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 04/28/2021

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
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with complaint #'s 161840, 160466, 157199, 157095, 155810, 155515, 155410, 151406, 151358, 148628, 145432 for the above named facility conducted on 4/22/2021, 4/26/2021, 4/27/2021, 4/28/2021.	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.	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
	N023017	A. BUILDING: _____ B. WING _____	C 04/28/2021

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
S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (3) (E) The facility reported a census of 36 residents, the sample included 3 residents and 3 closed record reviews. Based on record review and interviews the operator failed to report to the department an allegation of sexual abuse for resident # 113, within 5 working days of the initial report. Findings included: Record review on 4/22/2019 at 10:00 AM revealed the resident was admitted on 5/27/2019 with diagnoses of dementia and allergies. Review of the annual Functional Capacity Screen dated 3/17/2020 revealed the resident had impaired cognition with short- and long-term memory, memory recall and impaired decision making. She required supervision for bathing, and independent with dressing, toileting, transfers, and walking. She lacked the ability to manage her own medications and required a walker assist device for mobility. Review of the updated Negotiated Service Agreement/Health Service Plan dated 12/23/2020 revealed/instructed staff resident required stand by assist for showers, and she was independent toileting. Review of the Resident Notes revealed the following entries; 4/13/2021 resident reported to the physical therapist she had been raped by a staff member. Operator B and licensed nurse C went to resident	S3028		

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 04/28/2021

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
S3028	Continued From page 2 and interviewed resident and started an investigation. The resident reported that a man raped her about a week ago. 4/13/2021 licensed nurse C spoke to resident's daughter and the daughter did not want anything done at this time. Interview on 4/22/2021 at 11:15 AM revealed the following; when asked about the inappropriate sexual conduct the resident responded that it happened a year ago, and "my daddy is a big guy and took care of him." When resident asked if she felt safe the resident responded "Yes", and "they are very nice here". Interview on 4/22/2021 at 12:45 PM with resident #113 family member revealed the following; she did not feel the incident happened, and the incident was a memory of her past. She continued with an allegation from the resident a in 2020 when resident made an allegation of being raped. The investigation at that time revealed the resident had spent the night in another resident room. Resident #113 family took resident to the local emergency room and follow up was performed with an inconclusive outcome. Resident #113's family member stated she felt resident was safe and happy. Interview on 4/22/2021 at 10:30 with operator B confirmed she did not report the allegation of rape to the department after the facility investigation was completed. The operator failed to report to the department an allegation of sexual abuse for resident # 113 within 5 working days of the initial report.	S3028		

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 04/28/2021

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
S3175	Continued From page 3	S3175		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (a) The facility reported a census of 36 residents the sample included 3 residents and 3 closed record reviews. Based on record review and interview the operator failed to ensure the licensed nurse performed an assessment on resident #576 to determine if resident could perform the function safely and accurately without staff assistance. Findings included: Review of the resident roster on 4/22/2021 provided by facility revealed the resident administered her own medications.	S3175		

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 04/28/2021

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
S3175	Continued From page 4 Record review on 4/27/2021 at 2:00 PM revealed the resident admitted to the facility on 1/31/2019 with diagnoses of hypertension, kidney disease stage 3, atrial fibrillation, depression, hypothyroidism, and allergies. Review of the annual Function Capacity Screen dated 4/9/2021 revealed the resident had impaired decision making and lacked the ability to manage her own medications. She was independent with all bathing, dressing, toileting, transferring and mobility. Review of the updated Negotiated Service Agreement/Health Service Plan dated 4/24/2021 revealed/instructed staff resident was independent with all activities of daily living and the facility would manage and administer resident medications. Review of signed physician's orders dated 2/17/2021 revealed the following Novolog Flex pen - resident to administer own insulin dose Tresiba Flextouch - resident administers own insulin dose Trulicity - resident administers own insulin dose Review of physician signed Self - Administration of Medications Review dated 2/4/2019 revealed the resident may administer own insulin from a set up pen "only" and "per Medical doctor diabetes mellitus uncontrolled history of patient not following doctor orders". Interview with licensed nurse C on 4/26/2021 revealed the resident self-administers her eye drops and injects her own insulin.	S3175		

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 04/28/2021

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
S3175	Continued From page 5 Interview with operator B on 4/26/2021 revealed the resident chart lacked the assessment to determine if resident could perform the function safely and accurately without staff assistance. The operator failed to ensure the licensed nurse performed an assessment on resident #576 to determine if resident could perform the function safely and accurately without staff assistance.	S3175		