STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175530	A. Building B. Wing	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Homestead at Stafford	405 Grand Avenue Stafford, KS 67578

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44288 The facility reported a census of 39 residents. Based on interview and record review, the facility failed submit within the required timeframe, the results of a completed investigation into an allegation of Abuse, Neglect, Exploitation (ANE), regarding Resident (R)1 occurring on 06/30/22. Findings included: - The facility investigation #2920 documented on the Kansas Department of Aging and Disabilities (KDADS) incident reporting form revealed Administrative Staff A signed the form on 06/30/22. The two-page form reported an incident involving R1, which the initial report documented as occurring on 06/29/22, noting R1 was confused, mumbling and was difficult to wake for morning medication and breakfast. The LN suspected R1 had a stroke. R1 was then transferred to the emergency room (ER) for evaluation. A drug screen was completed at the ER and was positive for Methadone (narcotic pain medication that treats severe pain). The local Police Department and County [NAME] were notified on 06/29/22, as reported on the submitted form; however, they were notified on 06/30/22. (See F684). While onsite on 07/07/22, Administrative Staff A provided copies of three witness statements not notarized, one notarized witness statement, and stated he faxed the investigation in to the State Agency. Upon review, with the State Agency on 07/07/22 at 05:45 PM, the State Agency had not received a copy of the investigation, only a two-page KDADS incident reporting form numbered #2920. On 07/08/22 (five working days after the incident) at 02:38 PM Administrative Staff A electronically mailed the State Agency a one-page summary, which contained a timeline of events attached as a word document, regarding the R1's incident from 06/30/22. The subject of the electronic mail was titled Investigation and the body of the email noted Summary attached. The one-page summary word document was the only attachment to the electronic mail. Review of the attached one-page summary revealed a short timeline of events including various staff members finding R1 in her room sleeping and not waking up easily, the assessment being completed and sending R1 to the ER for suspected stroke. The one-page summary lacked documentation to indicate the results of a completed investigation (See F610). The summary noted two staff were suspended pending further investigation. The final statement in the summary stated: 07/08/2022 - Results received from the second drug screen are negative. Law enforcement has been contacted and investigation by law enforcement to cease. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/14/22 at 01:05 PM with Administrative Staff A revealed he notified the state agency hotline of the Methadone incident and electronically mailed the investigation to the state agency. Verification with the State Agency determined the facility faxed an initial report on a KDADS incident reporting form (two pages only) on 07/01/22, provided the onsite surveyor on 07/07/22 four witness statements (three not notarized), and electronically mailed a one-page summary word document via email on 07/08/22 at 02:38 PM. The documentation submitted by the facility as on 07/08/22 did not constitute a meeting the reporting of results of a completed investigation within the five working days. On 07/18/22 at 11:08 AM, the surveyor electronically requrested a copy of the Medication Error Report referenced in an interveiw. At 02:33 PM on 07/18/22 Administrative Staff A electronically sent the requested Medication Error Report which noted the facility concluded a medication error for R1 in which she required hospitalization due to CMA K administered another residents medication to R1 on the evening on 06/29/22. The report noted CMA K vehemently disagreed and was signed by CMA K on 07-02-22, signed by Adminsitrative Nurse C on 07/08/22, and signed by Administrative Staff A on 07/08/22. The Medication Error Report was not included in the facility reported investigation submitted to the state agency. Interview on 07/06/22 at 01:55 PM with Administrative Nurse C revealed the investigation was turned over to the police department and that the police department would continue and complete the investigation. Interview on 07/14/22 at 02:48 PM with Administrative Nurse C revealed Administrative Staff A was responsible for completing facility investigations and turning in the paperwork to the state agency. Administrative Nurse C stated she was not asked by the facility to complete a witness statement as part of the investigation. Interview on 07/14/22 at 04:00 PM with Administrative Staff A and Administrative Staff B revealed the initial notification was completed and signed on 06/30/22, then sent to the state agency hotline. The final summary was completed