STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

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 -** Immediate jeopardy **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** The facility identified a census of 44 residents. The expanded sample included 20 residents. Based on observation, interview, and record review, the facility failed to prevent resident to resident abuse. On 01/23/20, Resident (R) 9 entered the room of a cognitively impaired female resident, who was unable to consent to physical relations. R9 held the resident's hand and attempted to touch her belly and kiss her . On 02/23/2020, the same male resident entered the room of another cognitively impaired resident, who was unable to consent to physical relations, and touched her on the chest and/or breast area. Both interactions created an environment of fear on the part of the female residents and/or their representatives. The facility transferred R41 to another unit and the R195 and/or her representative chose to discharge from the facility, ending her Medicare Part A benefit early, as a result of the resident to resident abuse. This deficient practice placed all cognitively impaired female residents on both health care units in immediate jeopardy on 02/23/2020. The immediate jeopardy was removed on 03/12/2020 when the facility implemented measures to prevent further episodes of sexual abuse. Findings included: - R9's Electronic Medical Record (EMR), recorded [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set ((MDS) dated [DATE] recorded R9 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated he was cognitively intact. R9 had no behaviors, but he hallucinated (sensing things while awake that appear to be real, but the mind created). He used a wheelchair for mobility and required limited assistance of one person for locomotion. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/23/19 documented R9 had occasional instances of short-term memory loss. The CAA for Activities of Daily Living (ADLs) recorded R9 was alert with forgetfulness. He made his needs known and scored 13 on his BIMS assessment . He propelled himself in his wheelchair and required reminders on safety. He had significant changes with mood, weight loss, and incontinence. The CAA recorded he verbalized changes in his mood. The CAA for Behaviors documented R9 had increased anxiety and weight loss related to his possible discharge. R9's care plan titled Cognitive Loss/Dementia, dated 01/06/20, documented R9 had impaired decision and cognitive deficits related to [MEDICAL CONDITION] and dementia. It directed staff to provide daily orientation to routines, activity schedules, and therapy. It further directed staff to use environmental cues as needed for memory. The Psychosocial Well-being care plan, dated 01/06/2020, directed staff to remind and redirect R9 as needed if at any time he approached any female resident or current companion that it is always to be consensual and that at no time is it appropriate to touch or initiate contact without permission and verbal agreement and understanding from the female. The Behavior Problems care plan, dated 01/06/2020, documented R9 had impaired behavior related to making inappropriate sexual comments and gestures. It directed staff to intervene as necessary to ensure safety of the resident and others. It directed staff to remind him of the importance of being respectful and all acts should be consensual. It further directed staff to remind him he was not to initiate contact of any sort with others without permission and understanding of companion. Staff were to help redirect him. The care plan directed staff to remind R9 that inappropriate touching and sexual comments were unacceptable and to redirect. The Facility Investigation included a note, dated 01/23/20 at 07:01 PM, copied from R41's EMR which recorded a statement copied from a witness statement written by Certified Nurse Aid (CNA) O. The note documented CNA O took R41 to her room around 05:30 PM. CNA O walked past R41's room a few minutes later and observed a male resident in her room. CNA O entered the room and asked why the male resident was in the room. R41 answered the male resident was in there to kiss her. CNA O observed the residents holding hands. CNA O asked the nurse if the male resident was supposed to be in there and the nurse said no. CNA O then went to R41's room and removed the male resident from the room. The male resident went back to the dining room. At that time, R41 told CNA O the male resident was trying to touch her belly. CNA O reported the incident to the nurse. The note further recorded that at 6:00 PM R41 walked to the nurse's station and asked if she could have a room, pointing to a room. The note recorded LN J told R41 where her room was. R41 stated she did not want to go to her room because people keep telling her what to do. LN G documented R41 had a look of worry or concern on her face. LN J told R41 she could stay in an empty room near the nurse and escorted R41 into an empty room. The note documented notification of the occurrence to R41's representative. A note dated 01/23/20 at 06:59 PM, in R9's EMR, under the Interdisciplinary (ID) Notes tab, recorded CNA O took R41 to her room around 05:30 PM. A few minutes later, CNA O observed R9 in R41's room. When CNA O asked why R9 was in the room, R41 stated R9 was in there to kiss her. CNA O observed R9 and R41 holding hands. CNA O asked the nurse if R9 was supposed to be in the room with R41 and the nurse stated no. CNA O returned to the room and removed R9 from the room. At that time, R41 stated R9 tried to touch her belly. CNA O remained in R41's room until R9 returned to the dining room. CNA O then reported the whole incident to the nurse. The note documented the female resident (R41) was cognitively impaired with advanced dementia. R9 stated he was in R41's room and he did hold her hand, but denied anything further. Staff notifiedR9's Durable Power of Attorney (DPOA). A note, dated 01/31/20, in R9's EMR, under the ID Notes tab, documented on 01/23/20 R9 was reported to be in another female resident's room. Staff redirected R9 as the female resident was cognitively impaired. R9 visited with the floor nurse that same evening regarding the incident. The confused female resident voiced concerns about other people coming to her room and telling her what to do. She requested a room change and staff redirected her with reassurance. Staff reported the event to both resident's DPOAs. Documentation on 01/27/20 indicated the social worker and Vice President (VP) Healthcare Services visited with R9 to discuss the incident on 01/23/20. R9 reported R41 kissed him. R9 reported he was not concerned about the incident because he was not the one soliciting it. Staff re-educated R9 about consent and the fact that not all of the residents at the facility were able to provide true consent due to certain conditions, referring to R41's cognitive impairment related to dementia. R9 verbalized understanding. The note recorded the Care Plan had been updated with interventions