STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175551	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Olathe	21250 West 151st Street Olathe, KS 66061

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752 The facility identified a census of 59 residents. The sample included three residents. Based on observation, record review, and interview the facility failed to ensure Resident (R) 1 remained free from verbal abuse when staff made inappropriate statements to R1. On 05/16/24 Certified Nurse Aide (CNA) M became irritated with R1 and made disparaging remarks about the size of R1's genitals. This placed R1 at risk for impaired psychosocial well-being including humiliation and degradation. Findings included: - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of muscle weakness, reduced mobility, need for assistance with personal care, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 had impairment on one side for the upper and lower extremities. R1 required supervision or touching assistance with eating and oral hygiene. R1 was dependent for toileting hygiene and required staff to complete the activity. R1 was dependent on staff for bed mobility and transfers. R1 had no behaviors. The Activities of Daily Living [ADL] Care Area Assessment (CAA) dated 03/22/24 documented R1 needed assistance with transfers and ADLs related to weakness associated with neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). The Pressure Ulcer CAA dated 03/22/24 documented R1 needed assistance with bed mobility and weakness. R1 triggered for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) due to R1's ADL and mobility impairment and incontinence. The Urinary CAA dated 03/22/24 documented R1 had a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) The Mood CAA and Behavior CAA did not trigger. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan revised 03/28/24 directed staff that R1 required assistance to use the toilet. R1 required substantial to maximum assistance with rolling left and right, sitting to lying, and lying to sitting. R1's Care Plan directed staff that he was dependent for toileting hygiene. R1 required staff supervision or touching assistance with eating. R1's care plan documented R1 had excessive worry. A review of the undated Facility Investigation documented CNA M told R1 that R1 had a small penis while providing peri-care on 05/15/24. CNA N reported the incident on 05/16/24. Staff spoke with R1 about the event but R1 did not want to discuss the incident. R1 confirmed that the staff said something inappropriate while giving R1 care. R1 was embarrassed. R1 refused to share who made the inappropriate comment but confirmed CNA M, CNA N, and CNA P were in R1's room providing care. The Facility Investigation lacked witness statements from CNA N and CNA P. A review of CNA M's typed statement documented CNA M cleaned R1's penis and testicles. CNA M documented she tried to pull back R1's foreskin and CNA N stated she should pull the foreskin back further. CNA M documented she told CNA N that she could not see any more skin to pull back. CNA M documented R1 made a statement regarding the size of his penis that she felt it was inappropriate but she said nothing. On 05/21/24 at 10:46 AM R2 stated that there were times that staff would be rude to the residents but nothing more than that, not heavy abuse in his opinion, but staff did get upset with R1 because R1 pushed his call light too much. On 05/21/24 at 10:50 AM R1 stated he felt terrible when CNA M talked about his genitals. R1 stated that is not how staff should operate. R1 further stated that he was afraid to say too much because he was concerned the direct care staff would punish him. On 05/21/24 at 01:39 PM, CNA N stated that R1 required three staff members in there to change him. CNA N stated that when CNA M was cleaning R1's catheter, she said something about R1's penis being small and not being able to see it. CNA N noticed that this upset R1 because R1 started to say that it was not always that small and began to describe it as it was. CNA N stated that the statement made him very uncomfortable and he later pulled CNA M aside and informed her that what she said to R1 was inappropriate. CNA N stated he was not sure how to approach what happened in R1's room as he was so upset with himself over it. CNA N again reiterated that he felt very uncomfortable when CNA M said that to R1, and he approached Administrative Nurse D about it. CNA N said he realized he should have reported it sooner, but he was unsure what to do. On 05/21/24 at 01:47 PM CNA P was unavailable for interview. On 05/21/24 at 01:51 PM, CNA M stated that when she was assisting CNA N in getting R1 up, she did say something about R1's genitals, but it was due to not being able to see them anymore with R1's catheter. CNA M stated she did not know if R1 or CNA N interpreted her meaning correctly. CNA M stated that R1 then commented on the size his genitals used to be. On 05/21/24 at 02:47 PM Licensed Nurse (LN) G stated that if there was a concern of verbal abuse, she would report it to a manager immediately and investigate to see what needed to happen for the resident. LN G stated she would remove the staff member from the situation and follow up with the resident to see that the resident was ok. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 03:05 PM Administrative Nurse D stated that during the investigation he could not find out what exactly was said. Administrative Nurse D stated because he was unable to find out what exactly was said to R1, he could not substantiate that any abuse happened to R1. Administrative Nurse D stated he spoke with all three staff members but only had CNA M write anything out. On 05/21/24 at 03:09 PM Administrative Staff A asked if R1 reported exactly what was said to him. Administrative Staff A stated R1 would only say that it embarrassed him. Administrative Staff A stated the facility could not substantiate any abuse without knowing what exactly was said to R1. Administrative Staff A stated that CNA N, CNA M, and CNA P were verbally interviewed but CNA M and CNA P were not asked by the facility to write a witness statement. The facility's Abuse: Prevention and Prohibition Against Freedom from Abuse, Neglect Exploitation revised December 2023 documented each resident had the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. The facility would provide oversight and monitoring to ensure that its staff, who are agents of the facility, deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Abuse included verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Mental abuse included, but is not limited to humiliation, harassment, and threats of punishment or deprivation. Verbal abuse included the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The facility failed to ensure R1 remained free from verbal abuse. This placed R1 at risk for impaired psychosocial well-being including humiliation and degradation.