and emailed to the state agency email on 07/08/22. Administrative Staff A and Administrative Staff B stated they believed CMA K gave R1 another resident's medication [Seroquel (antipsychotic) 25 milligrams (mg) by mouth] on the evening of 06/29/22. They believed CMA K grabbed the wrong medication card by accident since the medication cards are back-to-back in alphabetical order by residents' last name, in the medication cart. Interview on 07/18/22 at 10:16 AM with Pharmacy Consultant M revealed he went to the facility to assist with the investigation after Administrative Staff B notified him the evening of 06/30/22 of the potential medication error. The facility did not know for sure what happened with R1, but determined R1 most likely received another residents' Seroquel, which caused her transfer to the ER for evaluation. Pharmacy Consultant M stated he signed a copy of the Medication Error Report on 07/11/22 (11 days after the incident, and three days past the required five working day timeframe). The facility's 01/2014 Reporting of Abuse, Neglect, and Exploitation of Residents in Adult Care Homes and Medical Care Facilities policy, documented any information that might be helpful in an investigation of the case and the protection of the resident must be reported to the state agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 10/07/21 Abuse, Neglect, and Exploitation Policy and Procedures documented the facility would ensure that all alleged violations were thoroughly investigated, and the investigation would be completed, and a determination made regarding corrective action within five working days. The facility failed to submit the results of a completed investigation into an allegation of ANE regarding an 06/30/22 incident with R1 and her noted change in condition/suspected stroke and the hospital reported positive drug screen/potential medication error.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44288 The facility reported a census of 39 residents. Based on interview and record review, the facility failed to complete a thorough investigation into an allegation of Abuse, Neglect, Exploitation (ANE) when facility staff found Resident (R)1 with a noted change in condition/suspected stroke, did not send her out or call for EMS support immediately, and after hospitalization transfer the hospital reported a positive drug screen/potential medication error for R1 on 06/30/22. The facility submitted investigation into the allegations of ANE involving R1 included only the following six items: a two page reporting form (emailed to the State Agency complaint hotline), a one page timeline summary (emailed to the State Agency), and four witness statements (given to the surveyor onsite). Findings included: - The facility investigation #2920 documented on the Kansas Department of Aging and Disabilities (KDADS) incident reporting form revealed Administrative Staff A signed the form on 06/30/22. The two-page form reported an incident involving R1, which the initial report documented as occurring on 06/29/22, noting R1 was confused, mumbling and was difficult to wake for morning medication and breakfast. The LN suspected R1 had a stroke. R1 was then transferred to the emergency room (ER) for evaluation. A drug screen was completed at the ER and was positive for Methadone (narcotic pain medication that treats severe pain). The local Police Department and County [NAME] were notified on 06/29/22, as reported on the form. (See F684). While onsite on 07/07/22, Administrative Staff A provided copies of three witness statements not notarized, one notarized witness statement, and stated he already faxed the investigation to the State Agency. Upon review with the State Agency on 07/07/22 at 05:45 PM, the State Agency had not received a copy of the completed investigation. On 07/08/22 (five working days after the incident) at 02:38 PM Administrative Staff A electronically mailed the State Agency a one-page summary of events attached as a word document, regarding R1's incident from 06/30/22. The subject of the electronic mail was titled Investigation and the body of the email noted Summary attached. The one-page summary was all that was attached to the electronic mail. Review of the attached one-page summary revealed a short timeline of events including various staff members finding R1 in her room sleeping and not waking up easily, the assessment being completed, and sending R1 to the ER for suspected stroke. The summary noted while in the ER, hospital staff notified the facility that R1 tested positive for Methadone, Law Enforcement was notified, and Law enforcement went to the facility to investigate. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/22 at 11:08 AM, the surveyor electronically requrested a copy of the Medication Error Report referenced in an interveiw. At 02:33 PM on 07/18/22 Administrative Staff A electronically sent the requested Medication Error Report which noted the facility concluded a medication error for R1 in which she required hospitalization due to CMA K administered another residents medication to R1 on the evening on 06/29/22. The report noted CMA K vehemently disagreed and was signed by CMA K on 07-02-22, signed by Adminsitrative Nurse C on 07/08/22, and signed by Administrative Staff A on 07/08/22. The Medication Error Report was not included in the facility reported investigation submitted to the state agency. Interview on 07/14/22 at 01:05 PM with Administrative Staff A revealed he notified the state agency hotline of the Methadone incident and electronically mailed the investigation to the state agency. Verification with the State Agency determined the only submission received was a one-page summary via email on 07/08/22 at 02:38 PM and the 2 page KDADS reporting form submitted to the complaint hotline. Interview on 07/14/22 at 02:48 PM with Administrative Nurse C revealed Administrative Staff A was responsible for completing facility investigations and turning in the paperwork to the state agency. Administrative Nurse C stated she was not asked by the facility to complete a witness statement as part of the investigation. Interview on 07/06/22 at 01:55 PM with Administrative Nurse C revealed the investigation was turned over to the police department and that the police department would continue and complete the investigation. Interview on 07/14/22 at 04:00 PM with Administrative Staff A and Administrative Staff B revealed the initial notification was completed and signed on 06/30/22, then sent to the state agency hotline. The final summary was completed and emailed to the state agency email on 07/08/22. Administrative Staff A and Administrative Staff B stated they believed CMA K gave R1 another resident's medication [Seroquel (antipsychotic) 25 milligrams (mg) by mouth] on the evening of 06/29/22. They believed CMA K grabbed the wrong medication card by accident since the medication cards are stored back-to-back in alphabetical order by the residents' last name. Interview on 07/18/22 at 10:16 AM with Pharmacy Consultant M revealed he went to the facility to assist with the investigation after Administrative Staff B notified him the evening of 06/30/22 of the potential medication error. The facility did not know for sure what happened with R1, but determined R1 most likely received another residents' Seroquel, which caused her transfer to the ER for evaluation. Pharmacy Consultant M stated he signed a copy of the Medication Error Report on 07/11/22 (11 days after the incident and three days past the required five working day timeframe). The facility's 01/2014 Reporting of Abuse, Neglect, and Exploitation of Residents in Adult Care Homes and Medical Care Facilities policy, documented any information that might be helpful in an investigation of the case and the protection of the resident must be reported to the state agency. The facility's 10/07/21 Abuse, Neglect, and Exploitation Policy and Procedures documented the facility would ensure that all alleged violations were thoroughly investigated and doucmented the investigation would be completed and a determination made regarding corrective action within five working days. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to complete a thorough investigation into an ANE regarding an 06/30/22 incident involving R1. The facility submitted a one page summary timeline, a two-page KDADS reporting form, and four witness statements as the complete investigation into the incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44288 The facility reported a census of 39 residents, with three sampled for quality of care. Based on interview and record review, the facility failed to provide care in a timely manner consistent with standards of nursing practice on 06/30/22 when staff found Resident (R) 1, a resident with a history of transient ischemic attack (TIA, episode of cerebrovascular insufficiency), with altered mental status around 08:30 AM, and at 09:00 AM Licensed Nursing staff presumed R1 displayed stroke symptoms. Near 09:45 AM, Administrative Staff B (non-medical personnel) propelled R1 to the emergency room (ER) in a wheelchair. This failure placed R1 at risk for delay in care/treatment for potential stroke. Findings included: - R1's pertinent diagnoses from the Physician's Order in the Electronic Medical Record (EMR) dated 05/30/22 revealed a history of transient ischemic attack and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The 02/01/22 Admission Minimum Data Set (MDS) revealed R1 with a brief interview for mental status (BIMS) of 10, indicating moderately impaired cognition. R1 was independent with all activities of daily living (ADL) including dressing, bathing, toileting, eating and ambulating (walking) with a walker. R1 weighed 111 pounds and did not receive antipsychotics (class of medications used to treat psychosis and other mental emotional conditions), antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression), or antianxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension). The 