which included education for R9 on recognizing difference in consents from female counterpart and asking staff for guidance and support as needed. It also recorded staff were to monitor resident interactions related to appropriateness with female residents and document as needed. A note, dated 02/06/20 , in R41's EMR under ID Notes recorded R41 transferred to a different building on that date. R9's EMR recorded a note, dated 02/23/20 under the ID Notes tab documented R9 entered a female resident's room, R195, without her permission. R9 explained that R195 invited him to come in and waved him to come into her room. The note recorded R9 admitted that once he was in the room R195 asked him to leave so he left. R9 reported to staff at that time he observed R195 in the hallway earlier and he thought she seemed lost. The note documented staff encouraged R9 to speak with the nurses prior to entering any rooms. A notarized Witness Statement signed by Certified Medication Aid (CMA) S documented on 02/23/20 at about 01:00 PM, CMA S observed R195 in the hallway heading towards R195's room. CMA S documented R9 followed behind R195, heading towards the same direction. CMA S documented a few hours later, R195 approached CMA S and reported that R9 was trying to follow her into her room and she stopped him. CMA S documented R195 appeared to be very worried and CMA S calmed R195, provided reassurance, and then reported the incident to the nurse. A notarized Witness

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

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.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Statement signed by CNA P documented on 02/23/20 at 03:40 PM R195 and her representative called CNA P to complain very unhappy because R9 tried to get into R195's room and tried to touch her in an inappropriate way. CNA P documented she did not witness the interaction. A notarized Witness Statement signed by LN K documented on 02/23/2020 she received report from a CMA that R9 had followed R195 into her room at approximately 02:05 PM. LN K visited with R195 in her room. She observed R195 seated in the recliner and R195's family member had just arrived as well. LN K documented R195 had just told her family member about the incident. R195 reported R9 went into her room, but R195 did not feel scared and R9 left when asked to leave. LN K documented R195's family member reported he did not want repercussions for R9 but did want the facility to make sure R9 would not enter R195's room again. A notarized Witness Statement signed by Administrative Staff B documented on 02/24/20 R195's representative stated she needed to talk to Social Services LL about an incident that occurred over the weekend when a resident entered R195's room and touched R195 inappropriately on the chest. A notarized Witness Statement signed by Social Service LL documented on 02/24/20 she received a request to visit R195 and R195's family member regarding a male resident entering (R195)'s room on 02/23/20, touching her sexually. Social Services LL documented she informed social services of the issue and then went to R195's room. R195 stated to Social Services LL she was so sorry for the trouble but did not want any other residents to experience unwanted touch from the male resident. Social Services LL documented R195 told her R195 entered her room in the afternoon, but though R195 was uncertain of the time. Social Services LL documented R195 said a man followed her in, reached out, touched her breast. R195 reported she took the man's hand and put it back where it belonged. Social Services LL documented Social Services X and Y were in R195's room at that point and took notes. R195 stated she would like to go home instead of staying one more night in case the male resident returned. The facility Report of Complaint or Grievance form, signed by Social Services X and dated 02/24/20 documented an incident on or about 02/23/20 at 02:00 PM involving R9 and R195. The reporting party was R195 and her representative. The report recorded at approximately 02:45 PM Social Services X received notice from Administrative Staff B that R195's representative called and stated there was an incident on the weekend when a resident went into R195's room and touched R195 inappropriately on the chest. The report documented Social Services X, Social Service Y, and Social Service LL met with R195 and her representative in R195's room for further investigation. R 195 stated another resident went into her room shortly after lunch. R195 initially stated the resident walked into her room, but upon further questioning R195 was unable to remember if the resident walked using a walker, a wheelchair, or other. R195's representative stated R195's family member was present just after the incident reported R195 reported the resident wasin a wheelchair. R195 stated the resident placed his hand above her breast. R195 also reported that the resident went back to her room after R195's family member arrived and R195 identified the male resident to her family member as the resident who entered her room previously. The report documented Social Services X contacted R195's family member for statement. R195's family member reported to Social Services X that he arrived at the facility shortly after the incident and R195 stood in her room doorway. R195 looked rattled and attempted to phone someone. R195's family member asked what happened and R195 said a gentleman followed her and came into her room. R195 told her family member the man got too close to her and she pushed his hand away. The report documented R195's family member stated R195 continued to appear rattled for the following three-hour visit. He reported the male resident went by R195's room in his wheelchair and R195 identified the male resident as the man who entered her room. The family member stated he reported this to the staff. He also reported R195 chose to eat her dinner in her room. The family member reported R195 stated she wished she could lock her room. R195 requested her family member call her later in the evening to check on her. The family member called later that night. He reported R195 stated at that time her room door was closed and she left her light on. The report documented the family member reported R195 made the decision to discharge a day early. The Facility Investigation included a copy of an email sent from Social Services Y to Social Services X on 02/24/20 at 04:06 PM. The email documented an observation in which Social Services Y walked R195 and her family member out to the car. Social Services Y documented an occurrence in which R195 saw R9 at the double doors and stated, I can't go that way, I can't go that way. Social Services Y documented she wanted to alert Social Services X to R195's reaction to seeing R9 in the hall. The EMR for R195, under the ID Notes documented a late entry note on 02/25/20, corrected on 02/27/20, by Social Services X. The note recorded Social Services X met with R195 and her representative. R195 explained how another resident entered her room and touched