STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N052009	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF BASEHOR LLC	15707 PINEHURST DRIVE BASEHOR, KS 66007

(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 represents the findings of a resurvey with attached complaint #185500, #185407, #184453, #184385, and #182940 at the above named assisted living conducted on 01/30/24 and 01/31/24.	S 000		
S3026 SS=J	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 facility reported a census of 18 residents, with three residents included in the sample and one closed record review. Based on interview and record review, the operator failed to protect Resident (R) 1 from exploitation when "Certified Medication Aide" (CMA) D took a photo of R1 and posted to social media with a statement indicating the resident passed away without consent from the resident's family/representatives. This placed the resident in immediate jeopardy on 01/23/24 at approximately 05:00 PM. The operator failed to protect another resident, R4, from exploitation when CMA E took a photo of her. Findings included:	S3026		

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

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S3026	Continued From page 1 - Record review for R1 revealed an admission date of 06/01/22 with a diagnosis of aphasia following cerebral infarction. The 11/02/23 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting, and transfers; and she had short-term memory, memory/recall, and decision-making difficulties. The undated/unsigned "Negotiated Service Agreement" (NSA) identified facility staff would provide R1 physical assistance with bathing, dressing, toileting, and transfers; and supervision and encouragement to attend activities for cognitive difficulties. The 04/28/18 "Photograph Authorization" documented photographs of her person or portions thereof were not to be taken for publicity purposes. The 01/25/24 "Intake Information" sent to the State Agency documented R1 passed away on 01/22/24. The next day on 01/23/24 CMA D posted a photo of R1 on her social media account. Review of the undated facility's "Investigation Report" to the State Agency revealed a photo with R1's face and CMA D's face with a mask on in the photo. Under the photo read "rest in peace. . ." The facility's "Investigation Report" further documented CMA D was counseled on 01/22/24 regarding HIPAA (Health Insurance and Portability and Accountability Act) and violation of resident's rights. CMA D was terminated on	S3026		

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S3026	Continued From page 2	S3026		

01/24/24 for continuing to violate HIPAA laws and company policies and procedures.

The 01/24/24 a written statement by an unidentified staff member documented they had witnessed photos of residents on CMA D's social media account prior to the incident on 01/23/24.

The 01/24/24 a written statement by another unidentified staff documented they had witnessed photos of residents on CMA D's social media account prior to the incident on 01/23/24.

The 01/26/24 facility's in-service about social media and HIPAA was signed by 15 staff members.

On 01/30/24 at 10:39 AM Administrative Staff A stated she took photos of residents who had signed photo release agreements on her personal cell phone, sent them to the marketing director, and then deleted the photos after sending. She stated she expected staff not to take photos of the residents.

On 01/30/24 at approximately 12:44 PM Administrative Staff A stated all staff were trained upon hire regarding HIPAA and Resident Rights.

On 01/30/24 at 02:18 PM CMA F stated he was only allowed to use his phone while on breaks. He had witnessed other staff using their cell phones during their shift.

On 01/30/24 at 02:26 PM Certified Nurse Aide (CNA) G stated the facility's policy was staff could use cell phones only while on break. She had witnessed staff use their phones during work time. She asked for clarification from Administrative Staff A after a recent in-service

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S3026	Continued From page 3	S3026		

when staff were told they could take photos of residents during activities, send them to the director for marketing purposes, and then delete the photo. She had taken photos of residents before but deleted it.

The facility's "HIPAA Caregiver Guide" documented the company policy was to follow HIPAA standards. Confidential information included any information regarding the resident's medical condition (which includes death).

The facility's undated "Cell Phone Policy" documented no cell phone use except on breaks with no exceptions. Cell phones were to be silenced and left with staff personal belongings. Breaks were to be taken outside or in an empty room with the door closed (away from residents).

The facility's undated "Confidentiality Policy" documented staff were expected to agree to hold resident information including medical information, resident's needs and/or preferences in strict confidence both during and after employment and was not to be discussed with anyone including resident family members.

The operator failed to protect R1 from exploitation when CMA D took a photo of R1 and posted to social media.

