| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N081006 | A. BUILDING: _____ B. WING _____ | C 06/16/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HOMESTEAD OF MANHATTAN | 1923 LITTLE KITTEN AVE MANHATTAN, KS 66502 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations are the result of a licensure re-survey with complaint (# 94487) at the above named assisted living facility on 6/13/16, 6/14/16, 6/15/16 and 6/16/16. Revised 2567 mailed to facility 6/24/2016 | S 000 | | |
| S3028 SS=D | 26-41-101 (f) (3) Staff Treatment of Residents Reporting<br><br>(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:<br>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.<br>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.<br>(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.<br>(D) Appropriate corrective action shall be taken if the alleged violation is verified.<br>(E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.<br>(F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.<br><br>This REQUIREMENT is not met as evidenced | S3028 | | |

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

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| S3028 | Continued From page 1<br>by:<br>KAR 26-41-101 (f) (1) (3)<br><br>The facility reported a census of 27 residents. The sample included 3 residents and 2 focus review residents. Based on record review and interview for 1 (# 616) focus review resident, the administrator failed to ensure that for allegations of abuse and neglect that were reported to the department within 24 hours, an investigation was started of the violation and the department ' s complaint investigation reports were completed and submitted to the department within five working days of the initial report.<br><br>On 6/14/16 at 5:15pm with administrative staff #A and #B, requested copies of the facility report for resident #616, report # 96542, incident reported to the department on 1/27/16. Review of department records document copies of facility report requested on 3/17/16 and 5/3/16 with no report received.<br><br>Review of resident #616 clinical notes dated 1/26/16 at 3:52pm recorded the following: " (resident ' s family member) visited with director yesterday about resident reporting to his/her physician that someone came to his/her door at this facility late at night on a Friday and said he/she had been paid to rape him/her.<br><br>Review of resident #616 physician progress notes dated 1/25/16 recorded physician notified administrative staff #A about above reported allegation. Progress note was noted by licensed staff # C on 1/25/16.<br><br>Interview on 6/14/16 at 6:35pm with administrative staff #A, requested copies of the statements for 96542 report on resident #616, | S3028 | | |

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| S3028 | Continued From page 2<br>he/she stated, " I don ' t have them anymore, I threw them out. "<br><br>Interview on 6/14/16 at 5:50pm with administrative staff #A and #B, administrative staff #A stated, " I do not have an investigation for 96542. My boss at the time (administrative staff #X) told me to call it in, I got a number, (licensed staff #C) and I both wrote out statements, we did not get notarized because we sent him/her to the (behavior unit). "<br><br>Review of resident #616 clinical notes recorded resident was admitted to the (behavior unit) on 3/1/16.<br><br>On 6/15/16 at 12:45pm administrative staff #A presented documentation, including statements, for report #96542, stating, " It was in my state report file. "<br><br>For resident #616, the operator failed to ensure each allegations of abuse and neglect was investigated with the department ' s complaint investigation reports completed and submitted to the department within five working days of the initial report. | S3028 | | |
| S3261 SS=D | 26-41-105 (f) (11) Resident Record Documentation of Incidents<br><br>(f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action | S3261 | | |

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| S3261 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105(f)(11)<br><br>The facility reported a census of 27 residents. The sample included 3 residents and 2 focus review residents. Based on record review and interview for one focus review resident (#616), the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.<br><br>Findings included:<br><br>- Record review for resident #616 recorded admission date of 12/2/15 with diagnoses including: unspecified dementia without behavioral disturbances and diabetes mellitus type 2.<br><br>Functional capacity screen dated 3/11/16 recorded resident required assistance with bathing, medications and treatments, was incontinent, was not cognitively impaired (score of zero), had no behavior problems, and had no communication problems.<br><br>Negotiated service agreement/ health care service plan dated 3/11/16 recorded resident to receive assistance with bathing, and management of medications and treatments. Behavior: resident was at (behavior unit) prior to readmission for evaluation. Resident is not an | S3261 | | |

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| S3261 | Continued From page 4<br>elopement risk at this time.<br><br>Clinical notes report entry dated 6/1/16 at 1:08am by licensed staff #C, recorded resident decided to walk to the store. Resident unable to go very far and he/she stopped at a house nearby and asked to call for a ride. Resident was unable to state where he/she lived with the exact name of facility.<br><br>Interview with licensed staff #C confirmed clinical note was written at 1:08am at home, and note lacked the following: actual time and date of event (5/31/16 at 9am), the location of the house resident stopped at (2 blocks from facility), that the resident told staff he/she was leaving and the length of time the resident was gone from facility (one hour).<br><br>Clinical note lacked documentation of the actual time of event, staff knowledge of resident leaving building, length of time resident was out of the building, location of house resident stopped at, notification of family and physician and nursing assessment upon resident ' s return to facility.<br><br>For resident #616, the operator failed to ensure the record included documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action. | S3261 | | |