STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175366	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Atwood	650 Lake Road #216 Atwood, KS 67730

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 - Immediate jeopardy to resident health or safety 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** 43204 The facility identified a census of 24 residents with three residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to ensure staff immediately reported Resident (R)1's allegation of sexual abuse to the Licensed Nursing Home Administrator (LNHA) and further failed to report the sexual abuse allegation to the required state agencies including law enforcement. On 07/24/24 at 09:37 PM, R1 told her representative that a dirty old man came into her room and tried to get into her pants. At 10:00 PM R1's representative called the facility and reported the allegation to Licensed Nurse (LN). LN G told R1's representative there were no male staff working that night and said she had been down R1's hallway passing medications and had not seen anyone walking in the hall. LN G told R1's representative she would go down and talk to R1 and report the incident to Administrative Nurse D. At 11:00 PM, R1 asked LN G if she had told the nurse that she was molested. LN G did not report the abuse allegation until 07/25/24 at 09:03 PM. Administrative Staff A stated the allegation of sexual abuse was not reported to the appropriate state entities because LN G determined the resident had been dreaming. The facility failed to ensure staff reported an allegation of sexual abuse to the LNHA immediately and further failed to report the sexual abuse allegation to the required state entities including law enforcement. This placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (high blood pressure), weakness, and macular degeneration (progressive deterioration of the retina). The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 was independent with eating and oral care and required moderate assistance from one staff for toileting, transfer, dressing, personal hygiene, and bathing. The MDS recorded R1 had no behaviors including hallucinations (sensing things while awake that appear to be real, but the mind created) or delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). (continued on next page)

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The Functional Abilities Care Area Assessment (CAA), dated 03/05/24, documented R1 was alert and oriented with a BIMS score of 15. The CAA documented R1 had macular degeneration but was able to see well enough to assist with her activities of daily living (ADLs). The CAA documented R1 was independent with mobility in her wheelchair and at times walked short distances in her room using her walker to go to the bathroom. The facility goal for R1 was for R1 to maintain her independence as much as possible and to provide R1 help when she needed it. The Visual Function CAA, dated 03/05/24, documented R1 had a diagnosis of macular degeneration. The CAA documented R1 was not able to see well enough to read a book but was able to see well enough to safely navigate the halls and feed herself. R1's Care Plan, documented R1 primarily used a wheelchair in the hall and self-propelled herself using her feet or the handrails. R1 could walk in her room with assistance from one staff and her walker. R1 chose to sleep in her recliner and could make position changes in the recliner. The care plan documented R1 required one staff's assistance for dressing, toileting, and transfers. On 07/30/24, a new focus was placed in R1's Care Plan which documented R1 had a behavior symptom related to dreaming. The plan documented R1 would have no evidence of behavior problems of dreaming of men being in her room and minimize the potential for R1's disruptive behaviors of feeling men in her room by having a second person in the room when a male is in the room with R1. The Mood/Behavior Note, dated 07/25/24 at 04:20 AM, documented LN G received a phone call from R1's representative at 10:00 PM on 07/24/24. R1's representative just got off the phone with R1 and R1 stated some man had come into her room, pulled off her covers while R1 sat in her recliner, and tried to get into her pants. R1's representative asked LN G if there were any male staff working and LN G stated no. R1's representative asked if it could have possibly been a male resident. LN G explained there were three male residents down R1's hall but they were at the end of the hallway and were all in bed and no other males were in the facility. R1's representative requested the incident be reported to Administrative Nurse D. LN G explained to R1's representative that she had been down R1's hall multiple times between 09:00 PM and 10:00 PM. LN G explained to R1's representative R1 seemed tired that