her without her consent. The note recorded R195 and her representative made the decision for R195 to discharge on that date (one day early) due to R195's concerns the other resident may return to her room. On 03/10/20 at 12:20 PM R9 sat in his wheelchair between two female residents, also in wheelchairs. He spoke to the resident on his right. On 03/11/20 at 11:05 AM R9 sat in his wheelchair, alone, in the common room, and read the newspaper. No staff were observed in the area. On 03/12/20 at 12:11 PM CMA R stated staff received education and in-services regarding abuse through an electronic training website. She stated she had training on abuse but was uncertain when she last completed the training. CMA R stated the staff received specific information on how to care for residents in a shift to shift verbal report as well as a Care Sheet. She said the Care Sheet had specific information about how the residents transferred and toileted. She stated she did not think resident's specific behaviors were listed on the Care Sheet. CMA R said the staff monitored for behaviors and documented any behavior and what intervention staff used for the behavior in their charting system. CMA R stated she was aware of an occurrence between R9 and another female resident on 02/23/20 but did not witness it herself. On 03/12/20 at 12:22 PM CNA N stated staff received education and training on abuse and various other topics via online training. He stated he was unsure when the last time he received the training, but he felt it had been recently and stated they received training often. CNA N said the staff knew how to care for the residents by the Care Sheets and by report from the nurses. He said the care sheets tell things about how a resident transfer, if they needed help toileting and things like that. He said the nurses let the staff know about any resident behaviors and staff would document the behaviors in the charting system. CNA N stated he had not witnessed any behaviors from R9, but was aware there had been previous incidents. CNA N stated he thought most of the incidents had been with the short stay residents, who come and go. CNA N stated R9 was supposed to let staff know where he was at all times but R9 was pretty independent in his wheelchair and could take himself to the different units. The only time R9 needed help were the times R9 was tired or wore out. CNA N stated he had no memory or knowledge of the incident that occurred on 02/23/20. On 03/12/220 at 01:01 PM LN I stated staff received training on abuse, neglect, and exploitation. LN I reported they received updates and information about residents' needs through verbal report. He stated if a resident had behaviors, this would be reported in verbal report between nurses. The nurses would then do a huddle to let the direct care staff know how to care for the residents and the behaviors. LN I said residents with behaviors have the behaviors listed on the electronic Treatment Administration Record (eTAR). LN I stated R9 had a history of [REDACTED]. LN I stated there were no specific interventions he was aware of regarding R9's behaviors. LN I stated if they saw R9 behaving in a sexually inappropriate manner, staff were to intervene, stop the behavior, report it to the facility administrative staff, R9's family, and the physician. LN I stated there were no specific intervention that he was aware of for the prevention of sexually inappropriate behaviors by R9. On 03/12/20 at 02:11 PM Administrative Nurse D stated staff notified her about the occurrence on 01/23/20 between R9 and R41 via email. She said she emailed back to the facility to find out if an investigation had been started. Staff informed her Administrative Staff A was aware and he initiated the investigation. Administrative Nurse D said facility staff met with R9 and reeducated him. Facility staff explained to R9 not all residents had ability to consent to physical contact. They educated R9 on consensual guidance and R9 was to check with staff prior to touching any residents. Administrative Nurse D stated this was not the first resident to resident occurrence of sexually inappropriate behavior involving R9, but it was the first since Administrative D had been in her position so she thought the prior incident may have been more than a year ago. Regarding the incident on 01/23/20, Administrative Nurse D stated she did not think R9 touching R41's belly and holding her hand with R41 seemed like sexual abuse. She stated R41 was friendly and very touchy feely and R41 changed her statement. Administrative Nurse D did say that sexually inappropriate behaviors would be determined by the person receiving the touching and the person's perception of the touching. She also stated R9 had a documented history of sexual behaviors. Administrative Nurse D stated if R41 had any signs of emotional distress or signs that something occurred, she would have viewed the situation differently. Regarding the occurrence on 02/23/20, Administrative Nurse D stated she called the resident to resident incident to the state agency on 02/26/20. Administrative Nurse D reviewed the witness statements and confirmed one of the statements alleged R9 touched R195's breast. Administrative Nurse D also confirmed that according to the documentation, it appeared R195 had a negative psychosocial impact related to the event. Administrative Nurse D stated staff received abuse training on the online training site last year and it was due again and scheduled on the training site. Administrative Nurse D stated R9 had unrestricted access to both healthcare units in the building where he resided. She reported staff tried to keep track of his whereabouts, though she was unable to find documentation related to continuous staff monitoring

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) in the investigation report, EMR, and/or care plan. Administrative Nurse D reported staff had not received any specific resident-centered training on prevention and intervention related to R9's specific behaviors. On 03/12/20 at 03:00 PM Administrative Staff A reported she was out of the facility for the occurrence on 01/23/20. She became aware of it on 01/27/20. She stated she read the report and knew the female resident involved. Administrative Staff A said no one actually saw what happened and the reports were very unclear as to what happened. Regarding the occurrence on 02/23/20, Administrative Staff A stated she was out of the facility at the time of the situation. She stated it should have been reported to the state agency sooner and the person in change at the facility during the incident should have recognized the allegation regarding the touching of R195's breast and acted accordingly. Administrative Staff A stated R9 had repeated behaviors regarding sexual inappropriateness in the past. She said there were no recent resident to resident behaviors, but he had been inappropriate with staff on many occasions. She said facility staff educated R9 and redirected him in regard to the sexual inappropriateness with staff on repeated occasions, but R9 