STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	C 02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	**105 N HIGHWAY 99 WESTMORELAND, KS 66549**

(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 investigations #KS01780601, KS00177588, KS00176082, and KS00175400. The 2567 was sent electronically on 02/23/23.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/23/2023

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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by:
The facility identified a census of 30 residents. The sample included four residents; one resident reviewed for abuse. Based on observations, record review, and interviews, the facility failed to ensure staff identified and reported an allegation of abuse for Resident (R) 1 to facility administration in a timely manner. This deficient practice placed R1 at risk for unidentified and ongoing abuse.

Findings included:

- R1 was admitted to the facility on 10/14/21.

The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and enterocolitis (inflammation of both the small and large intestine) due to clostridium difficile (bacteria that can cause infection of the large intestine).

The "Annual Minimum Data Set (MDS)" dated 10/22/22, documented a Brief Interview for Mental Status (BIMS) was not conducted due to rarely/never understood. R1 required limited assistance with two staff for bed mobility; total dependence with two staff for transfers, dressing, and personal hygiene; total dependence with one staff for locomotion; and supervision with setup help with eating. R1 was always incontinent of urine and feces.

The "Quarterly MDS" dated 01/31/23, documented a BIMS was not conducted due to

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rarely/never understood. R1 required total dependence with two staff for bed mobility, transfers, dressing, and personal hygiene; total dependence with one staff for locomotion; and was independent with setup help only with eating. R1 was always incontinent of urine and feces.

The "Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 11/05/22, documented R1 required assistance of one to two staff for all ADLs. R1 was incontinent of both urine and feces.

The "ADLs/Mobility Care Plan" dated 10/30/21, directed R1 had an ADL self-care performance deficit and required one to two staff assistance to turn and reposition in bed.

The facility's "Investigation" dated 02/10/23, documented on 02/08/23 at 01:30 PM Dietary BB reported to Social Services X and Administrative Nurse E that Certified Medication Aide (CMA) R took a picture of R1's backside with bowel movement on him and showed it to her. Dietary BB stated the incident occurred in mid-January. Social Services X and Administrative Nurse E reported it to Administrative Staff A at 01:35 PM. An investigation was completed to find out who took the picture and who it was shown to. It was discovered that while on a smoke break, CMA R had shown the picture to Dietary BB. CMA R was terminated from facility employment on 02/08/23.

In a "Witness Statement," not dated, Administrative Staff A stated CMA R was asked to provide a statement on more than one occasion. CMA R voiced to Administrative Staff A that he did not take a picture of R1 at all.

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In a "Witness Statement" on 02/08/23, Dietary BB stated she and CMA R went to her car on a smoke break and she asked him how R1 was doing and if he was keeping food down. Dietary BB stated CMA R responded with no, R1 was having a lot of "blow outs" [slang for large bowel incontinence episode] then CMA R showed her a picture of R1's backside covered in fecal matter.

In a "Witness Statement" on 02/09/23, Social Services X stated during a care plan conference, Dietary BB stated CMA R showed her a picture of R1's back side covered in bowel movement. Social Services X stated she notified Administrative Staff A as soon as possible.

In a "Witness Statement" on 02/09/23, Administrative Nurse E stated during a care plan meeting, it was stated by Dietary BB that she was shown a picture of R1 covered in bowel movement. She stated CMA R had shown her the picture while on break.

On 02/13/23 at 01:40 PM, R1 sat in his recliner with his eyes closed, he appeared to be resting comfortably.

On 02/13/23 at 12:42 PM, Dietary BB stated on the day of the incident, she and CMA R went out to smoke and she asked him how R1 was doing, if R1 was eating all of his food and retaining his food. CMA R stated R1 was having major blow outs then showed her a picture on his phone. Dietary BB stated she did not think anything of it at that time then during the care plan meeting on 02/08/23, she asked the same questions about R1 then mentioned CMA R showed her a picture of one of R1's "blow outs." Dietary BB stated the

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incident happened the second to last week of January and at the time, she did not know it was wrong to have a picture of it. She stated if it happened again, she would report it to Administrative Staff A or Administrative Nurse D.

On 02/13/23 at 01:02 PM, Dietary BB stated she knew the picture was of R1 because CMA R stated it was. She stated the picture was of a mid-back to lower thighs covered in bowel movement and she could not tell who the resident was in the picture.

On 02/13/23 at 01:57 PM, Certified Nurse Aide (CNA) M stated if there was an allegation, she reported it to the head nurse who was to report it to Administrative Nurse D but if she felt like it was not going up the chain of command, she reported it to Administrative Nurse D. CNA M stated it was considered exploitation to take pictures of residents and any incident was reported immediately.

On 02/13/23 at 02:02 PM, Licensed Nurse (LN) G stated any abuse allegation was reported to Administrative Staff A and included exploitation from taking pictures of residents. She stated if she was shown any inappropriate pictures of residents, she would report it to Administrative Nurse D and Administrative Staff A immediately.

On 02/13/23 at 02:13 PM, Administrative Nurse D stated she was notified CMA R showed Dietary BB a picture of R1's bottom while on a smoke break. CMA R was terminated and as far as she was aware, only Dietary BB had seen the picture. She stated she did not know why the incident was not reported immediately but it should have been as inappropriate pictures was considered abuse,

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neglect, and exploitation.

On 02/13/23 at 02:30 PM, Administrative Staff A stated during a care plan meeting on 02/08/23 with Dietary BB, Social Services X, and Administrative Nurse E when Dietary BB stated there was a picture of R1 that CMA R had shown her. Administrative Staff A stated she had never seen any picture but when Dietary BB was shown the picture, she should have reported it to Administrative Staff A immediately.

On 02/14/23 at 10:48 AM, CMA R stated he was terminated for pictures that he did not take and was not asked to make a statement until after he was terminated.

The facility's "Abuse, Neglect, and Exploitation Policy," dated 07/28/22, directed all facility employees were educated that all alleged or suspected violations involving mistreatment, neglect, abuse, or exploitation were reported immediately to the Administrator but not later than two hours after the alleged incident.

The facility failed to ensure staff identified and reported an allegation of abuse for R1 to facility administration in a timely manner. This deficient practice placed R1 at risk for unidentified and ongoing abuse.