STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175332	A. BUILDING _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation # 156195.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility reported a census of 71 residents. Based on record review and interviews, the	F 609		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175332	A. BUILDING _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

(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) COMPLETION DATE
F 609	Continued From page 1	F 609		

facility failed to report a resident to resident altercation to the state agency, between Resident (R)1 and R2, as required. R1 grabbed R2 on both arms.

Findings included:

- The signed "Physician Order Sheet" (POS), for Resident (R1), dated 10/14/20, revealed the following diagnoses; major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The annual "Minimum Data Set" (MDS), dated 04/08/20, documented the resident admitted 04/05/20, and revealed the resident had a "Brief Interview for Mental Status" (BIMS) score of 7, indicating he had moderately impaired cognition. The resident received anti-psychotropics, anti-anxiety, and anti-depressant medications.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 04/18/20, revealed the resident was at risk for adverse effects related to the use of anti-psychotic, anti-anxiety and anti-depressant medication.

The care plan, dated 04/07/20, revealed the resident used psychotropic medications related to psychosis and behavior management. Staff should consult with counselors for behaviors health as needed. Staff were to approach the resident in a calm manner, reposition him, offer him a snack, assess him for pain, provide a quiet environment, encourage him to express his feelings, attend an activity, and provide him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175332	A. BUILDING _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

(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) COMPLETION DATE
F 609	Continued From page 2	F 609		

reassurance.

On 08/06/2020, the clinical records lacked documentation of a resident to resident altercation.

Review of the facility's "Internal Investigation", revealed on 08/06/2020 at 05:30 PM, a resident altercation occurred between R1 and R2. Staff heard R1 and R2 yelling out at each other. R2 reported R1 grabbed her arms in the altercation. R2 reported she expressed feelings of fear from R1.

Observation, on 10/15/20 at 10:25 AM, revealed R1 without behaviors.

On 10/15/20 at 10:42 AM, Certified Nurse Aide (CNA) P, provided cares on R1. R1 was compliant with his cares.

On 10/15/20 at 02:11 PM, R1 was calm, and had no negative behaviors.

On 10/19/20 at 08:48 AM, R1 rested in his bed, without behaviors.

On 10/16/20 at 08:18 AM, Licensed Nurse (LN) G stated she was in the medication room and heard R1 yelling loudly. R1 was in R2's bedroom doorway. R2 reported R1 grabbed both of her arms in the altercation.

On 10/16/2020 at 10:27 AM, R2 verbalized she did not want to discuss the incident.

On 10/16/20 at 11:41 AM, LN I stated that she was in her office, located on the west hall, when she heard someone yell on the east hall. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175332	A. BUILDING _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

(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) COMPLETION DATE
F 609	Continued From page 3	F 609		

witnessed R1 in his wheelchair at R2's doorway, with R2 standing behind him, however, when she approached the residents, she was unable to determine if either of the residents had physical contact. She reported R2 as alert and oriented.

On 10/15/20 at 08:43 AM, Administrative Staff A verified she did not report the incident to the State agency.

The facility's policy "Reporting Alleged Violations of Abuse and Neglect", dated 11/15/2018, documented the resident has the right to be free from abuse and must not be subjected to abuse from other residents in the facility.

The facility failed to report to the state agency, a resident to resident altercation when one resident grabbed another residents arm, which placed R1 at fearful for this resident's physical aggression.