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	175404	A. BUILDING _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #116004.	F 000		
F 166 SS=F	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman	F 166		

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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program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

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(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

This REQUIREMENT is not met as evidenced by:

The facility census totaled 51 residents. Based on record review and interview the facility failed to develop a grievance policy that included the contact information of the grievance official with whom a grievance could be filed, and failed to include a resident's right to obtain a written decision regarding his/her grievance. This had the potential to affect all residents.

Findings included:

- Review of the facility's undated grievance policy identified the Director of Nursing as the contact person for reporting a grievance but failed to include his/her contact information to report a grievance. The policy also failed to include the resident's right to obtain a written decision regarding his/her grievance.

During an interview on 6/6/17 at 4:30 PM administrative staff A stated the policy had just been revised in August 2016 and thought it had the appropriate information needed. Staff A stated administrative nursing staff B should be more

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F 166	Continued From page 3 informed about the new regulations and their changes. The facility failed to have a grievance policy that included appropriate information on how a resident/family/or staff could contact the grievance officer and obtain a written decision about their grievance.	F 166		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect,	F 225		

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exploitation, or mistreatment, the facility must:

(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.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(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 census totaled 51 residents with 1 resident selected for sample. Based on interview and record review the facility failed to notify police when a resident initially stated he/she wanted to

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call the police and alleged rape by direct care staff G. (#10)

Findings included:

- Review of resident #10's signed physicians orders dated 5/22/17 included diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and muscle weakness.

Review of the admission minimum data set assessment (MDS) dated 12/2/16 revealed a brief interview for mental status (BIMS) score of 13, indicating no cognitive impairment. The resident had no hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and no inappropriate behaviors. The resident required extensive assistance of 1 staff for bed mobility, transfers, and toileting. The resident had continence of bowel and bladder.

Review of the quarterly MDS dated 5/22/17 revealed a BIMS score of 12, indicating moderate cognitive impairment. The resident required extensive assistance of 2 staff for bed mobility, transfers and toileting.

Review of the 12/2/16 psychotropic medication care area assessment (CAA) revealed the resident received Cymbalta (an antidepressant medication) which increased the resident's risk for falls. The resident had a history of past sexual behaviors and cooperated since admission.

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Review of the 12/2/16 activities of daily living CAA revealed the resident fell once since admission. The resident had impaired gait and weakness and needed staff assistance with toileting and used the call light for assistance as needed (PRN).

Review of the care plan last reviewed on 3/7/17 revealed the resident had alteration in behavior related to inappropriate sexual overtures towards staff/pulling staff in bed with him/her. Family reported the resident had a long history of viewing caretakers in a "romantic /sexual" perception.
Interventions included:
Staff of the opposite gender were to request assistance of same gender (as the resident) staff PRN.
Staff educated to keep appropriate distance when approaching the resident. May give handshake, pat his/her hand or back.
Staff needed to maintain a calm, slow, understandable approach with the resident.
Praise the resident when his/her behavior was appropriate.
Set expectations and limits for the resident.
Explain to the resident that staff were there to help and not for romantic purposes, and utilize two staff when providing care.
When the resident started to become socially inappropriate, provide comfort measures for basic needs such as pain, hunger, toileting, or too hot/cold.

Review of the facility's investigation dated 5/18/17 revealed administrative nursing staff D told social service staff C the resident stated he/she had been "raped" the night of 5/17/17 and he/she wanted to call the police. Social service staff C met with the resident and he/she denied being

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raped by direct care staff G and that he/she asked staff G if he/she wanted to have fun and they engaged in consensual sex. The investigation revealed that per direct staff G at no time during cares on the night of 5/17/17 were there any sexual conversations with the resident or inappropriate touching by him/her or the resident. The investigation revealed that around 5:00 PM on 5/18/17, 11 hours after the original statement of the resident being raped and wanting the police called, the resident reported to social service staff C that the incident may have been a dream.

Review of the progress notes revealed the following:
5/18/17 at 11:02 PM revealed administrative nursing staff D informed social service staff C the resident reported sexual events occurred last night. Staff C spent much time with the resident asking for details and facts. The resident's story changed throughout the interview. Several staff and administrative nursing staff B were consulted. Staff C contacted the resident's family and he/she reported the resident had a history of sexual fantasies and innuendos.

5/18/17 at 3:48 PM the resident stopped social services staff C and stated that he/she had thought about recent events and believed his/her thoughts were more fantasy than reality.

The progress notes included documentation every shift from 5/18/17 to 5/26/17 that the resident did not have any type of sexual behaviors.

During an interview on 6/6/17 at 10:11 AM the resident denied every being physically or sexually

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abused, though the resident had difficulty following conversation.

During an interview on 6/6/17 at 8:45 AM social services staff C reported the resident did not want the police notified when he/she interviewed the resident. The longer staff C talked to the resident the more his/her story changed. Staff C stated by the time he/she got to the resident to talk to him/her the resident thought he/she might want to call the police and then the residents said he/she did not want to because it was consensual sex.

During an interview on 6/6/17 at 1:27 PM social services staff C stated if he/she thought there was anything of credence to the resident's story he/she would have called the police.

During an interview on 6/6/17 at 1:50 PM licensed nursing staff H stated the resident had sexual fantasies but had not accused anyone of sexual abuse.

During an interview on 6/6/17 at 3:30 PM licensed nursing staff I reported if a resident alleged raped he/she would contact the police and the administrator right away.

On 6/6/17 at 11:46 AM administrative nursing staff J stated he/she would have notified administrative nursing staff B and then notified the police unless he/she was told not to.

During an interview on 6/6/17 at 12:10 PM administrative staff A reported he/she had heard about the incident during a meeting at 8:30 AM. Staff A stated he/she did not know why social service staff C took the liberty to not call the police first thing that morning but did not think the

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F 225	Continued From page 9 outcome would have been any different had staff notified police. Review of the Prevention of Abuse, Neglect, and Misappropriate of resident property policy dated 12/13/16 revealed sexual abuse included, but not limited to, sexual harassment, sexual coercion, or sexual assault. If there was any evidence an incident met the definition of rape local law enforcement would be notified by the administrator, director of nursing or social worker. Team members would continue their investigation, and defer to law enforcement when requested. The facility failed to contact law enforcement when a resident alleged rape.	F 225		