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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	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** 39752 The facility identified a census of 59 residents. The sample included three residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure staff identified an incident as verbal abuse and reported the incident to the Administrator immediately. This deficient practice created the risk of unidentified and ongoing abuse. Findings included: - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of muscle weakness, reduced mobility, need for assistance with personal care, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 had impairment on one side for the upper and lower extremities. R1 required supervision or touching assistance with eating and oral hygiene. R1 was dependent for toileting hygiene and required staff to complete the activity. R1 was dependent on staff for bed mobility and transfers. R1 had no behaviors. The ADL Care Area Assessment (CAA) dated 03/22/24 documented R1 needed assistance with transfers and ADLs related to weakness associated with neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). The Pressure Ulcer CAA dated 03/22/24 documented R1 needed assistance with bed mobility and weakness. R1 triggered for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) due to R1's ADL and mobility impairment and incontinence. The Urinary CAA dated 03/22/24 documented R1 had a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). R1's Care Plan revised 03/28/24 directed staff that R1 required assistance to use the toilet. R1 required substantial to maximum assistance with rolling left and right, sitting to lying, and lying to sitting. R1's Care Plan directed staff that he was dependent for toileting hygiene. R1 required staff supervision or touching assistance with eating. R1's care plan documented R1 had excessive worry. A review of the undated Facility Investigation documented CNA M told R1 that R1 had a small penis while providing peri-care on 05/15/24. CNA N reported the incident on 05/16/24. Staff spoke with R1 about the event but R1 did not want to discuss the incident. R1 confirmed that the staff said something inappropriate while giving R1 care. R1 was embarrassed. R1 refused to share who made the inappropriate comment but confirmed CNA M, CNA N, and CNA P were in R1's room providing care. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 01:25 PM Administrative Nurse D stated he expected staff to report an incident like this right away and not wait. Administrative Nurse D stated they had received training related to reporting timely. On 05/21/24 at 01:39 PM, CNA N stated that R1 required three staff members in there to change him. CNA N stated that when CNA M was cleaning R1's catheter, she said something about R1's penis being small and not being able to see it. CNA N noticed that this upset R1 because R1 started to say that it was not always that small and began to describe it as it was. CNA N stated that the statement made him very uncomfortable and he later pulled CNA M aside and informed her that what she said to R1 was inappropriate. CNA N stated he was not sure how to approach what happened in R1's room as he was so upset with himself over it. CNA N again reiterated that he felt very uncomfortable when CNA M said that to R1, and he approached Administrative Nurse D about it. CNA N said he realized he should have reported it sooner, but he was unsure what to do. On 05/21/24 at 02:47 PM Licensed Nurse (LN) G stated that if there was a concern of abuse or neglect, she would report it to a manager immediately and investigate to see what needed to happen for the resident. LN G stated she would remove the staff member from the situation and follow up with the resident to see that the resident was ok. On 05/21/24 at 03:00 PM Administrative Staff A stated staff were expected to report all allegations or events of abuse immediately. The facility's Abuse: Prevention and Prohibition Against Freedom From Abuse, Neglect Exploitation revised December 2023 documented that all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. The facility failed to ensure staff identified an incident as verbal abuse and reported the incident to the Administrator immediately. This deficient practice created the risk of unidentified and ongoing abuse.