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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of the licensure resurvey with attached complaint number 182412 for the above named facility conducted on 09/05/23. | S 000 | | |
| S5026 SS=J | 26-42-101 (f) (1) Staff Treatment of residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-42-101 (f)(1)(A)(B)<br><br>The facility reported a census of 6 residents. The sample included 3 "Residents'" (R)'s 1, 2 and 3. Based on observation, interview, and record review the operator failed to ensure "Certified Nurse Aide" (CNA) B followed facility policies and education she was provided when she subjected R1 to physical abuse, a physical altercation where she physically shoved him, and then proceeded to hit him in the back with a wooden dining room chair. The operator further failed to ensure CNA B did not subject R2 to neglect when R2 requested assistance in going to bed for the evening, and CNA B refused to | S5026 | | |

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

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assist R2 to bed, telling him she had offered to lay him down earlier and now he would have to sleep in the living room recliner.

Findings included:

- Record review for R1 on 09/05/23 revealed an admission date of 05/10/23, with diagnoses of depressive disorder, Alzheimer's disease, essential hypertension, and edema of the lower extremity.

Record review of R1's "Functional Capacity Screen" (FCS) dated 05/10/23 revealed R2 required physical assistance with bathing, dressing, toileting, and supervision with transfers. He lacked the ability to manage his own medications, he had impaired short-term memory, impaired-long term memory, impaired memory recall and impaired decision making. He was frequently incontinent of his bladder, and was marked with falls, impaired decision making, wandering, and inappropriate behavior. He used no mobility device and rarely made himself understood and he rarely understood others.

Record review of R1 "Negotiated Service Agreement" (NSA) dated 05/10/23 identified the following health services would be provided by the qualified facility staff: Physical assistance with bathing twice weekly, instructions/supervision as needed for dressing, assist with regular toileting, and provide supervision with transferring as needed. Facility staff to manage his medications and monitor and observe all behaviors.

Record review of R1 "Health Service Plan" (HSP)

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dated 05/10/23 instructed facility staff to assist with bathing. "He can become resistant to bathing. Redirection and cueing to help with behaviors". On page three of five of the HSP it stated, "Resists Care" and "Yes" is marked. Staff instructions are "Qualified staff will use redirection and cueing as needed".

Record review of R1 electronic "Resident Notes" dated 06/05/23 to 08/26/23 revealed the following entries:

08/22/23 at 01:34 PM "Nurse's Note" revealed the "Resident is alert and oriented to person and place. He has been emotional the last couple of weeks, more in the afternoon and early evening. He can't describe what is bothering him, just that he was upset. The "Advanced Practice Registered Nurse" (APRN) made some adjustments to his medications recently. His Donepezil
increased from once daily to twice daily and she added Depakote sprinkles 125 milligrams every day, Amlodipine 5 milligrams every day and Melatonin 5 milligrams at hour of sleep. Will continue to monitor mood changes and behaviors".

08/26/23 at 10:12 PM "Nurse Note" revealed "On 08/26/23 at 08:57 PM nurse received a phone call from caregiver CNA B regarding an incident that had taken place at the facility. CNA B stated that R1 had tried hitting her with a chair in the living room and that she was on the patio calling and was scared. The nurse accessed the cameras in the home as CNA B was on the phone with the on call "Registered Nurse" (RN). During this time R1 was standing behind a

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recliner in the living room and paced back and forth. R1 was also going in and out of the kitchen looking through the windows. Upon the RN arrival, CNA B was to clock out and go home. Assessment of R1 was performed by the RN and this nurse was notified that he had no injuries, and his vital signs were stable. "Durable Power of Attorney" (DPOA) and "Primary Care Provider" (PCP) were notified. RN helped R1 to the restroom and assisted him to his room for bed.

Interview on 09/06/23 at 10:25AM with R1 revealed he could answer simple questions. When asked if he felt safe, he stated yes. When asked if the girls were nice to him, he stated yes. When asked if he had any complaints, he stated no.

Observation on 09/05/24 at 11:00AM revealed R1 sits in the common area in the recliner closest to the middle of the living room watching television. He is quiet and smiles at staff and other residents. He does not engage staff first with interactions, staff observe him walking and approach him, he smiles and denies needing care.

