STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008013	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAPLETON ANDOVER, LLC	1419 W CENTRAL AVE ANDOVER, KS 67002

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S 000	INITIAL COMMENTS The following citations represent the findings of the abbreviated survey for complaint investigations #154713 and #154736 conducted on 08/03/2020, 08/04/2020, 08/05/2020, 08/06/2020, 08/10/2020 and 08/11/2020.	S 000		
S3028 SS=F	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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (3) (B) The facility reported a census of 10 residents with 8 of 10 residents being identified as cognitively impaired. The sample included 3 residents. Based on observation, interview and record review for 1 of 3 sampled residents (#1) the operator failed to use all resources available to them (substantial video surveillance) to establish a likely timeline for an allegation of abuse and to aid in identifying alleged perpetrators. On 7/30/2020 outside provider staff reported their discovery of resident #1 with shaved pubic hair. Certified medication aide (CMA) D interviewed 5 staff and determined the incident most likely occurred between 7:00 a.m. on 07/29/2020 and 9:35 a.m. on 07/30/2020. The operator failed to take immediate measures to prevent further potential abuse while the investigation was in progress by a failure to suspend staff who provided care during the identified timeframe. The facility allowed direct care staff A, B and C who provided care to resident #1 during the time frame to remain on the schedule. The facility only suspended direct care staff A on Friday 07/31/2020 at 4:23 p.m. Direct care staff B worked and provided cares on 08/01/2020 and 08/02/2020 from 7p.m. to 7a.m. (the overnight shift). Direct care staff C worked and provided cares from 7a.m.-7p.m. on 07/30/2020 and 07/31/2020. The failure to review the video footage in enough detail to rule out staff and failure to suspend the 3 staff who provided care during the projected incident timeframe placed the majority of the residents at risk for abuse. Findings included:	S3028		

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S3028	Continued From page 2 - Record review resident #1 revealed an admission date of 03/25/2020 with diagnosis of dementia without behavior disturbances. The admission functional capacity screen dated 03/25/2020 identified the resident with deficit in all aspects of cognition, needed physical assistance with toileting, transfers, walk/mobility and eating. She was unable to bath and dress herself. The negotiated service agreement (NSA) dated 03/25/2020 included facility responsibility for meal preparation and feeding the resident, housekeeping and laundry, bathing, grooming, dressing, toileting, and mobility by a wheelchair. The NSA included the resident received outside provider services of Hospice care. The undated care sheet directed staff to provide physical assistance with shower, dressing, toileting, grooming, mobility and fed a pureed diet by staff. The sheet noted the resident as non-verbal with dementia. The Hospice aide visit note dated 07/30/2020 indicated the visit began at 9:31 a.m. until 10:26 a.m. In the narrative hospice staff wrote "noticed her pubic area has been shaved. We asked facility staff who shaved it and why, but they did not have an answer." Observation on 08/03/2020 at 11:45 a.m. with CMA D revealed the resident rested in bed with her eyes open towards the ceiling. CMA D told the resident she was going to check her brief and the resident provided no resistance to the care and mumbled a few non-sensical words. The resident's entire pubic and labia area was shaven and had some new growth of about 1/16th of inch.	S3028		

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S3028	Continued From page 3 Interview with CMA D on 08/03/2020 at 11:25 a.m. revealed on 07/30/2020 at about 10:30 a.m. the Hospice home health aide reported to her, while during the resident's scheduled bath they noted her peri-area had been shaved. CMA D reported she observed the area and noted the whole entire area had been shaved within the previous 24 to 48 hours. She said there was no new growth, no rash or noted injuries. She said she was acting on the operator's behalf while the operator was out of state and started an investigation. She reported moving backward from first shift on -07/30/2020 when she asked direct care staff C about the resident's pubic hair. Direct care staff C reported noting it shaved when she got the resident up that morning. She then asked nightshift direct care staff B who worked from 7:00 p.m. on 07/29/2020 to 7:00 a.m. on 07/30/2020. He said it was already shaved when he provided care around 10:30-11:00 p.m. She then asked the first shift staff who worked 7 a.m. to 7 p.m. on 07/29/2020 and direct care staff A initially said she didn't remember and then finally said late in the day about 2:30 p.m. the resident was not shaved. The previous shift direct care staff E who worked from 7:00 p.m. on 07/28/2020 overnight until 7:00 a.m. on 07/29/2020 and she indicated the resident had not been shaved. CMA D also reported searching the resident's room for any kind of evidence and the only thing she found was a few pubic hairs in the hand sink which is right inside the resident's room door. At this point the police had not been contacted. CMA D reported she was directed by the owner and the operator on 07/31/2020 to suspend direct care staff A. She reported the owner had viewed the video footage and the only one in the room long enough to do care was direct care staff A.	S3028		

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The resident care technician for the day was in and out only for trash and the resident had no outside visitors. When asked to review all the documentation and notes of the investigation gathered so far. CMA D reported all of the documents were sent to the operator's home for review. When asked to view the video surveillance footage she said the owners have the access and they live out of state. She would reach out to them to see if they could email the footage or a notarized statement of what they saw on the footage they reviewed 07/30/2020 & 07/31/2020.

