Neither message included an allegation of sexual abuse.	S3028		

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	N008011	A. BUILDING: _____ B. WING _____	12/16/2021

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S3028	Continued From page 14	S3028		

LN B said she then went to a meeting between the staff from the Skilled side of the facility where R2 resided and nothing was discussed about an allegation of sexual inappropriateness/abuse towards R2 by R1, so she was unaware of any protection interventions she needed to put in place.

Interview on 12/02/21 at 01:15 PM with Administrator A confirmed R2's family came to her office on 11/30/21 to discuss R2 moving out of the facility. Administrator A reported the resident's representative said R2 feels differently now about R1 following her hospital stay for alcohol detox. The family member told Administrator A she made a report to APS about R1 supplying R2 with alcohol and the possibility of sexual abuse. Administrator A confirmed she failed to talk with both residents as part of an investigation until the surveyor asked about interviews. She confirmed no interventions were put in place to protect other residents while an investigation was conducted.

During a phone interview with R2's Resident Representative D on 12/07/21 at 12:55 PM revealed the resident started drinking alcohol in November, which was provided by R1. The resident's representative stated she asked the facility to ask R1 to stop providing alcohol to R2, because she became so intoxicated, she could not perform her own cares. She further reported the family requested a doctor's order for R2 not to drink alcohol and reported more incidents of drinking occurred after that. R2's representative reported R2 was alert and oriented, but when she started drinking, she could not remember events. Once R2 completed alcohol detoxification she reported to her representative that R1 would hug and kiss her and tell her he liked seeing her in her

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S3028	Continued From page 15 underwear. The facility's undated policy, titled, Administration/Abuse, Neglect and Exploitation included a section titled, Protection which read; upon receiving a report of Abuse, Neglect or Exploitation the Resident Director will immediately examine the resident and ensure his or her well-being ... if another resident is the alleged perpetrator, the two residents will be separated and monitored to prevent additional contact. Every situation should be investigated to determine the factors involved. The section titled, Investigation of Abuse, Neglect or Exploitation which read; All incidents reported as suspected abuse, neglect or exploitation shall be investigated. Information to obtain during the investigation included: resident's name and room number, date of alleged incident, name and telephone number of the reporting party, name of witnesses and their statement, factual description of circumstance and event for the reported incident. The facility failed to take immediate measures to prevent further potential abuse and start an investigation when the Administrator became aware on 11/30/21 of an allegation regarding sexual abuse by Resident (R) 1, when he purchased alcohol for R2 and she was found excessively intoxicated and naked in her room . This failure placed all female residents of the facility in immediate jeopardy. The jeopardy was removed on 12/02/21 at 3:29 PM when the Administrator provided an abatement plan of the following: R 1 was asked to stay in his room until the investigation was completed. Nursing staff will check the resident every hour	S3028		

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S3028	Continued From page 16 with ADL assistance offered during those checks Meals will be delivered Education on Abuse/Neglect/Exploitation and reporting will be completed with all staff by 12/10/21	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: K.A.R. 26-41-204 (a) The facility reported a census of 75 residents. The sample included 6 residents. Based on observation, interview and record review the Administrator failed to ensure a Licensed nurse (LN) provided or coordinated the provision of necessary health care services to meet the needs for 1 of 6 sampled residents (#4) in accordance with the Functional Capacity Screening and the Negotiated Service Agreement regarding urinary bladder incontinence. Findings included: - Record review for resident #4 revealed an	S3155		

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S3155	Continued From page 17	S3155		

admission date of 07/06/21 with diagnoses of vascular dementia without behavioral disturbances, major depressive disorder, edema, hypertension and overactive bladder.

The Functional Capacity Screen (FCS) dated 09/03/21 identified the resident with intact cognition but under section III Licensed nurse (LN) B marked the resident with impaired decision making. She needed physical assistance with transfers, walking/mobility and toileting. The FCS indicated the resident was incontinent of urinary bladder (Incontinent -Lacks control. Multiple episodes of incontinence daily).