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752 The facility identified a census of 59 residents. The sample included three residents. Based on observation, record review, and interview the facility failed to ensure Resident (R) 1 received the required assistance with activities of daily living (ADL). This placed R1 at risk for skin breakdown, poor hygiene, and impaired psychosocial well-being. Findings included: - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of muscle weakness, reduced mobility, need for assistance with personal care, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 had impairment on one side for the upper and lower extremities. R1 required supervision or touching assistance with eating and oral hygiene. R1 was dependent for toileting hygiene and required staff to complete the activity. R1 was dependent on staff for bed mobility and transfers. R1 had no behaviors. The ADL Care Area Assessment (CAA) dated 03/22/24 documented R1 needed assistance with transfers and ADLs related to weakness associated with neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). The Pressure Ulcer CAA dated 03/22/24 documented R1 needed assistance with bed mobility and weakness. R1 triggered for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) due to R1's ADL and mobility impairment and incontinence. R1's Care Plan revised 03/28/24 directed staff that R1 required assistance to use the toilet. R1 required substantial to maximum assistance with rolling left and right, sitting to lying, and lying to sitting. R1's Care Plan directed staff that he was dependent for toileting hygiene. R1 required staff supervision or touching assistance with eating. The Progress Notes from 03/01/24 through 05/21/24 lacked any documentation regarding the refusal of staff assistance with toileting hygiene and /or eating. On 05/21/24 at 10:50 AM R1 laid in his bed on his back. R1 was covered with a blanket from his legs to his lower abdomen. R1 had a folded washcloth laid on his chest with 11 various-sized brown crumbs from breakfast on the washcloth. R1 wore a hospital gown with a brown clump on it which appeared to be food on the right upper chest area. R1's room had a distinct foul odor present. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 02:35 PM, R1 lay in bed, in the same position as previously seen but with his blanket pulled down to his mid-thighs. R1 had the soiled washcloth from that morning still in place. The cloth had additional food including taco salad spilled on it, and to the left of the washcloth on R1's bare chest. R1 stated he was waiting for staff assistance to be cleaned up. R1 had a brownish-black smear on his brief and left upper thigh. R1 stated he had been waiting for assistance since breakfast. R1 indicated he was not too worried about the food on him, but he was concerned by his soiled brief. R1 verified he had asked for staff assistance at breakfast time and was told he had to wait. R1 appeared distressed and upset with having to wait for assistance from staff. On 05/21/24 at 02:38 PM, Certified Nurses Aid (CNA) O verified she needed to get down to R1's room to help him. CNA O stated R1 had asked to get up after breakfast, but CNA O needed two other staff members to get him up. CNA O further stated she knew R1 needed to be cleaned up, but after breakfast, the staff were so busy running around. CNA O revealed that an unidentified CNA was on lunch break, and upon that CNAs return, R1 would hopefully be assisted. CNA O confirmed R1 had been waiting a while but said she had also taken her lunch break due to being hungry. On 05/21/24 at 02:41 PM Administrative Staff A stated that R1 should not have waited since breakfast to be assisted. Administrative Staff A verified it was unacceptable for a resident to sit in a soiled brief for any extended period. Administrative Staff A verified R1 had food on his chest and needed staff assistance. On 05/21/24 at 02:42 PM Administrative Nurse D stated that he expected staff to provide care to the residents promptly. On 05/21/24 at 02:47 PM Licensed Nurse (LN) G stated that if there were not enough staff available when a resident needed assistance, she would alert the staff that upon completion of their current task, the staff needed to attend to the other resident in need. LN G stated she would help provide ADL care so the resident received care in a timely manner. LN G stated a resident should not have to wait as long as R1 had that day. LN G stated it should never have happened. The facility's Quality of Care: ADL, Services to Carry Out policy revised in January 2024 documented it was the policy of the facility that residents were given the appropriate treatment and services to maintain or improve his or her abilities. The policy directed residents who were unable to carry out ADLS to receive the necessary services to maintain good nutrition, grooming, personal hygiene, and oral hygiene. The facility failed to ensure R1 received ADL assistance as required. This deficient practice placed R1 at risk for skin breakdown, a decreased quality of life, and impaired psychosocial well-being.