Interview on 08/03/2020 at 12:55 p.m. with operator F revealed there was no documentation yet in the resident's record because she had been on vacation the past week. She provided the documents of what CMA D had gathered so far for the incident. Review of those documents revealed a schedule, a partial copy of the daily report sheet for 07/29/2020 for just this resident. When surveyor requested notes or documentation by CMA D of the investigation components she had completed, CMA D reported she didn't have any, she may have some by text messages or she may have it on post-it notes.

Review of the schedule provided revealed:
Direct care staff E worked from 7:00 p.m. 07/28/2020 until 7:00 a.m. of 07/29/2020
Direct care staff A worked from 7:00 a.m. until 7:00 p.m. on 07/29/2020
Direct care staff B worked from 7:00 p.m. 07/29/2020 until 7:00 a.m. 07/30/2020
Direct care staff C worked from 7:00 a.m. 07/30/2020 until 7:00 p.m.

The daily report sheet for 07/29/2020 for 7am-7pm completed by direct care staff A

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indicated the resident had a good day and a small bowel movement. Nothing noted about any personal cares, bathing or shaving. The sheet dated 07/29/2020 from 7pm-7am written by direct care staff B revealed the resident slept good and was changed twice. No indicators of any bowel movement, bathing or shaving. The sheet for 07/28/2020 was not provided.

On 08/03/2020 at 1:50 p.m. CMA D provided a single sheet of paper with four different colored post-it notes attached and some handwriting on the paper itself. The top of the page indicated she spoke with direct care staff C on 07/30/2020 after the hospice aide informed her of the incident. The document did not include what if anything the staff member said about the incident. One post-it said direct care staff A was not sure (if the resident still had pubic hair on her shift) but when made to choose she said it was not (with no other clarifier). Another post-it noted indicated direct care staff B on 7/30/2020 stated he went in at 10:30-11:00 PM and it was shaved, Post-it notes for direct care staff E indicated she said it was 100% not shaved. CMA G reported she didn't have a clue she just passed meds that day. The page indicated CMA D looked through the room found no evidence and notified the owner to look through surveillance tape footage.

Direct care staff A had provided a handwritten statement dated 07/30/2020 which indicated she cared for the resident on 07/29/2020, changed her brief at all 3 meals when getting her up and each time she noticed she had pubic hair with no signs she had been shaved. Her notarized statement dated 07/31/2020 indicated she provided care on 07/29/2020 and she noticed no changes to the resident's pubic hair.

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Interview and notarized statement obtained on 08/03/2020 by the surveyor from direct care staff B revealed he came on duty at 7:00 p.m. on 07/29/2020. He noticed the shaved pubic hair at about 10:00 p.m. when he changed her brief and prior to the start of his shift she was changed by the day shift staff.

Multiple requests made on 08/03/2020 to review the footage and or a notarized statement from the owner who reviewed the footage previously with none provided that day. Several times during the day by phone and by email with operator F again requesting video footage or a statement from the owner of what he reviewed resulted in none provided. An email received on 08/05/2020 at 4:12 p.m. included a time record beginning at 7:00 a.m. 07/28/2020 through 07/30/2020 at 10:14 a.m. The record revealed most staff were in the room less than 10 minutes with 4 or 5 visits in a 12-hour shift as follows:
07/28/2020 7am-7pm direct care staff E 1 time 2 minutes (mins.) at 7:13 a.m., direct care staff J at 8:23 a.m. for 2 min., 12:41 p.m. 4 mins, 1:23 p.m. 5 mins, 5:28 p.m. for 9 mins and 6:27 p.m. for 5 mins
07/28/2020 at 7:24 p.m. direct care staff E for 1 min, 11:27 p.m. for 8 mins
07/29/2020 at 8:15 a.m. direct care staff A for 11 mins, 1:23 p.m. for 16 mins, 4:47 p.m. for 7 mins, 5:30 p.m. for 7 mins and 5:50 p.m. for 6 mins.
07/29/2020 direct care staff B entered the resident's room 11 times in the 12 hours scheduled to work for a total of 81 minutes spent in the resident's room as follows: 8:37 p.m. for 9 mins., 8:58 p.m. for 5 mins., 9:13 p.m. for 1 min., 9:23 p.m. for 3 mins., 9:35 p.m. for 4 mins., 9:42 p.m. for 22 mins., 10:05 p.m. for 1 min., 11:06 p.m. for 15 mins., 11:23 p.m. for 4 mins., 12:17 a.m. (after midnight) for 9 mins., then none until

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6:04 a.m. for 8 minutes.
07/30/2020 at 8:09 a.m. direct care staff C entered for 3 mins and the next time someone entered the room was at 9:34 a.m. when Hospice entered.

Notarized statement obtained on 08/03/2020 from CMA D matched her earlier interview for questioning staff with 7:00 a.m. on 07/29/2020 the resident still had pubic hair. Direct care staff A said the resident had pubic hair on her shift of 7a-7p. Direct care staff B reported his first bed check was around 10:30-11:00 p.m. and she was shaved. CMA D called and spoke to owner H who would watch the video and see if anyone was in her room for extended amounts of time.