02/01/22 ADL Care Area Assessment (CAA) documented staff were to monitor R1's abilities to complete ADL functions daily and assist as needed. The 05/04/22 Quarterly MDS had no changes from the previous MDS. The 05/03/22 Care Plan documented staff were to monitor R1 for possible signs and symptoms of adverse drug reactions including fatigue, lethargy (a lack of energy and enthusiasm), confusion, and poor appetite. The 06/30/22 Nurse's Note written by Licensed Nurse (LN) F at 09:47AM documented Certified Medication Aide (CMA) L notified LN F at 09:00AM that R1 was not getting up to take morning medication and was not herself. LN F completed an assessment of R1 and found R1 tearful, laying down in bed. R1 could not sit up on her own and staff assisted her into a seated position. R1 could not state her name or her current location, fell asleep throughout the assessment, did not respond to LN F's questions, and could not smile when asked. Administrative Nurse C and Administrative Staff B were present in R1's room throughout assessment and decided to send R1 to the hospital. The staff notified the emergency room (ER) at 09:30AM of R1's impending arrival. At 09:40AM, Administrative Staff B pushed R1 to the ER. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CMA H on 07/14/22 at 12:41 PM revealed when she brought in R1's breakfast tray around 08:30 AM on 06/30/22, R1 laid in bed, sleeping. R1 normally dressed herself and was up for the day before breakfast was served but seemed groggy on 06/30/22. CMA H stated R1 could not sit herself up in bed to eat, so CMA H assisted R1 into a seated position on the bed to eat breakfast. CMA H stated she had never seen R1 groggy or unresponsive like she was on 06/30/22. Interview with LN F on 07/14/22 at 02:05 PM revealed between 08:50AM and 09:00AM CMA L notified LN F that R1 did not want to get up to take her medications and acted tired. LN F and Administrative Staff B went into R1's room and LN F completed an assessment. LN F stated that R1 was normally alert and oriented and sharp thinking but R1 could not complete tasks asked of her that morning. LN F stated she believed R1 was having a stroke and asked Administrative Nurse C to advise her of the next steps. Administrative Nurse C told LN F to send R1 to the ER. LN F obtained an order from Provider E's office to send R1 to the ER. LN F stated Administrative Nurse C instructed Administrative Staff B to bring R1 to the ER, because Administrative Nurse C told LN F that use of an ambulance was not needed. Interview with Administrative Nurse C on 07/14/22 at 02:48 PM revealed LN F called her to R1's room at 09:25AM by LN F. They assessed R1 for potential stroke and decided to send R1 to the ER. R1 was difficult to rouse awake and would only say I'm tired. R1 was independent with walking using a walker but was unable to stand or stay awake. The staff transferred R1 to a wheelchair and Administrative Staff B pushed R1 to the ER at 09:50AM. Interview with Administrative Staff B on 07/14/22 at 04:00 PM revealed she saw R1 at 09:00AM and noted that R1 was sleepy, but nothing out of the ordinary for R1. Administrative Staff B stated she pushed R1 to the ER at 09:30AM. Interview with Provider D on 07/15/22 at 09:55 AM revealed Administrative Staff B brought R1 to theER on [DATE], 45 minutes after the facility staff suspected a stroke. The facility did not call EMS for assistance. Administrative Staff B pushed R1 to the ER in a wheelchair and informed the ER staff that R1 did not have altered mental status, was fine, and stated multiple staff had checked on R1 that morning. Provider D stated R1 looked as though she had a massive stroke and was not fine, and Provider D and the ER staff started stroke protocol for R1. Interview with Administrative Nurse C on 07/14/22 at 02:48 PM revealed if staff found a resident unresponsive, she expected staff to call for help and call the provider for an order to send to the ER for emergent issues. Administrative Nurse C stated sometimes if a serious acute issue were to occur, she expected her staff to bring the resident to the ER and get an order later. She also stated that bringing a resident to the ER was much faster than calling for EMS support. The facility 04/2022 Stroke Protocol documented that once a stroke strikes, every minute counts. The key was initiating 911 fast and that the nursing staff will follow the acronym FAST by initiating emergency services immediately and sending the resident to the ER. The facility failed to provide the timely care in accordance with nursing standards of practice when staff found R1 difficult to rouse on the morning of 06/30/22 and suspected stroke, however, the staff did not timely call EMS, and non-medical staff propelled R1 to the ER in a wheelchair, arriving over 45 minutes after the LN suspected a stroke.