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	N026008	A. BUILDING: _____ B. WING _____	07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HAYS	1801 E 27TH STREET HAYS, KS 67601

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints (#176348 and #174083) at the above named facility conducted on 07/03/23 and 07/05/23.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (C) The census totaled 35 residents. The sample included 3 residents and 1 closed record review resident. Based on record review and interview, Operator A failed to ensure Resident (R)5 was not subjected to exploitation when Certified Medication Aide (CMA) D video recorded R5 without permission while resident was on the toilet. Findings included: - Review of R5's medical record revealed she admitted to the facility on 06/15/20 with diagnoses of vascular dementia.	S3026		

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

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S3026	Continued From page 1 R5's "Functional Capacity Screen" (FCS) dated 06/20/22 recorded the resident as independent with eating, required physical assistance with bathing, dressing, toileting, transfer and walk/mobility and was unable to perform management of medications and treatments. R5 was frequently incontinent of urine, had short-term memory impairment, impaired memory/ recall, impaired decision making and was at risk for falls/ unsteadiness. R5's current "Personal Service Plan" dated 06/20/22 recorded resident was independent with eating, facility staff assisted with opening packets, cartons and cutting food, physical assistance of 1 staff member required for dressing and grooming, physical assistance required for bathing, staff prompted/ offered toileting throughout the day/ evening, physical assistance required for toileting, staff assisted with mobility with walker and wheelchair and cognition intact. CMA D's signed statement dated 01/13/23 recorded, "I have never taken video of residents to make fun of them. I have never posted videos of residents to any social media platform. I have never sent videos of residents to anyone in attempt to make fun of or them to post it. I did take a video of a resident on the toilet as a way to save a memory. After taking the video I showed the resident's family and my boss. My boss informed me to delete the video and not to do it again. My boss explained to me that it is an invasion of privacy, disrespectful and against policy."	S3026		

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S3026	Continued From page 2	S3026		

Operator A's signed statement dated 07/05/23 recorded, "September of 2022, CMA [D] came in my office and showed me a video with [R5], [R5] was sitting on the toilet, [CMA D] asked her a question and [R5] answered and they both laughed. I told [CMA D] that was unacceptable behavior and to delete the video. This was on her personal phone. [R5] had short-term and impaired decision making."

Record lacked a completed investigation of exploitation of R5 by facility until November 2022.

Review of CMA D's record lacked training on exploitation since 11/17/20.

Interview on 07/05/23 at 02:01 PM with CMA D confirmed she took a video of R5 on the toilet and further confirmed she did not obtain prior permission to video record R5.

Interview on 07/05/23 at 03:00 PM with Operator A confirmed she did not complete an investigation in September 2022.

Facility's "Associate Handbook" recorded, "Telephone Calls ... The use of cell phones or cameras to produce electronic images (photographs or videos) of [facility name] residents, without the prior permission of management, is strictly prohibited. Abuse of these guidelines will result in corrective action, up to and including termination of employment."

Facility's "Abuse, Neglect and Exploitation Policy" dated 10/01 recorded, "Instances or allegations of abuse, neglect or exploitation

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S3026	Continued From page 3 should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow up ... ...Protection of Resident: Upon learning of alleged abuse, neglect or exploitation, the Executive Director or supervisor on duty should attempt to take necessary steps to ensure that the residents are protected from subsequent episodes or abuse, neglect or exploitation while a determination on the matter is pending." Operator A failed to ensure Resident R5 was not subjected to exploitation when Certified Medication Aide (CMA) D video recorded R5 without permission while resident was on the toilet.	S3026		
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	S3028		

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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.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-101 (f) (3)

The facility reported a census of 35 residents. The sample included 3 residents and 1 closed record review resident. Based on record review and interviews for 1 closed record review Resident (R)5, Operator A failed to ensure each incident of potential exploitation was reported to the department within 24 hours and thoroughly investigated when facility staff video recorded R5 on the toilet and Operator A viewed the video recording.