Observation on 09/06/23 at 10:25AM R1 is sitting in the recliner closest to the middle of the living room and R2 is sitting in the recliner on the south wall of the living room. They are watching television. R1 is calm and has positive interactions with facility staff doing a ball and cup game.

- Record review for R2 revealed an admission date of 03/07/23 with a diagnosis of dementia.

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| S5026 | Continued From page 4<br><br>Record review of R2 FCS dated 03/07/23 revealed R2 required physical assistance with bathing, dressing, and transferring. He was unable to manage his toileting and he was unable to walk. He required supervision with eating, he lacked the ability to manage his own medications, was incontinent of bladder, and had impaired short-term memory, impaired memory recall and impaired decision making. He was sometimes able to make himself understood and he usually understood others. He was marked with falls and impaired decision making, and he used a wheelchair mobility device.<br><br>Record review of R2 NSA dated 03/07/23 revealed the following health services would be provided by qualified facility staff: physical assistance with bathing twice a week and as needed, regular toileting and assistance with personal hygiene after toileting, briefs provided by hospice. Staff to provide assistance with dressing and undressing, assist with wheelchair mobility, one facility staff to assist with transfers, bed to be placed in lowest position with a fall mat in place, staff to prompt and redirect resident with decision making and prompt and reassure resident with communication. Resident had hospice identified as an outside provider.<br><br>Record review of R2's HSP dated 03/07/23 instructed staff to provide 1 person assist with bathing, toileting, dressing, and provide moderate assistance with wheelchair mobility.<br><br>Record review of R2's electronic "Resident Notes" dated 06/12/23 to 08/22/23 revealed the following entry: | S5026 | | |

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| S5026 | Continued From page 5<br><br>08/22/23 at 01:59 PM Nurse note: "Resident was alert and oriented times three (person, place, and time). He was doing well; he was maintaining his weight and was eating good. He was having more difficulty with transferring. He was an assist with one person to transferring and two persons in times of greater need. Will continue to keep an eye on this and address if concerns with transfers arise. No other concerns at that time."<br><br>Interview on 09/06/23 at 10:23AM with R2 revealed he could answer simple questions. When asked if he felt safe, he stated yes. When asked if the girls were nice to him, he stated yes. When asked if he had any complaints, he stated no.<br><br>- Record review of CNA B employee file revealed she began employment on 12/01/22. The registry check for the CNA certificate revealed an expiration date of 01/31/24 and lacked a date for when the facility checked the registry. The background check from the department was received back on 12/08/22 and did not show a prior existence of any criminal history related to prohibited offenses. The other facility provided documents included a background check for the "Adult Abuse, Neglect, Exploitation Central Registry Release of Information" which resulted with "No Match" on 08/23/23, an "Exclusions Search Results" with a result of "No Match" from the Office of Inspector General, and a document from the "Kansas Department for Children and Families" with a result of "No Match" dated 08/18/23.<br><br>- Review of one of two of the facility provided | S5026 | | |

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recorded video footages revealed the following: At 08/26/23 at 08:49PM R2 sat in the recliner on the south wall of the living room, a female resident was in the chair on the north wall of the living room and CNA B was at the oak kitchen table on the west side of the dining room cleaning the top of the table, there were three-armed kitchen chairs visible in the video. The video started and R2 said something that was not understood, CNA B stated R2 must stay in the recliner all night as she could mpt lift him by herself, and "we are not gonna do that" CNA B continued to state "listen I tried to put you to bed earlier tonight and you were not ready, now that the other person is gone I don't have help, she continues to state something that is not understood and then she continued "so therefore you have to stay in the chair". R2 apologizes, and stated, "you could use the wheelchair". CNA B's response was she could not lift the resident by herself. R2 replied

that he was being punished, CNA B replied" I am not punishing you", R2 responded "yes you are", CNA B stated, "I am not going to break my back when I tried to put you to bed earlier", she continued in a very soft tone "you think of yourself", she continued to wipe the tabletop. At 08:51:43 PM CNA B stated she "guess she could call the on-call nurse to see if she could come help".