On 08/04/2020 a notarized statement from operator F indicated she instructed CMA D to interview the staff and obtain notarized statements. She instructed her to notify owner H to look at security cameras for footage. Following review of the footage and staff statements she instructed CMA D to suspend direct care staff A because at that time she was the only staff seen on camera entering the resident's room between 7am-7pm on 07/29/2020. In her statement she does not indicate the length of time for the security camera footage review. Per interview on 08/03/2020 she thought it was just for the 7a-7p shift of 07/29/2020 because direct care staff B said it was shaved at his first incontinent check.

Interview on 08/05/2020 at approximately 4:30 p.m. with operator F revealed she did not suspend direct care staff B or C because staff B said the resident was already shaved when he checked her at 10:00 p.m. When asked what she thought about the video footage results she said, my understanding was he did not go in the room

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until 10:30 p.m. however, the timeline shows 8:37 p.m. I have asked him to come give another statement since it appears, he was dishonest in the first one.

Interview by phone on 08/06/2020 at 3:40 p.m. with owner H revealed he only reviewed the footage between 7am and 7pm for 07/29/2020 because he understood CMA D had narrowed it down to the day shift. He reported conducting the quick scan feature where it stops if motion is detected, but later after requested by surveyor he reviewed the footage from 7:00 a.m. on 07/28/2020 through 10:14 a.m. of 07/30/2020.

The undated facility's policy on resident abuse directed the first priority is to prevent abuse from occurring in the first place. It listed abuse of residents may take many forms included any physical injury not caused by an accident, neglect resulting in physical harm, discomfort or loss of the resident's dignity and unwanted sexual contact with another resident or staff person. The policy directed to take any allegation of resident abuse seriously and report it immediately. If an employee is suspected of abuse, he/she should immediately separate him/herself from the resident he/she is accused of abusing (this does not indicate guilt but as a step in diffusing a potentially volatile situation). Suspending the employee immediately or reassigning staff pending on the results of an investigation may be appropriate. It will be the operator/administrators function to do the following actions upon notification: ..., An investigation shall be started when the administrator/operator or designee received notification of an alleged violation. The operator/administrator or designee should begin immediately to investigate the allegations speaking with all involved parties, including all

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S3028	Continued From page 9 staff on duty at the time the abuse supposedly occurred, to determine what happened. Document all conversations (witnesses may also be asked to put their statements in writing). The operator failed to use all resources available to them (substantial video surveillance) to establish a likely timeline for an allegation of abuse and to aid in identifying alleged perpetrators. On 07/30/2020 outside provider staff reported their discovery of resident #1 with shaved pubic hair. Certified medication aide (CMA) D interviewed 5 staff and determined the incident most likely occurred between 7:00 a.m. on 07/29/2020 and 9:35 a.m. on 07/30/2020. The operator failed to take immediate measures to prevent further potential abuse while the investigation was in progress by a failure to suspend staff who provided care during the identified timeframe. The facility allowed direct care staff A, B and C who provided care to resident #1 during the time frame to remain on the schedule. The facility only suspended direct care staff A on Friday 07/31/2020 at 4:23 p.m. Direct care staff B worked and provided cares on 08/01/2020 and 08/02/2020 from 7p.m. to 7a.m. (the overnight shift). Direct care staff C worked and provided cares from 7a.m.-7p.m. on 07/30/2020 and 07/31/2020. The failure to review the video footage in enough detail to rule out staff and failure to suspend the 3 staff who provided care during the projected incident timeframe placed the majority of the residents at risk for abuse.	S3028		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff	S3248		

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S3248	Continued From page 10 records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (d)(2)(3) The facility reported a census of 10 residents. Based on interview and record review the operator failed to have evidence of criminal background checks at the time of hire for 3 of 3 certified staff reviewed (certified nursing assistants A, B and C), and verification of nurse aide registry for 1 of 3 (certified nurse aide C) as required to ensure the individual did not have a finding of abuse/neglect/exploitation. The 3	S3248		

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certified staff had the potential to provide care to all the residents.

Findings included:

- Personnel record review for certified nursing assistant (CNA) A revealed she began employment on 06/04/2020. The operator failed to check the criminal background until 06/24/2020.

The personnel record for CNA B revealed he began employment on 1/01/2020. The operator failed to check the criminal background check until 06/25/2020 (6 months after he began providing care to residents).

The personnel record for CNA C indicated she began employment on 06/19/2020. The operator failed to check the criminal background until 06/24/2020 and had no evidence of a nurse aide registry verification until 08/10/2020.

Review of the facility's staffing schedule on 08/03/2020 revealed all 3 staff worked and provided care to the residents the week of 07/26/2020 thru 08/01/2020.

Per email on 08/10/2020 operator F confirmed the above dates for the criminal background checks for direct care staff A, B and C. She said the record for direct care staff C lacked evidence of a registry checked at the time of hire.

The operator failed to have evidence she requested a criminal background check on CNA A, B and C at the time of employment and failed to verify the nurse aide registry for CNA C before she began providing care to the residents. This failure had the potential to provide care to all the

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S3248	Continued From page 12 residents.	S3248		