continued to deny the behaviors. She further stated she felt the behaviors towards staff and inappropriate behaviors towards residents should be viewed differently since she felt R9 had the ability to understand the teaching about consensual relationships. She stated she felt R9 viewed the other female residents as potential sexual partners. Administrative Staff D stated she was uncertain what the facility did at the time of the incident to protect the other residents. She said she was informed staff would monitor his location hourly and she felt it was documented somewhere, perhaps on paper. Administrative Staff A said the local law enforcement agency was not notified because R195's family did not desire law enforcement intervention. She further stated the facility should have reported the incident within two hours. She reported she was aware the facility was not allowed to delay reporting in order to further investigate but since she was not present for the occurrence, she could only go by what was reported to her by nursing. Administrative Staff A stated the ID team had discussed possible interventions such as one to one monitoring for R9 but R9 lacked the funds for such measures. She stated there was no way for her to know if R9 had constant supervision. Administrative Staff A reported facility staff has received abuse training in the last calendar year and the training was scheduled again in the next month or so . The facility policy Abuse and Neglect effective 07/18/16 recorded the facility had the responsibility to ensure each resident had the right to be free from verbal, sexual, physical, and mental abuse. The policy recorded the facility would identify events, occurrences, patterns, and trends of potential or suspected abuse of residents. The policy further documented staff would protect residents from harm during an investigation of alleged abuse. The facility failed to prevent occurrences of sexual resident to resident abuse when the facility failed to prevent an alert and oriented resident from inappropriately touching two cognitively impaired females. The first incident occurred on 01/23/20 and the second on 02/23/20. The deficient practice placed all cognitively impaired female residents on both health care units in Immediate Jeopardy. The Immediate Jeopardy was determined to first exist on 02/23/2020 and was removed on 03/12/2020 at 05:43 PM when the facility implemented the following: All nursing staff were required to read and sign the Abuse, Neglect, and Exploitation policy before beginning his/her shift at the facility. Nursing staff were assigned additional online training regarding the reporting of abuse. R9's care plan was updated to include one to one caregiver and all interventions to address and prevent inappropriate sexual behaviors towards other residents. Care plan interventions for R9 were printed and shared with nursing staff to assure knowledge of all interventions to prevent R9 from entering other resident's rooms or having inappropriate sexual contact with other residents. CNA worksheets were updated to reflect R9s risk for sexually inappropriate behavior and the related interventions. A one to one caregiver was confirmed for R9 each day, for each shift. The deficient practice remained at a scope and severity of a G.
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.** The facility identified a census of 44 residents. The expanded sample included 20 residents. Based on observation, interview, and record review, the facility failed to report allegations and/or suspicions of resident to resident sexual abuse to the appropriate state and law enforcement agencies within the required timeframe. Findings included: - Review of a Facility Investigation included a note, dated 01/23/20 at 07:01 PM, copied from R41's EMR which recorded a statement copied from a witness statement written by Certified Nurse Aid (CNA) O. The note documented CNA O took R41 to her room around 05:30 PM. CNA O walked past R41's room a few minutes later and observed a male resident in her room. CNA O entered the room and asked why the male resident was in the room. R41 answered the male resident was in there to kiss her. CNA O observed the residents holding hands. CNA O asked the nurse if the male resident was supposed to be in there and the nurse said no. CNA O then went to R41's room and removed the male resident from the room. The male resident went back to the dining room. At that time, R41 told CNA O the male resident was trying to touch her belly. CNA O reported the incident to the nurse. The note further recorded that at 6:00 PM R41 walked to the nurse's station and asked if she could have a room, pointing to a room. The note recorded LN J told R41 where her room was. R41 stated she did not want to go to her room because people keep telling her what to do. LN G documented R41 had a look of worry or concern on her face. LN J told R41 she could stay in an empty room near the nurse and escorted R41 into an empty room. The note documented notification of the occurrence to R41's representative. A note dated 01/23/20 at 06:59 PM, in R9's EMR, under the Interdisciplinary (ID) Notes tab, recorded CNA O took R41 to her room around 05:30 PM. A few minutes later, CNA O observed R9 in R41's room. When CNA O asked why R9 was in the room, R41 stated R9 was in there to kiss her. CNA O observed R9 and R41 holding hands. CNA O asked the nurse if R9 was supposed to be in the room with R41 and the nurse stated no. CNA O returned to the room and removed R9 from the room. At that time, R41 stated R9 tried to touch her belly. CNA O remained in R41's room until R9 returned to the dining room. CNA O then reported the whole incident to the nurse. The note documented the female resident (R41) was cognitively impaired with advanced dementia. R9 stated he was in R41's room and he did hold her hand but denied anything further. Staff notified R9's Durable Power of Attorney (DPOA). A note, dated 01/31/20, in R9's EMR, under the ID Notes tab, documented on 01/23/20 R9 was reported to be in another female resident's room. Staff redirected R9 as the female resident was cognitively impaired. R9 visited with the floor nurse that same evening regarding the incident. The confused female resident voiced concerns about other people coming to her room and telling her what to do. She requested a room change and staff redirected her with reassurance. Staff reported the event to both resident's DPOAs. Documentation on 01/27/20 indicated the social worker and Vice President (VP) Healthcare Services visited with R9 to discuss the incident on 01/23/20. R9 reported R41 kissed him. R9 reported he was not concerned about the incident because he was not the one soliciting it. Staff re-educated R9 about consent and the fact that not all of the residents at the facility were able to provide true consent due to certain conditions, referring to R41's cognitive impairment related to dementia. R9 verbalized understanding. The note recorded the Care Plan had been updated with interventions which included education for R9 on recognizing