At 08:51:51 PM CNA B said something that could not be understood and then she stated, "it's time for you to get ready for bed R1". R1 attempted to say something, then there was an audible thump, and CNA B yelled toward where R1 was located and CNA B yelled "R1 stop, I'm not playing with

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you, stop" and bumping was heard. CNA B stepped out of the video stream, and stated "I don't want", (and the rest was not understood) her voice continued to be raised, R1 stated "I ain't playing either", CNA B stated" leave me alone", and she is now facing the west towards were R1 was standing. CNA B returned to the screen and repeated "leave me alone". the banging continued.

At 08:52:20 PM CNA B had a kitchen chair in her hands, she jerked the chair towards her, and she kept repeating "leave me alone", you can't understand what R1 was saying. CNA B raised her hand and said "you better go" she pushed at something out of the camera view and then stated "I'm not playing" R1 shoved the chair at her, and she is now on the south side of the table behind R2's chair where he continues to set. R1 stepped into the video when he shoved the chair at CNA B.

At 08:52:23 PM R1 tried to say something, and he had a raised voice, while he pointed his finger at CNA B. CNA B responded in a raised voice "stop".

At 08:52:29 PM CNA B got her phone and stated" I'm gonna call "Licensed Nurse" (LN) A right now" where R1 responded "good, good, come on" and clapped his hands, he then attempted to say something, and CNA B yelled "stop" at him.

At 08:52:34 PM R1 picked up the edge of the dining room table and shoved it at CNA B, forcing her to step closer to the back of R2's chair.

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| S5026 | Continued From page 8<br><br>At 08:52:39 PM CNA B had her phone in her hand and was tapping on her phone.<br><br>At 08:52:40 PM R1 started tapping on the dining room table.<br><br>At 08:52:42 PM R1 swiped across the table at CNA B, where she raised both hands in a surrender position, she appeared inches away from the back of R2's chair.<br><br>At 08:52:43PM CNA B stated, "don't touch me."<br><br>At 08:52:44 PM R1 stated "I didn't touch you" CNA B then stated, "leave me alone". R1 then attempted to say something, he was loud and pointing his finger at CNA B as he spoke, CNA B then stated, "leave me alone, I'm not doing nothing to you", she repeats "I'm not doing nothing to you".<br><br>At 08:52:54 PM CNA B told R1 to "please go over there, I can't even take care of the other residents".<br><br>At 08:53 PM R1 attempted to say something, and CNA B started tapping on her phone and put it to her ear and told R1 "I'm calling". R1 attempted to reply. R1 moved back to the west side of the table and CNA B picked up a chair in her left hand with her phone in her right hand and stated "I'm not doing this you need to go", she was standing the with dining room chair in her left hand with 3 legs on the floor with the phone in her right hand, and she moved from behind R2's chair to the chair next to it in the near center of | S5026 | | |

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the room with the female resident who continued to sit in the chair on the north side of the living room. R1 came around the table and advanced towards CNA B, trying to say something and CNA B held the chair and yelled "stop".

At 08:53:15 PM R1 walked around the chair and advanced towards CNA B, which left less the 2 feet between R1, and CNA B. CNA B released the chair and shoved R1 with an open palm on the left upper chest backwards hard enough he had to step backwards to keep from falling. R1 had ahold of the dining room chair in his right hand and the female resident is less than 2 feet from both R1 and CNA B.

At 08:53:19 PM R1 tipped the chair on its side, picked it up and charged CNA B with the chair the feet of the chair pointed towards CNA B. CNA B and R1 ended in the middle of the living room, CNA B screamed and R1 attempted to say something, at this point CNA B and R1 started a tug of war with the chair. During the tug of war with the chair CNA B repeated the word "quit" and calls R1's name.

At 08:53:33 PM R1 stated "I'm tired of you", the tug of war continued, and CNA B kept pushing the chair during the tug of war until R1 lost his grip on the chair. CNA B right hand comes up and she grabbed at R1 with her phone in her right hand.

At 08:53:37 PM R1 was no longer holding the chair but was advancing on CNA B, CNA B shoved the chair at R1, and you hear a thump when it hit R1's right knee.

