STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B073001	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LARNED HOME PLUS	710 W 9TH STREET LARNED, KS 67550

(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 citation represents the findings of a resurvey with complaints (#186049 and #183029) at the above named home plus facility conducted on 09/17/24.	S 000		
S5028 SS=D	26-42-101 (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 home 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 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:	S5028		

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

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S5028	Continued From page 1 KAR 26-42-101(f) (3) The facility reported a census of 9 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)4, Operator/ Licensed Nurse (LN) A failed to ensure each incident of potential neglect was reported to the department within 24 hours and thoroughly investigated when an unplanned death occurred. Findings included: - Review of R4's medical record revealed he admitted to the facility on 10/28/21 with diagnoses of anxiety, depression, hypertension and history of stroke. R4's "Functional Capacity Screen" (FCS) dated 01/30/24 recorded the resident required supervision with eating. R4's current "Negotiated Service Agreement/ Health Care Plan" dated 01/30/24 recorded R4 fed himself and staff assisted as needed. Signed physician orders dated 10/18/22 recorded a regular diet was ordered for R4. Review of "Progress Notes" dated 02/22/24 by LN B recorded she responded to R4, who was laying on his right side. LN B noted R4 was not breathing with no carotid pulse present. Facility staff reported R4 had coughed during lunch and believed he had choked. The Heimlich maneuver and mouth sweeping was performed by facility staff. Reports indicated death occurred on 02/22/24 by choking at lunch time meal at the facility.	S5028		

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S5028	Continued From page 2 Record lacked a completed, thoroughly documented investigation of potential neglect by the facility. Interview on 09/17/24 with Operator/ LN A and LN B stated R4 appeared to have choked during lunch time meal on 02/22/24. LN B, Hospice and EMS (emergency medical services) responded. LN B stated the Heimlich maneuver and mouth sweeping was performed with no positive results. Telephone interview on 09/18/24 at 11:15 AM with Operator/ LN A confirmed facility failed to complete an investigation and report the incident to the department. Facility's "Reporting Requirements In case of Abuse, Neglect and Exploitation" policy" dated 2014 recorded, "The Director will thoroughly investigate all cases of suspected abuse, neglect, and exploitation, notify the abuse hotline, report to local law enforcement, keep a written record of such allegations and take all necessary actions to prevent further such actions." Operator/ LN A failed to ensure each incident of potential neglect was reported to the department within 24 hours and thoroughly investigated when an unplanned death occurred.	S5028		