

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/06/2024
NAME OF PROVIDER OR SUPPLIER ANTHOLOGY OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 151ST STREET OLATHE, KS 66061		
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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #188306, #188307, #185789, #185664, and #182446 at the above named facility conducted on 06/05/24 and 06/06/24.	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 26-42-101(f)(1)(A) The facility reported a census of 15 memory care residents and 47 assisted living residents for a total of 62 residents. Six residents were included in the sample. Based on interview and record review the administrator failed to protect Resident (R) 5 from abuse by the failure to ensure all direct care staff refrained from retaliatory menacing conduct. Findings included: - Record review for R5 revealed an admission date of 12/31/23 with a diagnoses of muscle weakness and repeated falls.	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3026	Continued From page 1 The 03/21/24 "FCS" identified R5 was marked for being at risk for falls. The 03/21/24 "NSA" identified facility staff provided R5 encouragement to call for assistance if she felt unsteady. The 06/05/24 facility's "Investigation" to the department documented the following: On 05/28/24 CMA D and CNA E responded to a call light activated by R5's husband, who shared the apartment with her. R5 stated the call light had been going off for one and a half hours, although the call light system did not reflect this. R5 stated her husband needed a pain pill. CMA D and CNA E assisted the husband with cares and explained to R5 that the CMA had other residents that required medication as well. R5 told them to "shut up" and when CMA D and CNA E exited the apartment, they told R5 "see if we answer your call light again." R5 expressed her concerns to Administrative Staff A. On 05/31/24 Administrative Staff A visited with R5 who reported no other incidents with staff occurred. On 06/02/24 at approximately 10:00 AM CMA D and CNA E reported while in R5 and R6's apartment to obtain monthly vital signs, R5 called them "bitches." CNA E then asked CMA D if they should ask R5 "who the white one is and who the black one is?" R5 became angry that the former incident she reported was brought up by staff again. She stated she did not want them in her apartment and requested they not come to her apartment anymore. CMA D and CNA E exited the apartment at that time. Approximately 30 minutes later R5 activated her call light. CMA D	S3026		

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S3026	Continued From page 2 and CNA E responded to the call light. R5 requested to see the nurse and requested CMA D and CNA E leave her apartment using profane language. The nurse was called to come assist. CMA D and CNA E did not leave as requested and further instigated the situation. CMA D began to record the conversation without R5's knowledge. CMA D provoked R5 to call them names again as heard in the recording. On 06/03/24 CMA D and CNA E were suspended pending investigation. On 06/05/24 CMA D and CNA E were terminated. The 06/03/24 "Witness Statement" by Licensed Nurse C reported that on 06/02/24 she received a call that R5 requested to speak with her. She saw CMA D, CNA E, and CNA F in the hall on her way to R5 and R6's apartment and asked them what was going on. CMA D and CNA E explained R5 was upset and asked them to leave the apartment. CNA E stated she had whispered to CMA D "I wonder if she knows which one of is black" and R5 responded "why are you bringing that back up?" Licensed Nurse C was not aware of the 05/28/24 incident. Licensed Nurse C entered R5's apartment and offered assistance. R5 explained what happened to Licensed Nurse C beginning with the prior incident on 05/28/24. She explained while talking to someone about it she tried to describe the staff involved as "one is white, and one is black." It upset her when CNA E brought it up again. R5 reported to Licensed Nurse C she raised her voice at CMA D and CNA E, and they raised their voices at her. Licensed Nurse C explained CMA D and CNA E still had to provide cares for her husband, but they would not do them together. Herself or CNA F would assist when needed. At some point during the day,	S3026		

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S3026	Continued From page 3 Licensed Nurse C heard CMA D talking to other staff and said she wanted R5 to say "one is black, one is white" again so she could record it. Licensed Nurse C informed CMA D she could not record residents. The 06/03/24 "Witness Statement" emailed to Administrative Staff A by CMA D reported on 06/02/24 she and CNA E and CNA F entered R5 and R6's apartment to obtain monthly weights. CNA E whispered to CMA D "should I ask her which one is white, and which is black?" R5 yelled and stated she did not want them in her apartment again. Thirty to 45 minutes later, R5 activated her call light. CNA E entered the room while CMA E stood at the doorway. R5 yelled she needed the nurse and "you can get out" with profane expletives. Licensed Nurse C was called, and CMA D and CNA E exited the apartment. The 06/03/24 "Witness Statement" emailed to Administrative Staff A by CNA E reported on 06/02/24 she and CMA E and CNA F went from room to room to obtain monthly weights. When they entered R5 and R6's apartment, R5 gave them "dirty looks." CNA E "mumbled" to CMA D "should I ask her which one is white and which one is black?" R5 began to yell, called them bitches and said she did not want them in her apartment again. Thirty minutes later, R5 activated her call light. When CNA E entered the apartment, R5 yelled she needed the nurse and "you can get out" with profane expletives. Licensed Nurse C was called, and CMA D and CNA E exited the apartment. The 06/04/24 "Witness Statement" by CNA F reported when R5 or R6 activated their call light on 06/02/24 she entered the apartment and saw R5 sitting on the sofa. CNA E stated, "should I	S3026		

