STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR PO BOX 5000 HESSTON, KS 67062

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #s 147013 and 147577. The 2567 was electronically sent to the facility on 11/15/19.	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.	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.

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F 609	Continued From page 1	F 609		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 98 residents. The sample included 21 residents, including 2 reviewed for abuse. Based on observation, interview, and record review, facility staff failed to report an allegation of abuse to administrative staff in a timely manner and failed to report the allegation to the state agency, as required, for 1 of the 2 residents reviewed, when Resident (R) 25 accused a staff member of hitting him.

Findings included:

- Resident (R) 25's signed "Physician Orders," dated 10/25/19, documented the resident admitted on 05/22/19, with the following diagnoses including; Alzheimer's disease (progressive mental deteriorate characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion) without behavior disturbances, mild cognitive impairment, and cognitive communication deficit.

The resident's admission "Minimum Data Set" (MDS) , dated 05/29/19, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. The resident had long and short-term memory problems and moderately impaired decision making.

The "Delirium Care Area Assessment" (CAA), dated 06/03/19, triggered due to mental status changes, inattention and altered LOC (level of consciousness). Confounding problems include a diagnosis of dementia and depression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 2	F 609		

The resident's quarterly "MDS," dated 08/26/19, revealed the resident had a BIMS score of nine, indicating moderately impaired cognition.

The care plan, reviewed on 08/29/19, documented the resident required assist of one to two staff for transfers with ambulation and used a wheelchair for mobility. The resident also had cognitive loss and to watch for signs of discomfort and to seek a remedy when something upset the resident..

The resident's electronic medical record lacked information related to the allegation of abuse.

Review of the "Complaint Investigation Witness Statement of Facts Before the Kansas Department on Aging," dated 11/02/19 at 10:20AM, documented R25 accused Certified Medication Aide (CMA) Q of hitting him. CMA Q immediately contacted the nurse on duty. The nurse on duty failed to report the allegation in a timely manner to the administrative staff. The incident occurred on 11/02/19 at 10:20AM and staff failed to notify Administrative Nurse D until 01:42PM (a period of 3 hours and 22 minutes.)

On 11/13/19 at 8:46 AM, Administrative Nurse D reported he received a phone call on 11/02/19 at 01:42 PM as it was a weekend. The staff calling stated CMA Q propelled the resident to his room. The resident accused the staff member of hitting him. CMA Q immediately notified Licensed Nurse G. They immediately put into place that R25 was to have two staff for cares. Administrative Nurse D then called Administrative Staff A and notified her per phone, of the accusation. Administrative Nurse D verified he failed to report the allegation of abuse to the State Agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 3 Interview on 11/13/19 at 09:26AM, Licensed Nurse G revealed she notified Administrative Nurse D and did not receive further instruction (as to suspend alleged perpetrator.) LN G lacked response as to why she waited over 3 hours to notify administrative staff. On 11/13/19 at 11:00AM, Administrative Staff A verbalized she failed to report the allegation of abuse to the State Agency. Review of the facility policy dated 06/13/18, "Abuse, Neglect, Exploitation, Mistreatment", the policy documented, all alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source, or misappropriation of resident property are to be reported immediately to the supervisor, charge nurse, Director of Nursing, or the Executive Director, designee, or other officials in accordance with Kansas law. The facility failed to ensure staff reported the allegation of abuse to administrative staff in a timely manner and failed to report the allegation to the State Agency, as required.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		

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F 610	Continued From page 4	F 610		

neglect, exploitation, or mistreatment while the investigation is in progress.

§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 98 residents. The sample included 21 residents, including two residents for abuse allegations. Based on interview and record review, the facility failed to have evidence of a thorough investigation and prevent potential abuse after Resident (R) 25 alleged Certified Medication Aide (CMA) Q abused him. Furthermore, the facility failed to implement measures to separate the alleged perpetrator from resident care to protect all the other residents residing on until staff completed a thorough investigation.