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44288 The facility reported a census of 39 residents. Based on interview and record review, the facility failed to ensure all clinical staff had the competencies and training required to respond to a resident change in condition and respond to resident emergent situation. (See F684) Findings included: - The facility investigation #2920 reported on [DATE] around 09:00 AM staff notified Licensed Nurse F that Resident (R)1 was not herself. LN F completed an assessment of R1 and found R1 tearful, laying down in bed, could not sit up on her own, and staff assisted her into a seated position. R1 could not state her name or her current location, fell asleep throughout the assessment, did not respond to LN F's questions, and could not smile when asked. Administrative Nurse C and Administrative Staff B were present in R1's room throughout assessment and decided to send R1 to the hospital. The staff notified the emergency room (ER) at 09:30AM of R1's impending arrival. At 09:40AM, Administrative Staff B, a non-medical staff member, propelled R1 in a wheelchair to the emergency room (ER). (See F684). Interview with Certified Medication Aide (CMA) H on [DATE] at 12:41 PM revealed a walking path connected the hospital with the facility and that to her knowledge, the ER staff had never been to the facility to assist with an emergency and that all residents were brought to the ER by facility staff, not Emergency Medical Services (EMS). Interview with LN F on [DATE] at 02:05 PM revealed that between 08:50AM and 09:00AM CMA L notified LN F that R1 was did not want to get up to take her medications and was acting tired. LN F and Administrative Staff B went into R1's room and LN F completed an assessment. LN F stated R1 was normally alert and oriented and sharp thinking but she could not complete tasks asked of her that morning. LN F stated she believed R1 was having a stroke and asked Administrative Nurse C to advise next steps. Administrative Nurse C told LN F to send R1 to the ER. LN F obtained an order from Provider E's office to send R1 to the ER. LN F stated that Administrative Nurse C instructed Administrative Staff B to bring R1 to the ER, because Administrative Nurse C told LN F that use of an ambulance was not needed. Interview with LN G on [DATE] at 11:05AM revealed the LN had the authority to determine if a resident needed to go the ER but an order would need to be obtained from the resident's provider. LN G stated that because the ER was so close to the facility, staff were expected to walk the residents to the ER and that an ambulance had never been used for emergencies. LN G stated that education was not provided to staff about what to do if a resident was found unresponsive, other than completing a checklist of what to send to the ER and who to notify. If a resident was found unresponsive and cardiopulmonary resuscitation (CPR) was required, LN G stated CPR would continue until the resident was stable and would then be placed on the back board and walked over to the ER. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Administrative Nurse C on [DATE] at 02:48 PM revealed she was called to R1's room at 09:25AM by LN F. They assessed R1 for potential stroke and decided to send R1 to the ER. R1 was transferred to a wheelchair and pushed to the ER by Administrative Staff B (non-medical staff) at 09:50AM. If staff found a resident unresponsive, she expected staff to call for help and call the provider for an order to the send to the ER for emergent issues. Administrative Nurse C stated that sometimes if a serious acute issue were to occur, she expected her staff to bring the resident to the ER and get an order later. She also stated that bringing a resident to the ER was much faster than calling for EMS support. Interview with Provider D on [DATE] at 09:55 AM revealed Administrative Staff B brought R1 to theER on [DATE], 45 minutes after the facility staff suspected a stroke. The facility did not call EMS for assistance. Administrative Staff B pushed R1 to the ER in a wheelchair and informed the ER staff that R1 did not have AMS, was fine, and stated multiple staff had checked on R1 that morning. Provider D stated R1 looked as though she had a massive stroke and was not fine, and Provider D and the ER staff started stroke protocol for R1. The walkway leading from the facility to the hospital was an unenclosed but covered pathway approximately 50 yards in distance. The end of the pathway connected to a door on the east side of the hospital and the ER was located on the west side of the hospital. This would mean facility staff would be required to go through the hospital to get to the ER with the residents. The ,d+[DATE] Stroke Protocol documented that once a stroke strikes, every minute counts. The key was initiating 911 fast and that the nursing staff will follow the acronym FAST by initiating emergency services immediately and sending the resident to the ER. The facility failed to ensure all clinical staff had competencies and education to appropriately respond to a resident emergency and resident change in condition.