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| S5026 | Continued From page 10<br><br>At 08:53:38 PM R1 no longer had ahold of the chair, and he advanced on CNA B. CNA B had ahold of the top back of the chair and the other hand holding the leg of the chair, using both hands she swung the chair and hit R1 on the back of the left upper arm, upper left forearm, and the back left side of his head. R1 attempted to say something, and CNA B was saying "stop it".<br><br>At 08:53:42 PM R1 and CNA B were standing in front of R2 when CNA B yelled "stop it". R1 was standing in front of her the chair between them upside down/legs in the air and CNA B was standing in front of the glass door.<br><br>At 08:53:43 PM CNA B said to R2 "R2 get him". She then repeated the request for R2 to get him. R2's head moved, and CNA B told R1 to listen to R2. R1 responded bringing his hand up with finger pointed in CNA B's face and backed away.<br><br>At 08:54:06 PM CNA B told R1 to go to his room, and R2 stated to R1 "R1, go to your room that would be the best". R1 turned and walked away from CNA B, and he stood in front of the recliner in the middle of the room. CNA B was by the glass doors with the chair upside down to the left side of her body. CNA B then stated to R1 "see listen to R2", R1 then walked behind the recliner in the middle of the room and leaned against the back of the chair and stated "yah, call them". CNA B then pushed the chair in front of the couch on its side to the east of the glass door, and CNA B exited the glass door at 08:54:26PM<br><br>Review of two of two of the facility provided recorded video footage revealed the following: | S5026 | | |

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| S5026 | Continued From page 11<br><br>The clip started at 08:54:06PM and contained the same footage as in the first video footage and continued to 08:54:31 where R1 stood behind the chair in the middle of the room and R2 continued to be in the chair on the south end of the living room the female resident remained in the chair on the north side of the room R1 stated "I can't stand that (unintelligible word). R2 responded by repeating what R1 had stated. R1 attempted to respond, there as an exchange of words with R1 and R2 and then R2 stated "I can't stand her either, but I don't have any choice". The female resident in the video never moved from her chair or appeared to react to the altercation.<br><br>Interview on 09/06/23 at 10:45AM with LN A, she stated CNA B did not call her until she exited the facility at 08:57 PM. She continued to state that she had the on-call nurse send CNA B home and that she was suspended at this point pending investigation of the incident. LN A stated this incident was turned into the local police department on 08/27/23, she stated she took the video to the police department and the officer watched the video twice. LN A continued that the officer reported to her that the family declined to press charges against CNA B, and the staff member declined to press charges against R1.<br><br>Interview on 09/06/23 at 11:00 AM with Operator C, she confirmed CNA B was suspended on 08/27/23 and, CNA B's employment with the facility was terminated on 09/01/23.<br><br>- Record review on 09/06/23 of the facility provided training revealed the following: | S5026 | | |

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| COMFORTCARE HOMES OF HARVEY COUNTY LLC M | 1504 TERRACE DRIVE NEWTON, KS 67114 |

| (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 |
|---|---|---|---|---|
| S5026 | Continued From page 12<br><br>The facility's "Employee Handbook" dated 11/16/20 revealed the following entry: "The facility does not permit the use of verbal, mental sexual or physical abuse including corporal punishment and involuntary seclusion. An Allegation will immediately start an investigation as deemed<br><br>necessary. Immediate action will be taken to prevent further occurrences. Employees may be suspended with or without pay during the investigation.<br><br>CNA B initialed and signed the employee handbook on 12/01/22.<br><br>Training dated on 12/07/22 titled "Redirection and Engagement" included the following communication tip for caregivers, "Speak slowly, at a normal level (not to loud), using a low-pitched voice. In addition, try to face the person when you are speaking to him or her. Speaking rapidly, loudly, or in a high-pitched voice can be overwhelming or upsetting for someone with dementia", and "Avoid arguing or disagreeing" with the person with dementia.<br><br>CNA B was signed in attendance at the training on 12/07/22.<br><br>Training dated 02/08/23 titled "Initial Engagement" was training that taught meaningful engagement was a person-centered approach that encouraged and invited people with dementia to participate in activities with purpose and interest.<br><br>CNA B signed in attendance at the training | S5026 | | |

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|---|---|---|---|
| | B040001 | A. BUILDING: _____ B. WING _____ | 09/05/2023 |