Findings included:

- Resident (R) 25's signed physician orders, dated 10/25/19, documented the resident admitted on 05/22/19, with the following diagnoses including; Alzheimer's disease (progressive mental deteriorate characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion) without behavior disturbances, mild cognitive impairment, and cognitive communication deficit.

The resident's admission "Minimum Data Set"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 5	F 610		

(MDS) , dated 05/29/19, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. The resident had long and short-term memory problems and moderately impaired decision making.

The "Delirium Care Area Assessment" (CAA), dated 06/03/19, triggered due to mental status changes, inattention and altered LOC (level of consciousness). Confounding problems include a diagnosis of dementia and depression.

The resident's quarterly "MDS," dated 08/26/19, revealed the resident had a BIMS score of nine, indicating moderately impaired cognition.

The care plan, reviewed on 08/29/19, documented the resident required assist of one to two staff for transfers with ambulation and used a wheelchair for mobility. The resident also had cognitive loss and to watch for signs of discomfort and to seek a remedy when the resident became upset.

The resident's electronic medical record lacked information related to the allegation of abuse and the facility lacked a thorough investigation.

On 11/13/19 at 8:46 AM, Administrative Nurse D reported he received a phone call on 11/02/19 at 01:42 PM, as it was a weekend. The staff calling stated CMA Q propelled the resident to his room. The resident accused the staff member of hitting him. CMA Q immediately notified Licensed Nurse G. They immediately put into place that R25 was to have two staff for cares. Administrative Nurse D then called Administrative Staff A and notified her per phone, of the accusation. Administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 6	F 610		

Nurse D verified he failed to report the allegation of abuse to the State Agency. Administrative Nurse D confirmed the alleged perpetrator continued to work with the residents on the 300-400 hall Unit.

Interview on 11/13/19 at 09:26AM, Licensed Nurse G revealed she notified Administrative Nurse D and did not receive further instruction (as to suspend alleged perpetrator.) LN G lacked response as to why she waited over 3 hours to notify administrative staff.

On 11/13/19 at 11:00AM, Administrative Staff A verified the facility failed to maintain documentation of a thorough investigation. She also confirmed the alleged perpetrator was not suspended or kept separate from the 9 residents residing on the 300-400 hall where the alleged perpetrator was working.

The facility policy, dated 06/13/18, documented, upon notification of a possible abuse situation the supervisor will remove the suspected individual from the direct care area. If the suspected individual is a Villa employee, they will be suspended pending completion of the investigation. All alleged violations are to be thoroughly investigated and documented. Precautions shall be taken to prevent further potential abuse while the investigation is in progress.

The facility failed to thoroughly investigate this allegation of abuse and separate the alleged perpetrator from the 9 residents residing on the 300-400 unit until facility staff completed a thorough investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 7	F 689		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 98 residents with 21 residents selected for review, including five residents reviewed for falls. Based on observation, record review, and interview, the facility failed to provide interventions to prevent repeated falls for one of the five residents selected, Resident (R) 83 related to failure to implement planned interventions of staff keeping the resident's door open for visual view and wheelchair placement including keeping the wheelchair locked and beside the resident's bed. In addition, the facility identified five residents as confused and self-mobile residing on the 300/400 halls and the facility failed to ensure hazardous chemicals were secure and out of the reach for these five confused self-mobile residents. Findings included: - The signed physician order sheet, dated 10/02/19, of Resident (R) 83, documented the resident admitted to the facility on 10/01/14, with diagnosis including Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 8	F 689		

The significant change "Minimum Data Set" (MDS), dated 10/17/19, revealed the resident had memory problems. She had moderately impaired decision-making ability. The resident required limited assistance from staff with bed mobility, transfers, and ambulation. Her balance was not steady. She required a wheelchair for mobility. The resident had one non-injury fall during the assessment period.

The "Falls Care Area Assessment" (CAA), dated 10/28/19, revealed the resident wandered. She had difficulty with her balance with transfers and ambulation. She was a fall risk and had a fall since the previous assessment. The resident required assistance of staff for her transfers and ambulation. The resident was unable to remember to call for staff assistance. The resident had a fall when she wandered into another resident's room, and she tripped on the resident's floor mat. Staff should place her locked wheelchair beside her bed to cue her to use the wheelchair when she got up without staff assistance.