evening when she received her night meds and breathing treatment and R1 had also been sleeping. R1's representative requested R1 be checked on throughout the night. LN G assured R1's representative staff would do so. LN G went down to check on R1. R1 was on the phone with her representative again. R1 seemed very confused. R1 asked her representative multiple times if it was August yet and R1 repeated the same topic over and over. Later at 11:00 PM, R1 asked LN G if she had told LN G that some man had molested her. R1 told LN G that some man came into her room and pulled on her butt hair. Later in the night, R1 rang for assistance to the bathroom and R1 asked LN G, Did I get molested by some man, or did I dream it? LN G documented R1 concluded that she had dreamt it. The Other Communication Note, dated 07/30/24, documented the ombudsman came to the facility to visit with R1 regarding R1's representative called and reported a man had been in R1's room and R1 claimed the man had pulled her pants down while she was in her recliner. R1 told the Ombudsman she was molested last night. The ombudsmen asked R1 if she felt safe at the facility. R1 said the staff were taking care of her and she felt safe. The ombudsman then asked R1 about men in her room and R1 said She did not want men in her room. Staff asked R1 about the bath house as the bath aide was a male and R1 said it was fine for him to give her a bath. The ombudsman and staff discussed R1's plan of care and staff stated R1's Care Plan had already been changed to not have males alone in R1's room. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility was unable to provide an investigation, incident report, and/or witness statements related to the incident. The updated timeline of events provided by the facility on 07/31/24, documented on 07/25/24 (this initial call occurred on 07/24/24) at 10:00 PM, LN G received a phone call from R1's representative. R1's representative had just got off the phone with R1 and R1 had stated some man had come into her room and pulled off her covers while R1 sat in her recliner and tried to get into her pants. At 11:00 PM, R1 asked LN G if she had told LN G that some man had molested her. Later in the night, R1 rang for assistance to the bathroom and R1 asked LN G, Did I get molested by some man, or did I dream it? On 07/25/24 at 09:03 PM LN G notified Administrative Nurse D of R1's mood and behavior and her findings of LN G's investigation. On 07/25/24 at 09:05 PM, Administrative Nurse D notified Administrative Staff A of R1's mood and behavior and LN G's investigation and findings. On 07/29/24, sometime in the morning, Administrative Staff A and Administrative Nurse D gave the results of the investigation to R1's representative. On 07/30/24, sometime in the afternoon, the ombudsman visited with the resident and social services. R1's Care Plan was reviewed and updated. On 07/31/24 at 09:45 AM, observation revealed R1 resided in a double occupancy room and sat in a recliner closest to the door with her eyes closed. On 07/31/24 at 09:45 AM, R1 stated that she thought a dirty old man had come into her room and tried to get in her pants, but he was gone now, and it had all been taken care of. R1 stated at the time of the incident she had feared the man coming back into her room. On 07/31/24 at 10:00 AM, R1's representative stated that on 07/24/24 at 09:37 PM she called R1 and R1 told her a dirty old man came into her room and was trying to get into her pants. R1's representative reported R1 slept in her recliner and said she had been dozing when it happened. R1's representative stated she called LN G to report the complaint. R1's representative stated LN G confirmed the were no male employees working that night. LN G told R1's representative she had been down R1's hallway passing medications and had not seen any residents walking in the hall. R1's representative stated LN G told her she would go down and talk to R1 and report the incident to Administrative Nurse D. R1's representative stated she called R1 back and was on the phone with R1 until 10:32 PM and no one came into R1's room. R1's representative stated she drove six hours to the facility on [DATE] and arrived at 05:00 PM and personally talked to LN G. LN G told R1's representative she documented the phone call in R1's chart and said R1 may have been dreaming; LN G said she notified Administrative Nurse D. On 07/31/24 LN G was unavailable for an interview. On 07/31/24 at 10:45 AM, Certified Nurse's Aide (CNA) M stated R1 had brought up the incident to her on Saturday, the weekend after it happened. R1 told CNA M that she had been molested and some man had put his hand down her pants. CNA M asked R1 if she was sure that happened and R1 stated Yes. CNA M stated she could not believe that this really happened to R1, and it must have been a dream or something in R1's mind that she thought really happened. CNA M stated R1 continued to bring up the incident. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/31/24 at 11:00 AM, Administrative Staff A stated that she and Administrative Nurse D had reviewed LN G's nurse's note and reviewed her investigation. Administrative Staff A stated R1 later told LN G that it may have been a dream. Administrative Staff A stated LN G reported that she was up and down the hall all evening passing meds and the two men on the hallway were in bed. Administrative Staff A stated the facility had not reported the incident to the state agency. Administrative Staff A stated she and Administrative Nurse D were satisfied with the investigation LN G had performed. Administrative Staff A stated she talked with Administrative Nurse D about having ongoing contact with family members when allegations of this type were reported. Administrative Staff A stated she did not know if there was any investigative report with witness statements related to this incident. Administrative Staff A stated she was notified of R1's allegations on 07/24/24 at 09:05 PM. On 07/31/24 at 11:30 AM, Administrative Staff A presented a handwritten timeline of the events and questioned if the facility was supposed to investigate allegations of abuse if the allegations were just a resident's dream. The facility failed to ensure staff immediately reported R1's allegation of sexual abuse to the LNHA and further failed to report the sexual abuse allegation to the required state agencies including law enforcement. This deficient practice placed R1 in immediate jeopardy. On 07/31/24 at 12:46 PM Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed of the IJ for R1. On 07/31/24 at 03:00 PM, the facility submitted a plan with corrective actions to remove the immediacy. The corrective actions included: The facility initiated an investigation on 07/31/24 for allegations of abuse and neglect for R1. The abuse allegation was reported to the appropriate state agency, law enforcement, the facility's Medical Director, and R1's family. Immediate education was initiated for all nursing staff on recognizing and reporting abuse and neglect allegations. All interviewable residents were interviewed to identify any safety concerns. The onsite surveyor verified the implementation of the corrective actions and removal of the immediacy on 07/31/24. The deficient practice remained at a scope and severity of D.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 24 residents with three residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to investigate an allegation of sexual abuse and initiate protective measures until an investigation was completed. On 07/24/24 at 09:37 PM Resident (R)1 told her daughter that a dirty old man came into her room and tried to get into her pants. At 10:00 PM R1's representative called the facility and reported the allegation to Licensed Nurse (LN). LN G told R1's representative there were no male staff working that night and said she had been down R1's hallway passing medications and had not seen anyone walking in the hall. LN G told R1's representative she would go down and talk to R1 and report the incident to Administrative Nurse D. At 11:00 PM, R1 asked LN G if she had told the nurse that she was molested. On 07/25/24 R1's representative arrived at the facility and spoke with LN G. LN G told R1's representative she felt R1 may have been dreaming. LN G did not report the allegation to administration for almost 24 hours. R1's representative returned to the facility on [DATE] and spoke with Administrative Nurse D. Administrative Nurse D told R1's representative LN G had already investigated the incident and determined the resident had been dreaming. Administrative Staff A confirmed no further investigation was conducted because she and Administrative Nurse D agreed with LN G's conclusion. The facility's failure to initiate protective measures to prevent further sexual abuse and failure to investigate the abuse allegation placed R1 and all other cognitively impaired residents in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (high blood pressure), weakness, and macular degeneration (progressive deterioration of the retina). The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 was independent with eating and oral care and required moderate assistance from one staff for toileting, transfer, dressing, personal hygiene, and bathing. The MDS recorded R1 had no behaviors including hallucinations (sensing things while awake that appear to be real, but the mind created) or delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The Functional Abilities Care Area Assessment (CAA), dated 03/05/24, documented R1 was alert and oriented with a BIMS score of 15. The CAA documented R1 had macular degeneration but was able to see well enough to assist with her activities of daily living (ADLs). The CAA documented R1 was independent with mobility in her wheelchair and at times walked short distances in her room using her walker to go to the bathroom. The facility goal for R1 was for R1 to maintain her independence as much as possible and to provide R1 help when she needed it. The Visual Function CAA, dated 03/05/24, documented R1 had a diagnosis of macular degeneration. The CAA documented R1 was not able to see well enough to read a book but was able to see well enough to safely navigate the halls and feed herself. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's Care Plan, documented R1 primarily used a wheelchair in the hall and self-propelled herself using her feet or the handrails. R1 could walk in her room with assistance from one staff and her walker. R1 chose to sleep in her recliner and could make position changes in the recliner. The care plan documented R1 required one staff's assistance for dressing, toileting, and transfers. On 07/30/24, a new focus was placed in R1's Care Plan which documented R1 had a behavior symptom related to dreaming. The plan documented R1 would have no evidence of behavior problems of dreaming of men being in her room and minimize the potential for R1's disruptive behaviors of feeling men in her room by having a second person in the room when a male is in the room with R1. The Mood/Behavior Note, dated 07/25/24 at 04:20 AM, documented LN G received a phone call from R1's representative at 10:00 PM on 07/24/24. R1's representative just got off the phone with R1 and R1 stated some man had come into her room, pulled off her covers while R1 sat in her recliner, and tried to get into her pants. R1's representative asked LN G if there were any male staff working and LN G stated no. R1's representative asked if it could have possibly been a male resident. LN G explained there were three male residents down R1's hall but they were at the end of the hallway and were all in bed and no other males were in the facility. R1's representative requested the incident be reported to Administrative Nurse D. LN G explained to R1's representative that she had been down R1's hall multiple times between 09:00 PM and 10:00 PM. LN G explained to R1's representative R1 seemed tired that evening when she received her night meds and breathing treatment and R1 had also been sleeping. R1's representative requested R1 be checked on throughout the night. LN G assured R1's representative staff would do so. LN G went down to check on R1. R1 was on the phone with her representative again. R1 seemed very confused. R1 asked her representative multiple times if it was August yet and R1 repeated the same topic over and over. Later at 11:00 PM, R1 asked LN G if she had told LN G that some man had molested her. R1 told LN G that some man came into her room and pulled on her butt hair. Later in the night, R1 rang for assistance to the bathroom and R1 asked LN G, Did I get molested by some man, or did I dream it? LN G documented R1 concluded that she had dreamt it. The Other Communication Note, dated 07/30/24, documented the ombudsman came to the facility to visit with R1 regarding R1's representative called and reported a man had been in R1's room and R1 claimed the man had pulled her pants down while she was in her recliner. R1 told the Ombudsman she was molested last night. The ombudsmen asked R1 if she felt safe at the facility. R1 said the staff were taking care of her and she felt safe. The ombudsman then asked R1 about men in her room and R1 said She did not want men in her room. Staff asked R1 about the bath house as the bath aide was a male and R1 said it was fine for him to give her a bath. The ombudsman and staff discussed R1's plan of care and staff stated R1's Care Plan had already been changed to not have males alone in R1's room. The facility was unable to provide an investigation, incident report, and/or witness statements related to the incident. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	The updated timeline of events provided by the facility on 07/31/24, documented on 07/25/24 (this initial call occurred on 07/24/24) at 10:00 PM, LN G received a phone call from R1's representative. R1's representative had just got off the phone with R1 and R1 had stated some man had come into her room and pulled off her covers while R1 sat in her recliner and tried to get into her pants. At 11:00 PM, R1 asked LN G if she had told LN G that some man had molested her. Later in the night, R1 rang for assistance to the bathroom and R1 asked LN G, Did I get molested by some man, or did I dream it? On 07/25/24 at 09:03 PM LN G notified Administrative Nurse D of R1's mood and behavior and her findings of LN G's investigation. On 07/25/24 at 09:05 PM, Administrative