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| S5026 | Continued From page 13<br>02/08/23.<br><br>Training dated 03/01/23 titled "Abuse, Neglect and Exploitation"<br><br>CNA B signed in attendance at the training on 03/01/23<br><br>Training dated 06/27/23 titled "Abuse and Neglect Post Test"<br><br>CNA B signed the test on 06/27/23 and received a score of 100.<br><br>The facility's "Abuse, Neglect, and Exploitation" policy dated 10/01/20 had the following statements: "the resident will be free from the treatment of abuse and neglect, and exploitation by staff or any additional service provider to Residents".<br>"Each allegation of abuse, neglect, or exploitation shall be reported to the nurse/home supervisor, operator, director of resident care, and/or vice president of operations as soon as staff is aware of the allegation."<br>"Appropriate corrective action shall be taken if the alleged violation is verified".<br><br>09/06/23 at 10:20AM operator C was informed that R1 was placed in jeopardy on 08/26/23 at 08:51PM when CNA B subjected R1 to verbal abuse that led to a physical altercation, and R2 was placed in jeopardy when CNA B neglected to assist R2 to bed after he requested assistance, and CNA B further neglected R2 when she failed to call for assistance for R2.<br><br>The operator failed to ensure "Certified Nurse | S5026 | | |

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| S5026 | Continued From page 14<br>Aide" (CNA) B followed the facility policies and education she was provided when she subjected R1 to physical abuse, a physical altercation where she physically shoved him, and then proceeded to hit him in the back with a wooden dining room chair. The operator further failed to ensure CNA B did not subject R2 to neglect when R2 requested assistance in going to bed for the evening, and CNA B refused to assist R2 to bed, telling him she had offered to lay him down earlier and now he would have to sleep in the living room recliner.<br><br>The abatement plan accepted on 09/06/23 at 12:16PM. The plan included the following actions:<br>R1 provider was notified on 08/27/23.<br>R1 was currently undergoing medication changes.<br>CNA B was immediately suspended when the on-call nurse arrived to the home, and her employment was terminated on 09/01/23.<br>The incident was reported to the local police department.<br>Staff were instructed on R1 behaviors in the "RTasks" facility communication program.<br>Staff will be re-educated on 09/06/23 and 09/07/23 on Abuse, Neglect and Exploitation, reeducation on How to talk to a person with Alzheimer's, and reeducation on the "Fine art of redirection".<br>Criminal background checks through the Kansas Department of Aging and Disability Services will continue to be collected on any new employee, in addition to the annual education on abuse, neglect and exploitation. | S5026 | | |

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| S5313 | Continued From page 15 | S5313 | | |
| S5313 SS=D | 26-42-205 (g) (3) Over the counter medication<br><br>(g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R 26-42-205 (g)(3)<br><br>The facility reported a census of 6 residents. The sample included 3 residents. Based on observation, interview, and record review the operator failed to ensure the pharmacist or the "Licensed Nurse" (LN) placed the full name of the resident on the bottles of the "Over the Counter" (OTC) medications that were located in the facility's only medication cart.<br><br>Findings included:<br><br>- Observation on 09/05/23 at 11:09 AM with LN A, she opened the locked medication cart and the following OTC bottles lacked the full name of the resident: | S5313 | | |

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| S5313 | Continued From page 16<br><br>1 card from the pharmacy labeled as "stock" Acetaminophen 500 milligrams<br>1 bottle of Equate Pain Reliever Acetaminophen 500 milligram capsules<br>2 bottles of Melatonin 5 milligrams<br>1 bottle of Polyethylene Glycol labeled as "stock"<br><br>Interview with LN A at 11:11 AM, she confirmed the OTC bottles lacked the full name of the residents.<br><br>Record review of the facility provided policy titled "Medication Management" revised 11/11/16 revealed the following under the section titled "Medication Orders": "Nursing/Home Supervisor shall place the full name of the resident on both the container and package".<br><br>The operator failed to ensure the pharmacist, or the "Licensed Nurse" (LN) placed the full name of the resident on the bottles of the "Over the Counter" (OTC) medications that were located in the facility's only medication cart. | S5313 | | |