difference in consents from female counterpart and asking staff for guidance and support as needed. It also recorded staff were to monitor resident interactions related to appropriateness with female residents and document as needed. The facility investigations, clinical records and documents provided lacked evidence the facility notified the appropriate state agency and law enforcement agency regarding the allegations. The facility Report of Complaint or Grievance form, signed by Social Services X and dated 02/24/20 documented an incident on or about 02/23/20 at 02:00 PM involving R9 and R195. The reporting party was R195 and her representative. The report recorded at approximately 02:45 PM Social Services X received notice from Administrative Staff B that R195's representative called and stated there was an incident on the weekend when a resident went into R195's room and touched R195 inappropriately on the chest. The report documented Social Services X, Social Service Y, and Social Service LL met with R195 and her representative in R195's room for further investigation. R 195 stated another resident went into her room shortly after lunch. R195 initially stated the resident walked into her room, but upon further questioning R195 was unable to remember if the resident walked using a walker, a wheelchair, or other. R195's representative stated R195's family member was present just after the incident reported R195 reported the resident was in a wheelchair. R195 stated the resident placed his hand above her breast. R195 also reported that the resident went back to her room after R195's family member arrived and R195 identified the male resident to her family member as the resident who entered her room previously. The report documented Social Services X contacted R195's family member for statement. R195's family member reported to Social Services X that he arrived at the facility shortly after the incident and R195 stood in her room doorway. R195 looked rattled and attempted to phone someone. R195's family member asked what happened and R195 said a gentleman followed her and came into her room. R195 told her family member the man got too close to her and she pushed his hand away. The report documented R195's family member stated R195 continued to appear rattled for the following

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) three-hour visit. He reported the male resident went by R195's room in his wheelchair and R195 identified the male resident as the man who entered her room. The family member stated he reported this to the staff. He also reported R195 chose to eat her dinner in her room. The family member reported R195 stated she wished she could lock her room. R195 requested her family member call her later in the evening to check on her. The family member called later that night. He reported R195 stated at that time her room door was closed and she left her light on. The report documented the family member reported R195 made the decision to discharge a day early. The Facility Investigation documented the state agency was notified of the allegation of abuse on 02/26/2020, three days after the incident occurred and administrative staff notified. The Facility Investigation, clinical records, and facility documentation of the occurrence lacked evidence the appropriate law enforcement agency was notified. On 03/10/20 at 12:20 PM R9 sat in his wheelchair between two female residents, also in wheelchairs. He spoke to the resident on his right. On 03/11/20 at 11:05 AM R9 sat in his wheelchair, alone, in the common room, and read the newspaper. No staff were observed in the area. On 03/12/20 at 02:11 PM Administrative Nurse D stated staff notified her about the occurrence on 01/23/20 between R9 and R41 via email. She said she emailed back to the facility to find out if an investigation had been started. Staff informed her Administrative Staff A was aware and initiated the investigation. She stated she did not notify the state agency or law enforcement at the time because she did not feel like the incident qualified as an allegation of abuse. She stated that although the investigation documented R9 had attempted to touch the belly and kiss a cognitively impaired female resident, since the female resident showed no signs of distress from the occurrence, it did not seem like abuse. Administrative Nurse D stated looking at the situation retrospectively, that may not have been the right decision. With regards to the occurrence on 02/23/2020, Administrative Nurse D stated she had called the state agency after the facility had begun investigating because the female resident involved had a negative outcome related to the incident. She said the facility did not notify law enforcement because the family of R195 did not want any action taken against R9 regarding the abuse. Administrative Nurse D stated she did most of the reporting for the facility. She stated she was uncertain of the specific timeframes for reporting abuse allegations and /or suspicions. She also stated she was unaware of the specific requirements related to notification of law enforcement for allegations and/or suspicions of abuse. On 03/12/20 at 03:00 PM Administrative Staff A reported she was out of the facility for the occurrence on 01/23/20. She became aware of it on 01/27/20. She stated she read the report and knew the female resident involved. Administrative Staff A said no one actually saw what happened and the reports were very unclear as to what happened. Regarding the occurrence on 02/23/20, Administrative Staff A stated she was out of the facility at the time of the situation. She stated it should have been reported to the state agency sooner and the person in change at the facility during the incident should have recognized the allegation regarding the touching of R195's breast and acted accordingly. Administrative Staff A said the local law enforcement agency was not notified because R195's family did not desire law enforcement intervention. She further stated the facility should have reported the incident within two hours. She reported she was aware the facility was not allowed to delay reporting in order to further investigate but since she was not present for the occurrence, she could only go by what was reported to her by nursing. Administrative Staff A reported facility staff has received abuse training in the last calendar year and the training was scheduled again in the next month or so. The facility policy Abuse and Neglect effective 07/18/16 recorded the facility had the responsibility to ensure each resident had the right to be free from verbal, sexual, physical, and mental abuse. The policy recorded the facility would identify events, occurrences, patterns, and trends of potential or suspected abuse of residents. The policy further documented staff would protect residents from harm during an investigation of alleged abuse. The facility failed to report allegations and/or suspicions of resident to resident sexual abuse to the appropriate state and law enforcement agencies within the required timeframe.