Nurse D notified Administrative Staff A of R1's mood and behavior and LN G's investigation and findings. On 07/29/24, sometime in the morning, Administrative Staff A and Administrative Nurse D gave the results of the investigation to R1's representative. On 07/30/24, sometime in the afternoon, the ombudsman visited with the resident and social services. R1's Care Plan was reviewed and updated. On 07/31/24 at 09:45 AM, observation revealed R1 resided in a double occupancy room and sat in a recliner closest to the door with her eyes closed. On 07/31/24 at 09:45 AM, R1 stated that she thought a dirty old man had come into her room and tried to get in her pants, but he was gone now, and it had all been taken care of. R1 stated at the time of the incident she had feared the man coming back into her room. On 07/31/24 at 10:00 AM, R1's representative stated that on 07/24/24 at 09:37 PM she called R1 and R1 told her a dirty old man came into her room and was trying to get into her pants. R1's representative reported R1 slept in her recliner and said she had been dozing when it happened. R1's representative stated she called LN G to report the complaint. R1's representative stated LN G confirmed the were no male employees working that night. LN G told R1's representative she had been down R1's hallway passing medications and had not seen any residents walking in the hall. R1's representative stated LN G told her she would go down and talk to R1 and report the incident to Administrative Nurse D. R1's representative stated she called R1 back and was on the phone with R1 until 10:32 PM and no one came into R1's room. R1's representative stated she drove six hours to the facility on [DATE] and arrived at 05:00 PM and personally talked to LN G. LN G told R1's representative she documented the phone call in R1's chart and said R1 may have been dreaming; LN G said she notified Administrative Nurse D. On 07/31/24 LN G was unavailable for an interview. On 07/31/24 at 10:45 AM, Certified Nurse's Aide (CNA) M stated R1 had brought up the incident to her on Saturday, the weekend after it happened. R1 told CNA M that she had been molested and some man had put his hand down her pants. CNA M asked R1 if she was sure that happened and R1 stated Yes. CNA M stated she could not believe that this really happened to R1, and it must have been a dream or something in R1's mind that she thought really happened. CNA M stated R1 continued to bring up the incident. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 07/31/24 at 11:00 AM, Administrative Staff A stated that she and Administrative Nurse D had reviewed LN G's nurse's note and reviewed her investigation. Administrative Staff A stated R1 later told LN G that it may have been a dream. Administrative Staff A stated LN G reported that she was up and down the hall all evening passing meds and the two men on the hallway were in bed. Administrative Staff A stated the facility had not reported the incident to the state agency. Administrative Staff A stated she and Administrative Nurse D were satisfied with the investigation LN G had performed. Administrative Staff A stated she talked with Administrative Nurse D about having ongoing contact with family members when allegations of this type were reported. Administrative Staff A stated she did not know if there was any investigative report with witness statements related to this incident. Administrative Staff A stated she was notified of R1's allegations on 07/24/24 at 09:05 PM. On 07/31/24 at 11:30 AM, Administrative Staff A presented a handwritten timeline of the events and questioned if the facility was supposed to investigate allegations of abuse if the allegations were just a resident's dream. The facility failed to investigate R1's allegation of sexual abuse and initiate protective measures until an investigation was completed. This deficient practice placed R1 in immediate jeopardy and placed all cognitively impaired residents at risk for unidentified and ongoing abuse. On 07/31/24 at 12:46 PM Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed of the IJ for R1. On 07/31/24 at 03:00 PM, the facility submitted a plan with corrective actions to remove the immediacy. The corrective actions included: The facility initiated an investigation on 07/31/24 for allegations of abuse and neglect for R1. The abuse allegation was reported to the appropriate state agency, law enforcement, the facility's Medical Director, and R1's family. Immediate education was initiated for all nursing staff on recognizing and reporting abuse and neglect allegations. All interviewable residents were interviewed to identify any safety concerns. The onsite surveyor verified the implementation of the corrective actions and removal of the immediacy on 07/31/24. The deficient practice remained at a scope and severity of E.