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S3026	Continued From page 4 ask who is white and who is black?" CNA F stated, "no, let's get this done." CMA D stated, "yes you should." R5 confronted CMA D and CNA E and they kept agitating R5. CNA F continued to encourage CMA D and CNA E to exit the apartment that they were not doing right. CNA E held the door open and tried to get R5 to call her names again so she could record it. R5 repeatedly asked for the nurse. The undated/unsigned handwritten note by an unknown person outlined an interview with R5. R5 reported she felt unsafe, CNA E was the worst, CNA E gave her dirty looks, and she did not want to run into her. On 06/05/24 at approximately 12:37 PM Licensed Nurse C stated on 06/02/24 there was an argument between R5 and staff. She was called upstairs and staff in the hallway told her that R5 called them names and asked them to leave the room. R5 was independent with all activities of daily living (ADL's) but her husband lived in the same apartment and required assistance with some ADL's and had been recently admitted to hospice. On 06/05/24 at approximately 03:49 PM CNA F stated she recently worked a shift with CMA D and CNA E. While all three of them were in R5's apartment, CNA F heard one of the others say, "I wonder if the lady is going to ask us which one of us black and which is white." CNA F tried to get the other staff to take care of R6 "because that's what they came to do" but CMA D and CNA E continued to argue with R5. One of them said "I just want her to say she doesn't want us to come in her apartment so we don't have to take care of her anymore." All three staff exited the apartment. A while later R5 activated the call light again.	S3026		

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S3026	Continued From page 5 CMA D and CNA E "ran" to answer the call light. They opened the door and said to R5 "you don't want us to take care of you anymore, remember?" And shut the door. On 06/06/24 at approximately 09:31 AM R5 stated a few days ago she had requested pain medication for her husband, R6. She got upset staff did not bring the pain medication. When CMA D and CNA E entered the apartment, she asked them when the pain medication was coming and they yelled at her and said, "it's not our fault, it's not our fault." One of them became "mouthy" and said "find another place" to live. When they exited the apartment one of them said "see if we answer the call light." She reported the incident to facility administrative staff but was not able to recall the staff's names. She stated they were not wearing name tags and did not introduce themselves upon entering the apartment. In trying to describe what they looked like she reported one of them was white and one of them was black. A few days later, CMA D and CNA E entered the apartment again. One of them stood in front of her, used her first name and said, "Miss _____ called one of us white and one of us black," then laughed. She felt like she was being mocked. She went by her middle name and never used her first name which was an added jab. She was stressed out because her husband was sick and in the hospital. She ended up calling CMA D and CNA E "bitches" which she never does. She was so upset, she cried after they left the apartment. R5 stated she was afraid to file a grievance now because CMA D and CNE found out what she said about them when she complained and treated her badly the next time they were in her apartment. Out of 10 facility staff interviewed during the	S3026		

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S3026	Continued From page 6 survey four of them reported witnessing staff to resident abuse. One staff reported staff were afraid of retaliation if they reported concerns to administrative staff because the other staff who she reported concerns about always came back and knew the exact words she used in reporting them. On 06/05/24 at approximately 12:37 PM Licensed Nurse C stated CNA E was "mouthy" and, referring to another resident, had threatened on 06/02/24 to "kick his ass" out of resident's earshot. On 06/05/24 at approximately 01:43 PM CMA H she observed CMA D took the resident's comments offensively and argued back to them. CNA E was frequently flustered and said bad things about residents sometimes within their hearing. She did not report it. On 06/05/24 at 05:55 PM CNA I stated she had witnessed some staff mistreat residents. They talked to them in a rude tone, belittled them, and treated them as if they were not important but did not provide specific names or examples. The facility's 02/2022 "Elder Abuse, Neglect, and Exploitation" policy documented resident abuse was prohibited. If any community staff member was told by a resident of an incident which appeared to be any form of abuse, the incident would be immediately reported to the Director of Health and Wellness and to the Executive Director. Staff were encouraged to take seriously any resident's comments about potential abuse. The administrator failed to ensure all direct care staff refrained from retaliatory menacing conduct toward R5.	S3026		

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S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 62 residents with four residents included in the sample and two closed record reviews. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 4 described the services she received for management of treatments and impaired vision based on her "Functional Capacity Screen" (FCS). Findings included: - Record review for R4 revealed an admission	S3085		

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S3085	Continued From page 8 date of 01/31/17 with a diagnoses of dementia and legally blind. The 02/29/24 "Functional Capacity Screen" (FCS) identified R4 was unable to perform management of treatments and was marked for impaired vision. The 02/29/24 "Negotiated Service Agreement" failed to describe services R4 recieved for management of treatments and impaired vision. On 06/06/24 at approximately 12:40 PM Administrative Nurse B confirmed R4's "NSA" failed to describe the services provided for management of treatments and impaired vision. On 06/06/24 at 01:42 PM an "NSA" policy was requested which the facility failed to provide. The administrator failed to ensure R4's "NSA" described the services she received based on her "FCS."	S3085		