F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 44 residents. The expanded sample included 20 residents. Based on observation, interview, and record review, the facility failed to protect residents from abuse while investigating episodes of resident to resident sexual abuse. On 01/23/20, Resident (R) 9 entered the room of a cognitively impaired female resident, who was unable to consent to physical relations. R9 held the resident's hand and attempted to touch her belly and kiss her. The facility to implement interventions to protect all cognitively impaired female residents while the facility investigated the allegation. On 02/23/2020, the same male resident entered the room of another cognitively impaired resident, who was unable to consent to physical relations, and touched her on the chest and/or breast area. The facility again failed to implement interventions aimed at protecting all cognitively impaired female resident while the occurrence was investigated. This deficient practice placed all cognitively impaired female residents on both health care units in immediate jeopardy on 01/23/2020. The immediate jeopardy was removed on 03/12/2020 when the facility implemented measures to prevent further episodes of sexual abuse and protect residents at risk. Findings included: - R9's Electronic Medical Record (EMR), recorded [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set ((MDS) dated [DATE] recorded R9 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated he was cognitively intact. R9 had no behaviors, but he hallucinated (sensing things while awake that appear to be real, but the mind created). He used a wheelchair for mobility and required limited assistance of one person for locomotion. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/23/19 documented R9 had occasional instances of short-term memory loss. The CAA for Activities of Daily Living (ADLs) recorded R9 was alert with forgetfulness. He made his needs known and scored 13 on his BIMS assessment. He propelled himself in his wheelchair and required reminders on safety. He had significant changes with mood, weight loss, and incontinence. The CAA recorded he verbalized changes in his mood. The CAA for Behaviors documented R9 had increased anxiety and weight loss related to his possible discharge. R9's care plan titled Cognitive Loss/Dementia, dated 01/06/20, documented R9 had impaired decision and cognitive deficits related to [MEDICAL CONDITION] and dementia. It directed staff to provide daily orientation to routines, activity schedules, and therapy. It further directed staff to use environmental cues as needed for memory. The Psychosocial Well-being care plan, dated 01/06/2020, directed staff to remind and redirect R9 as needed if at any time he approached any female resident or current companion that it is always to be consensual and that at no time is it appropriate to touch or initiate contact without permission and verbal agreement and understanding from the female. The Behavior Problems care plan, dated 01/06/2020, documented R9 had impaired behavior related to making inappropriate sexual comments and gestures. It directed staff to intervene as necessary to ensure safety of the resident and others. It directed staff to remind him of the importance of being respectful and all acts should be consensual. It further directed staff to remind him he was not to initiate contact of any sort with others without permission and understanding of companion. Staff were to help redirect him. The care plan directed staff to remind R9 that inappropriate touching and sexual comments were unacceptable and to redirect. The Facility Investigation included a note, dated 01/23/20 at 07:01 PM, copied from R41's EMR which recorded a statement copied from a witness statement written by Certified Nurse Aid (CNA) O. The note documented CNA O took R41 to her room around 05:30 PM. CNA O walked past R41's room a few minutes later and observed a male resident in her room. CNA O entered the room and asked why the male resident was in the room. R41 answered the male resident was in there to kiss her. CNA O observed the residents holding hands. CNA O asked the nurse if the male resident was supposed to be in there and the nurse said no. CNA O then went to R41's room and removed the male resident from the room. The male resident went back to the dining room. At that time, R41 told CNA O the male resident was trying to touch her belly. CNA O reported the incident to the nurse. The note further recorded that at 6:00 PM R41 walked to the nurse's station and asked if she could have a room, pointing to a room. The note recorded LN J told R41 where her room was. R41 stated she did not want to go to her room because people keep telling her what to do. LN G documented R41 had a look of worry or concern on her face. LN J told R41 she could stay in an empty room near the nurse and escorted R41 into an empty room. The note documented notification of the occurrence to R41's representative. A note dated 01/23/20 at 06:59 PM, in R9's EMR, under the Interdisciplinary (ID) Notes tab, recorded CNA O took R41 to her room around 05:30 PM. A few minutes later, CNA O observed R9 in R41's room. When CNA O asked why R9 was in the room, R41 stated R9 was in there to kiss her. CNA O observed R9 and R41 holding hands. CNA O asked the nurse if R9 was supposed to be in the room with R41 and the nurse stated no. CNA O returned to the room and removed R9 from the room. At that time, R41 stated R9 tried to touch her belly. CNA O remained in R41's room until R9 returned to the dining room. CNA O then reported the whole incident to the nurse. The note documented the female resident (R41) was cognitively impaired with advanced dementia. R9 stated he was in R41's room and he did hold her hand but denied anything further. Staff notified R9's Durable Power of Attorney (DPOA). A note, dated 01/31/20, in R9's EMR, under the ID Notes tab, documented on 01/23/20 R9 was reported to be in another female resident's room. Staff redirected R9 as the female resident was cognitively impaired. R9 visited with the floor nurse that same

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	175441	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) evening regarding the incident. The confused female resident voiced concerns about other people coming to her room and telling her what to do. She requested a room change and staff redirected her with reassurance. Staff reported the event to both resident's DPOAs. Documentation on 01/27/20 indicated the social worker and Vice President (VP) Healthcare Services visited with R9 to discuss the incident on 01/23/20. R9 reported R41 kissed him. R9 reported he was not concerned about the incident because he was not the one soliciting it. Staff re-educated R9 about consent and the fact that not all of the residents at the facility were able to provide true consent due to certain conditions, referring to R41's cognitive impairment related to dementia. R9 verbalized understanding. The note recorded the Care Plan had been updated with interventions which included education for R9 on recognizing difference in consents from female counterpart and asking staff for guidance and support as needed. It also recorded staff were to monitor resident interactions related to appropriateness with female residents and document as needed. Review of R9's care plan revealed an intervention initiated on 01/28/2020 which directed staff to monitor resident interaction related to appropriateness with female residents. It further directed R9 was educated on recognizing differences in consents from female counter part and