- Record review for R4 revealed an admission date of 06/06/23 with a diagnosis of Alzheimer's Disease.

The 06/01/23 "FCS" identified R4 required physical assistance with bathing, dressing, and toileting; and she had short-term and long-term memory, memory/recall, and decision-making difficulties.

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S3026	Continued From page 4 The 06/06/23 "NSA" identified facility staff would provide R4 physical assistance with bathing, dressing, and toileting. Services provided for cognitive difficulties were not described on the "NSA." Review of the 01/29/24 facility's "Intake Information" report to the State Agency revealed staff took a photo of a resident and sent it to the resident's family. The facility's undated "Investigation Report" documented CMA E was terminated for texting a photo of a resident even though she had been previously trained on the company's policy and HIPAA. The 01/26/24 facility's in-service about social media and HIPAA was signed by 15 staff members including CMA E. On 01/30/24 at 10:39 AM Administrative Staff A stated she took photos of residents who had signed photo release agreements on her personal cell phone, sent them to the marketing director, and then deleted the photos after sending. On 01/30/24 at approximately 12:44 PM Administrative Staff A stated all staff were trained upon hire regarding HIPAA and Resident Rights. The signed witness statement by Administrative Nurse C documented R4's unidentified family member complained she had observed staff taking photos of R4 and requested that only family take photos of R4. On 01/30/24 at 11:04 AM CMA E stated the most recent photo she took of a resident was of R4	S3026		

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around Christmas time. She had deleted the photo from her phone. But an unidentified family member was able to hack into her account, retrieve the photo from her deleted folder, and texted the photo making it look like it was from her.

Review of text messages provided in an email from CMA E between her and the unidentified family member revealed the family member apologized because she did not realize her actions would cause CMA E to be terminated from her job. She had hacked into her account to find something she could use against her.

On 01/30/24 at 02:18 PM CMA F stated he was only allowed to use his phone while on breaks. He had witnessed other staff using their cell phones during their shift.

On 01/30/24 at 02:26 PM CNA G stated the facility's policy was staff could use cell phones only while on break. She had witnessed staff use their phones during work time. She asked for clarification from Administrative Staff A after a recent in-service when staff were told they could take photos of residents during activities, send them to the director for marketing purposes, and then delete the photo. She had taken photos of residents before but deleted it.

The facility's "HIPAA Caregiver Guide" documented the company policy was to follow HIPAA standards. Confidential information included any information regarding the resident's medical condition (which includes death).

The facility's undated "Cell Phone Policy" documented no cell phone use except on breaks with no exceptions. Cell phones were to be

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S3026	Continued From page 6 silenced and left with staff personal belongings. Breaks were to be taken outside or in an empty room with the door closed (away from residents). The facility's undated "Confidentiality Policy" documented staff were expected to agree to hold resident information including medical information, resident's needs and/or preferences in strict confidence both during and after employment and was not to be discussed with anyone including resident family members. The operator failed to protect R4 from exploitation when CMA E took a photo of her. Jeopardy was removed on 01/30/24 when the following actions were documented by the facility in the "Credo Senior Living of Basehor Abatement Plan" and accepted by the department at 03:50 PM. 1) All staff completed an in-service on 01/26/24 regarding social media and HIPAA. 2) Staff re-educated on the "No Cell Phone" policy while on duty. 3) Staff re-educated on "Resident Rights." 4) Social media and HIPAA policies were signed by all staff upon hire. 5) Anyone caught with cell phones on duty would receive disciplinary action from the director. 6) One-on-one counseling was provided to CMA D on 01/22/24 regarding facility's Resident Rights and HIPAA policies. She was terminated after violating the policies on 01/24/24. 7) CMA E was terminated on 01/29/24 for violating facility's Resident Rights and HIPAA policies. 8) The facility will provide a designated company device to take photos for marketing purposes.	S3026		

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S3026	Continued From page 7 9) A mandatory all staff meeting was scheduled for 02/02/24 for training on facility's Resident Rights, HIPAA, Privacy, and Social Media policies.	S3026		