The fall care plan, dated 10/24/19, documented staff should leave the resident's door open, so staff could monitor the resident as they walked by her room. Staff should assist the resident with ambulation and transfer. Staff should keep the resident's wheelchair locked by her bed to encourage the resident to remember to use the wheelchair for transfers.

The "Fall Risk Assessment", dated 08/26/19, revealed the score of 23, which placed the resident as a high risk for falls.

Review of the electronic medical record, from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR PO BOX 5000 HESSTON, KS 67062

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F 689	Continued From page 9	F 689		

03/13/19 to 11/ 06/19, revealed the resident had a history of falls. On 09/17/19, the resident had a fall after she wandered into the wrong room. The intervention for the fall included to keep the resident's wheelchair beside her bed, to encourage her to use the wheelchair.

On 11/04/19 at 11:30 AM, the resident was in her room, with her entry door closed tightly. Administrative Nurse F sat outside the resident's room, across the hall. She reported she had to monitor two residents at the same time. She verified the resident was in her room, with the resident's door closed, unattended by staff.

On 11/06/19 at 09:01 AM, the resident was in her bed. The resident's unlocked wheelchair was approximately five feet from her bed.

On 11/06/19 at 09:04 AM, Certified Nurse Aide (CNA) LL, reported the resident's wheelchair was across the room related to the resident did not use the wheelchair. She reported staff did not need to lock the resident's wheelchair. Staff verified the wheelchair was unlocked and placed out of the resident's reach, because the resident was unable to use the wheelchair correctly.

On 11/06/19 at 10:04 AM, Administrative Nurse D, reported staff should be aware of interventions placed for the resident, to keep her safe from falls.

On 11/06/19 at 10:32 AM, Licensed Nurse I, reported staff should place the resident's locked wheelchair next to her bed. Staff should keep the resident's door open while she was in the room so staff could monitor her.

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	175386	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR PO BOX 5000 HESSTON, KS 67062

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F 689	Continued From page 10 The facility's undated policy for "Falls, Accident/incident Report", documented staff should monitor, reassess and document the resident's status and response to interventions. The facility failed to provide planned fall interventions of keeping the resident's bedroom door open to monitor the resident while she was in her room. In addition, staff failed to keep the resident's locked wheelchair next to her bed, in reach, to prevent possible repeated falls. - On 11/06/19 at 09:05 AM, observation at the nurse station for the 300 and 400 halls, revealed in an unlocked drawer Clorox Germicidal Bleach Wipes, Great Value disinfectant spray and a can of lemon furniture polish. All labeled to "Keep Out of Reach of Children." On 11/06/19 at 09:10 AM, Licensed Nurse H reported five ambulatory confused residents resided in this area of the facility and confirmed staff should not store these chemicals in unlocked cabinets. On 11/07/19 at 12:25 PM, Administrative Staff A reported there was no facility policy for chemicals to be locked as this was a standard of practice. The facility failed to secure these chemicals to prevent these five ambulatory confused residents from access to prevent potential accident hazards.	F 689		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR PO BOX 5000 HESSTON, KS 67062

(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 921	Continued From page 11 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility reported a census of 98 residents. Based on observation and interview, the facility failed to provide a clean and sanitary environment in the kitchen. Findings included: - The kitchen tour, on 11/06/19 at 10:00AM, with dietary staff CC revealed the following environmental concerns: 1. The cabinets, above the divided sink, had peeling paint. 2. The outlet, below the large mixer and across from the stove, had a grime build-up. 3. The floor, of the kitchen, had a dark, grime build-up around the edges. On 11/06/19 at 10:30AM, dietary staff CC verified the above findings. The facility policy, dated 2019, for "Cleaning and Sanitation of Dining and Food Service Areas," documents the food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. The facility failed to provide a clean and sanitary environment in the kitchen for the residents at this facility	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	**200 W CEDAR PO BOX 5000 HESSTON, KS 67062**

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