Findings included:

- Review of R5's medical record revealed she admitted to the facility on 06/15/20 with diagnoses of vascular dementia.

R5's "Functional Capacity Screen" (FCS) dated 06/20/22 recorded the resident as independent with eating, required physical assistance with bathing, dressing, toileting, transfer and

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walk/mobility and was unable to perform management of medications and treatments. R5 was frequently incontinent of urine, had short-term memory impairment, impaired memory/ recall, impaired decision making and was at risk for falls/ unsteadiness.

R5's current "Personal Service Plan" dated 06/20/22 recorded resident was independent with eating, facility staff assisted with opening packets, cartons and cutting food, physical assistance of 1 staff member required for dressing and grooming, physical assistance required for bathing, staff prompted/ offered toileting throughout the day/ evening, physical assistance required for toileting, staff assisted with mobility with walker and wheelchair and cognition intact.

Reports indicated R5 was exploited in September 2022 by Certified Medication Aide (CMA) D.

Record lacked a completed investigation of accusation by facility.

CMA D's signed statement dated 01/13/23 recorded, "I have never taken video of residents to make fun of them. I have never posted videos of residents to any social media platform. I have never sent videos of residents to anyone in attempt to make fun of or them to post it. I did take a video of a resident on the toilet as a way to save a memory. After taking the video I showed the resident's family and my boss. My boss informed me to delete the video and not to do it again. My boss explained to me that it is an invasion of privacy, disrespectful and against

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policy."

Operator A's signed statement dated 07/05/23 recorded, "September of 2022, CMA [D] came in my office and showed me a video with [R5], [R5] was sitting on the toilet, [CMA D] asked her a question and [R5] answered and they both laughed. I told [CMA D] that was unacceptable behavior and to delete the video. This was on her personal phone. [R5] had short-term and impaired decision making."

Record lacked a completed investigation of exploitation of R5 by facility until November 2022.

Review of CMA D's record lacked training on exploitation since 11/17/20.

Interview on 07/05/23 at 02:01 PM with CMA D confirmed she took a video of R5 on the toilet and further confirmed she did not obtain prior permission to video record R5.

Interview on 07/05/23 at 03:00 PM with Operator A confirmed she did not complete an investigation in September 2022.

Facility's "Associate Handbook" recorded, "Telephone Calls ... The use of cell phones or cameras to produce electronic images (photographs or videos) of [facility name] residents, without the prior permission of management, is strictly prohibited. Abuse of these guidelines will result in corrective action, up to and including termination of employment."

Facility's "Abuse, Neglect and Exploitation

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S3028	Continued From page 7 Policy" dated 10/01 recorded, "Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow up ...Protection of Resident: Upon learning of alleged abuse, neglect or exploitation, the Executive Director or supervisor on duty should attempt to take necessary steps to ensure that the residents are protected from subsequent episodes or abuse, neglect or exploitation while a determination on the matter is pending ...Internal Investigation: Upon receipt of an allegation of abuse, neglect or exploitation, the Administrator and/ or Executive Director, or their designee, should conduct a confidential internal investigation of the incident ...Timing of Investigation: The investigation should be initiated as soon as practicable upon becoming aware of an incident." Operator A failed to ensure each incident of potential exploitation was reported to the department within 24 hours and thoroughly investigated when facility staff video recorded R5 on the toilet and Operator A viewed the video recording.	S3028		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced	S3171		

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S3171	Continued From page 8 by: KAR 26-41 204 (i) The census totaled 35 residents. The sample included 3 residents and 1 focused record review resident. Based on observation, interview and record review, Operator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 focused record review resident (R)4. Findings included: - The "Resident Roster" obtained on 07/03/23 identified one resident as having a bed assistive device (R4). R4's "Medical Record" revealed she admitted to the facility on 02/13/23 with diagnoses of sleep apnea, cardiomyopathy, hyperglycemia, chronic embolism, benign prostatic hyperplasia and duodenal ulcer. The "Resident Functional Capacity Screen" (FCS) dated 05/01/23 recorded the resident as independent with eating, required physical assistance with bathing, dressing, toileting, transfers and walk/mobility, and unable to perform management of medications and treatments. R4 had short term memory impairment, impaired decision making and was at risk for falls/ unsteadiness. The "Personal Service Plan" dated 05/01/23 recorded R4 needed assistance with bathing,	S3171		

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S3171	Continued From page 9	S3171		

dressing and toileting, ambulated independently to and from meals and in apartment independently and used a halo ring on his bed for transfers. The "Personal Service Plan" further recorded R4 went in and out of confusion at times.