directed R9 to ask staff for guidance and support as needed. The facility investigations, clinical records and documents provided lacked evidence interventions were put in place regarding protection of female residents from R9 during the investigative process. R9's EMR recorded a note, dated 02/23/20 under the ID Notes tab documented R9 entered a female resident's room, R195, without her permission. R9 explained that R195 invited him to come in and waved him to come into her room. The note recorded R9 admitted that once he was in the room R195 asked him to leave so he left. R9 reported to staff at that time he observed R195 in the hallway earlier and he thought she seemed lost. The note documented staff encouraged R9 to speak with the nurses prior to entering any rooms. A notarized Witness Statement signed by Certified Medication Aid (CMA) S documented on 02/23/20 at about 01:00 PM, CMA S observed R195 in the hallway heading towards R195's room. CMA S documented R9 followed behind R195, heading towards the same direction. CMA S documented a few hours later, R195 approached CMA S and reported that R9 was trying to follow her into her room and she stopped him. CMA S documented R195 appeared to be very worried and CMA S calmed R195, provided reassurance, and then reported the incident to the nurse. A notarized Witness Statement signed by CNA P documented on 02/23/20 at 03:40 PM R195 and her representative called CNA P to complain very unhappy because R9 tried to get into R195's room and tried to touch her in an inappropriate way. CNA P documented she did not witness the interaction. A notarized Witness Statement signed by LN K documented on 02/23/2020 she received report from a CMA that R9 had followed R195 into her room at approximately 02:05 PM. LN K visited with R195 in her room. She observed R195 seated in the recliner and R195's family member had just arrived as well. LN K documented R195 had just told her family member about the incident. R195 reported R9 went into her room, but R195 did not feel scared and R9 left when asked to leave. LN K documented R195's family member reported he did not want repercussions for R9 but did want the facility to make sure R9 would not enter R195's room again. A notarized Witness Statement signed by Administrative Staff B documented on 02/24/20 R195's representative stated she needed to talk to Social Services LL about an incident that occurred over the weekend when a resident entered R195's room and touched R195 inappropriately on the chest. A notarized Witness Statement signed by Social Service LL documented on 02/24/20 she received a request to visit R195 and R195's family member regarding a male resident entering (R195)'s room on 02/23/20, touching her sexually. Social Services LL documented she informed social services of the issue and then went to R195's room. R195 stated to Social Services LL she was so sorry for the trouble but did not want any other residents to experience unwanted touch from the male resident. Social Services LL documented R195 told her R195 entered her room in the afternoon, but though R195 was uncertain of the time. Social Services LL documented R195 said a man followed her in, reached out, touched her breast. R195 reported she took the man's hand and put it back where it belonged. Social Services LL documented Social Services X and Y were in R195's room at that point and took notes. R195 stated she would like to go home instead of staying one more night in case the male resident returned. The facility Report of Complaint or Grievance form, signed by Social Services X and dated 02/24/20 documented an incident on or about 02/23/20 at 02:00 PM involving R9 and R195. The reporting party was R195 and her representative. The report recorded at approximately 02:45 PM Social Services X received notice from Administrative Staff B that R195's representative called and stated there was an incident on the weekend when a resident went into R195's room and touched R195 inappropriately on the chest. The report documented Social Services X, Social Service Y, and Social Service LL met with R195 and her representative in R195's room for further investigation. R 195 stated another resident went into her room shortly after lunch. R195 initially stated the resident walked into her room, but upon further questioning R195 was unable to remember if the resident walked using a walker, a wheelchair, or other. R195's representative stated R195's family member was present just after the incident reported R195 reported the resident was in a wheelchair. R195 stated the resident placed his hand above her breast. R195 also reported that the resident went back to her room after R195's family member arrived and R195 identified the male resident to her family member as the resident who entered her room previously. The report documented Social Services X contacted R195's family member for statement. R195's family member reported to Social Services X that he arrived at the facility shortly after the incident and R195 stood in her room doorway. R195 looked rattled and attempted to phone someone. R195's family member asked what happened and R195 said a gentleman followed her and came into her room. R195 told her family member the man got too close to her and she pushed his hand away. The report documented R195's family member stated R195 continued to appear rattled for the following three-hour visit. He reported the male resident went by R195's room in his wheelchair and R195 identified the male resident as the man who entered her room. The family member stated he reported this to the staff. He also reported R195 chose to eat her dinner in her room. The family member reported R195 stated she wished she could lock her room. R195 requested her family member call her later in the evening to check on her. The family member called later that night. He reported R195 stated at that time her room door was closed and she left her light on. The report documented the family member reported R195 made the decision to discharge a day early. Review of R9's care plan revealed an intervention was implemented on 02/23/2020 which documented R9 was encouraged to check in with staff before accepting invitations from other female residents to go into their room. The Facility Investigation,, clinical records and facility documentation of the occurrence lacked evidence interventions were implemented in order to protect the cognitively impaired female residents accessible to R9 from sexual abuse during the investigative process. On 03/10/20 at 12:20 PM R9 sat in his wheelchair between two female residents, also in wheelchairs. He spoke to the resident on his right. On 03/11/20 at 11:05 AM R9 sat in his wheelchair, alone, in the common room, and read the newspaper. No staff were observed in the area. On 03/12/20 at 12:11 PM CMA R stated staff received education and in-services regarding abuse through an electronic training website. She stated she had training on abuse but was uncertain when she last completed the training. CMA R stated the staff received specific information on how to care for residents in a shift to shift verbal report as well as a Care Sheet. She said the Care Sheet had specific information about how the residents transferred and toileted. She stated she did not think resident's specific behaviors were listed on the Care Sheet. CMA R said the staff monitored for behaviors and documented any behavior and what intervention staff used for the behavior in their charting system. CMA R stated she was aware of an occurrence between R9 and another female resident on 02/23/20 but did not witness it herself. CMA R stated she was not