STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N096009	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF WELLINGTON	500 N PLUM STREET WELLINGTON, KS 67152

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 190774, 189603, 189269, 189132, and 184304 for the above named facility conducted on 01/22/25 and 01/23/25.	S 000		
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 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.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: K.S.A. 26-41-101 (f) (3) (C) The facility reported a census of 24 residents. The sample included 5 residents and 2 closed record reviews. Based on record review and interview the Operator failed to report an allegation of neglect to the department withing 24 hours. Findings included: - Record review for "Certified Medication Aide" (CMA) D revealed she began her employment on 01/22/24. Review of CMA D's personnel record revealed a document titled "Employee Disciplinary Action Record". Dated 09/06/24. In the section titled "Work Rule Violation" it was typed "failed to follow proper policy medication administration". In the section titled "Corrective Action to be Taken" it was typed "Written disciplinary/verbally called and let her go from her position with us." Review of the untitled handwritten document in CMA D's personnel record revealed the following; The document had handwritten at the top of the page "For 09/06/24" 02:00PM to 10:00PM R8 "Did not get any of her Tylenol on 02-10 shift"	S3028		

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S3028	Continued From page 2 she was to take Tylenol at 03:00PM and 06:00PM R9 CMA D stated the facility did not have Donepezil or Hydroxyzine. The medications were in the facility's medication cart with R9's "name card", and R9's Atorvastatin and Cetirizine were found in R13's room sitting "in front of the TV" (television). R10's Tramadol was signed out by CMA D at a time she did not receive the dose. R12 did not receive her Tramadol. Record review of the facility provided document titled "Certified Medication Aide Job Description" dated 08/18/24 revealed the following instruction; Accurately and safely prepare, administer, and document the oral and/or topical medications that are commonly used in the community that may be ordered for resident use by the attending physician or the Medical Director. Interview with Regional Vice President C confirmed that CMA D was terminated for failure to follow the facility medication policy and job description, she further confirmed the allegation of neglect of services of medication administration was not reported to the department within 24 hours. The Operator failed to report an allegation of neglect to the department withing 24 hours.	S3028		
S9999	Final Observations	S9999		

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S9999	Continued From page 3	S9999		

Kansas Statute 39-981.

Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions.
(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 facility reported a census of 24 residents. The sample included 5 residents and 2 closed record reviews. Based on observation and interviews for all residents, the facility failed to post a conspicuous notice at 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.

Findings included:

- Observation on 01/22/25 at approximately 02:00 PM revealed on the northwest hall a sign that stated the room was being electronically

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S9999	Continued From page 4	S9999		

monitored.

Interview on 01/22 24 at approximately 02:00PM with Operator A confirmed that the room observed was the only room in the facility where the family had placed a camera, and she further confirmed that it was the only room in the facility with a posting of the resident having video surveillance.

Record review for "Resident" (R) 4 revealed an admission date of 12/04/24 with diagnoses of essential hypertension, edema, depression, paroxysmal atrial fibrillation, and chronic fatigue.

Record review of R4's combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) dated 01/14/25 revealed R4 required physical assistance from one staff member with bathing, dressing, toileting, and management of her medications and medical treatments. R4 was independent with transferring, and walking/mobility. She required supervision with eating. R4 was occasionally incontinent and was cognitively intact. R4 was able to make herself understood and she understood others. R4 was marked at risk for falls, impaired vision and impaired hearing. R4 used a walker mobility device.

Review of R4's "Health Service Plan" (HSP) instructed facility staff to assist R4 in and out of the shower, assist with dressing as needed, "supervision with toileting", monitor for risk of falls, and monitor her skin.

For all residents, the facility failed to post a conspicuous notice at the entrance to the adult

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S9999	Continued From page 5 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		