Record review lacked an annual assessment of the resident to confirm the device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an annual assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.

Observation with Licensed Nurse (LN) B on 07/05/23 at 01:00 PM in R4's room revealed a halo ring bed assist device to the left side of his bed.

Interview on 07/05/23 at 12:40 PM with LN B confirmed no safety checks and bed assistive device assessments for R4 were completed.

The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows:
Zone 1 within the rail should measure less than 4 and 3/4 inches
Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches
Zone 3 between the rail and the mattress should

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S3171	Continued From page 10 measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. Operator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of R4 regarding use of a bed assistive device.	S3171		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy	S3215		

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S3215	Continued From page 11 provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) (4) The facility reported a census of 35 residents. The sample included 3 residents and review of 5 newly hired employees. Based on observation, record review and interview for 3 of 5 sampled staff (Licensed Nurse (LN) E, Certified Nurse Aide (CNA) F and Dietary Staff F), Operator A failed to ensure medications were not administered beyond the manufacturer's or pharmacy provider's recommended date of expiration. Findings included: - Observation during the initial tour on 07/03/23 at 02:03 PM with Licensed Nurse (LN) B revealed a medication refrigerator in the locked medication room of the facility. The medication refrigerator contained one opened bottle of tuberculosis (TB) solution inside an opened pharmacy labeled box. The pharmacy label was dated "12/27/22." The TB solution bottle nor pharmacy labeled box had an open date on it. The solution was accessible to staff for administration.	S3215		

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S3215	Continued From page 12 Interview on 07/03/23 at 02:08 PM with LN B stated the TB solution found in the medication refrigerator was opened on 12/30/22. Interview on 07/05/23 at 01:18 PM with LN B confirmed the lot number (57592) and expiration date (05/24) matched the lot number and expiration date on LN E's 2-step TB skin test administered on 05/17/23 by LN B, CNA F's 2-step TB skin test administered on 03/29/23 by LN C and 04/17/23 by LN B and Dietary Staff G's 2-step TB skin test administered on 05/02/23 by LN B and 05/15/23 by LN C. The FDA (Federal Drug Administration) tuberculosis (tubersol) package insert directed the tubersol testing solution would expire 30 days after the date of opening. Facility's "Medication and Treatments- Unused Medication Disposal/Return to Resident/ Legal Responsible Party or Pharmacy" policy dated 03/01/03 recorded, "Expired medications should be disposed of properly at the community within 30 days." Operator A failed to ensure medications were not administered beyond the manufacturer's or pharmacy provider's recommended date of expiration.	S3215		
S9999	Final Observations Kansas Statute 39-981. Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions.	S9999		

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(d) A resident, or such resident's guardian or legal representative, who wishes to conduct authorized electronic monitoring shall notify the adult care home on a form prescribed by the secretary for aging and disability services.
(i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

This Requirement is not met as evidenced by:

Scope and severity of E:

The census equaled 35 residents. The sample included 3 residents. Based on observation and interviews, for all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

- Observation on 07/03/23 revealed a sign posted on R1's door stating video surveillance may be in progress, but no sign posted at the entrance of the facility and every other resident's room stating video surveillance may be in progress.

Interview on 07/03/23 at 03:16 PM with Operator A confirmed Resident (R)1 had a surveillance camera in her room. Operator A confirmed a sign was posted on R1's door but not on each

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S9999	Continued From page 14 resident's room stating video surveillance may be in progress and further confirmed no sign posted on the entrance door. For all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.	S9999		