The 09/03/21 Negotiated Service Agreement (NSA) dated 09/03/21 and without revision, identified the resident as being incontinent of bladder and bowel. The section for toileting lacked identification of the resident's need for physical assistance. LN B marked her as incontinent frequently and check marked supplies. Typed directions included staff to assist with toileting and incontinence as needed. The NSA included weekly apartment cleaning, check marked for daily bed making, typed in for daily room tidy and trash pick-up. She was to received personal and linen laundry service weekly by facility staff.

The Health Service Plan (HSP) dated 09/03/21 and without revision, indicated the resident was alert, oriented times 3 (person, place, time) and cooperative. The HSP directed staff to assist the resident with dressing and she was independent with mobility/transfers using a walker. Under the section identified as Bowel/Bladder LN marked incontinent, wears pads and self manages with directions to staff to assist with care PRN.

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S3155	Continued From page 18 A "Health Status Note" by LN B dated 10/12/21 at 04:08 PM read, Mobile Solutions arrived and the could not perform the X-ray due to issues with the environmental status of the room. The note identified a linked document which did not open when clicked on. On 12/08/21 LN B said the environmental issue was strong pervasive urine odor. Observation of a picture provided by Resident Representative (RR) E date stamped as 10/13/21 revealed 95% of the formerly white bed sheet was discolored to various shades of tan, darker tan and brown at edges of some areas which was indicative of repeated urinary incontinence episodes. During a phone interview with resident #4 and RR E on 12/13/21 at 02:03 PM the resident was able to voice her name, her family members name, where she was and the day of the week. She reported she had some trouble remembering things. She reported the facility staff give her a sheet to sign about the care she is receiving but could not remember what the sheet was called. When asked about urinary incontinence she reported being incontinent, taking diuretics and when she stands up it gushes out and she can't get to the bathroom. She said she can put on and take off her incontinent brief but would ask for help if the staff were in the room. RR E said the resident's vascular dementia interferes with her ability to process the need to use the bathroom which contributed to her incontinence. RR E said the resident wore an incontinent brief, had the ability to put on and take off independently but she lacked the ability to clean up any incontinent messes or doing laundry which gets soiled from the incontinence. RR E also said due to the vascular dementia the resident would not call for	S3155		

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S3155	Continued From page 19	S3155		

assistance to change soiled linens and would put some other fabric like towels or blankets over the wet area and then lay back down on them. She explained the resident would have an urge to urinate however, the vascular dementia would not always allow her brain to process the signal correctly for her to know to get up and go to the bathroom. RR E reported when she spends the day with resident #4 and takes her to the bathroom on a schedule the resident with have less incontinence or at least smaller more manageable amounts. RR E reported no changes were made to the service plan for the resident's incontinence following the 10/12/21 episode that she was aware of. She reported picking up resident #4 today (12/13/21) for an appointment and the resident had a urine smell about her person.

In an electronic communication with LN B on 12/14/21 at 07:19 AM she reported the resident does have forgetfulness and memory issues. The resident makes some of her own decisions and had a Durable Power of Attorney (DPOA) in place. She confirmed there were no revisions to the NSA or HSP after being made aware the resident did not manage her own incontinence by the episode on 10/12/21 when an outside provider refused to enter the resident's room due to a pervasive strong urine smell. She reported the resident routinely refused assistance with toileting and chose to lay in the bed and be incontinent. LN B failed to provide any evidence of attempts by staff to provide assistance and/or involvement with the DPOA to develop a plan for urinary incontinence management.

The Administrator failed to ensure a Licensed nurse (LN) provided or coordinated the provision of necessary health care services to meet the

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S3155	Continued From page 20 needs for resident #4 in accordance with the Functional Capacity Screening and the Negotiated Service Agreement regarding urinary bladder incontinence.	S3155		