aware of any interventions related to R9's sexually inappropriate behaviors towards other residents and or steps to prevent a sexually inappropriate interaction. She stated staff were told when and if an incident occurred but were not trained on what to do to prevent it or what to do if it occurred. On 03/12/20 at 12:22 PM CNA N stated staff received education and training on abuse and various other topics via online training. He stated he was unsure when the last time he received the training, but he felt it had been recently and stated they received training often. CNA N said the staff knew how to care for the residents by the Care Sheets and by report from the nurses. He said the care sheets tell things about how a resident transfer, if they needed help toileting and things like that. He said the nurses let the staff know about any resident behaviors and staff would document the behaviors in the charting system. CNA N stated he had not witnessed any behaviors from R9 but was aware there had been previous incidents. CNA N stated he thought most of the incidents had been with the short stay residents, who come and go. CNA N stated R9 was supposed to let staff know where he was at all times but R9 was pretty independent in his wheelchair and could take himself to the different units. The only time R9 needed help were the times R9 was tired or wore out. CNA N stated he had no memory or knowledge of the incident that occurred on 02/23/20. CNA N stated he had not received any specific training on preventing R9's sexually inappropriate behaviors towards other residents. He said he was not aware of any specific interventions related to the sexual behaviors. On 03/12/220 at 01:01 PM LN I stated staff received training on abuse, neglect, and exploitation. LN I reported they received updates and information about residents' needs through verbal report. He stated if a resident had behaviors, this would be reported in verbal report between nurses. The nurses would then do a huddle to let the direct care staff know how to care for the residents and the behaviors. LN I said residents with behaviors have the behaviors listed on the electronic

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She said R9 did have some issues controlling his sexual impulses. LN G stated R9 moved around the facility in his wheelchair independently. LN G stated she felt that R9 had too much freedom perhaps, considering his inability to control his impulses. She stated staff did try to stay aware of where he was and what he was doing. LN G stated she was unaware of any specific training or interventions put into place as a result of risk presented by R9's behaviors. She said all interventions would be on the care plan and she had not looked at R9's care plan for a long time. She did say that though R9 spent a great deal of time on her unit, she did not receive verbal or written report when changes occurred with R9 or when incidents or behaviors occurred. On 03/12/20 at 02:11 PM Administrative Nurse D stated staff notified her about the occurrence on 01/23/20 between R9 and R41 via email. She said she emailed back to the facility to find out if an investigation had been started. Staff informed her Administrative Staff A was aware and he initiated the investigation. Administrative Nurse D said facility staff met with R9 and reeducated him. Facility staff explained to R9 not all residents had ability to consent to physical contact. They educated R9 on consensual guidance and R9 was to check with staff prior to touching any residents. Administrative Nurse D stated this was not the first resident to resident occurrence of sexually inappropriate behavior involving R9, but it was the first since Administrative D had been in her position so she thought the prior incident may have been more than a year ago. Regarding the incident on 01/23/20, Administrative Nurse D stated she did not think R9 touching R41's belly and holding her hand with R41 seemed like sexual abuse. She stated R41 was friendly and very touchy feely and R41 changed her statement. Administrative Nurse D did say that sexually inappropriate behaviors would be determined by the person receiving the touching and the person's perception of the touching. She also stated R9 had a documented history of sexual behaviors. Administrative Nurse D stated if R41 had any signs of emotional distress or signs that something occurred, she would have viewed the situation differently. Regarding the occurrence on 02/23/20, Administrative Nurse D stated she called the resident to resident incident to the state agency on 02/26/20. Administrative Nurse D reviewed the witness statements and confirmed one of the statements alleged R9 touched R195's breast. Administrative Nurse D also confirmed that according to the documentation, it appeared R195 had a negative psychosocial impact related to the event. Administrative Nurse D stated staff received abuse training on the online training site last year and it was due again and scheduled on the training site. Administrative Nurse D stated R9 had unrestricted access to both healthcare units in the building where he resided. She reported staff tried to keep track of his whereabouts, though she was unable to find documentation related to continuous staff monitoring in the investigation report, EMR, and/or care plan. Administrative Nurse D reported staff had not received any specific resident-centered training on prevention and intervention related to R9's specific behaviors. After reviewing the care plan interventions for R9 implemented after each episode of abuse, Administrative Nurse D stated the interventions did seem redundant and was unable to provide documentation regarding the monitoring and effectiveness of the interventions. Administrative Nurse D verified R9 had unrestricted movement between the two health acre units at the facility. She said staff tried to always be aware of R9's location but she was unable to provide documentation of staff's continuous monitoring of R9. On 03/12/20 at 03:00 PM Administrative Staff A reported she was out of the facility for the occurrence on 01/23/20. She became aware of it on 01/27/20. She stated she read the report and knew the female resident involved. Administrative Staff A said no one actually saw what happened and the reports were very unclear as to what happened. Regarding the occurrence on 02/23/20, Administrative Staff A stated she was out of the facility at the time of the situation. She stated it should have been reported to the state agency sooner and the person in change at the facility during the incident should have recognized the allegation regarding the touching of R195's breast and acted accordingly. Administrative Staff A stated R9 had repeated behaviors regarding sexual inappropriateness in the past. She said there were no recent resident to resident behaviors, but he had been inappropriate with staff on many occasions. She said facility staff educated R9 and redirected him in regard to the sexual inappropriateness with staff on repeated occasions, but R9 continued to deny the behaviors. She further stated she felt the behaviors towards staff and inappropriate behaviors towards residents should be viewed differently since she felt R9 had the ability to understand the teaching about consensual relationships. She stated she felt R9 viewed the other female residents as potential sexual partners. Administrative Staff D stated she was uncertain what the facility did at the time of the incident to protect the other residents. She said she was informed staff would monitor his location hourly and she felt it was documented somewhere, perhaps on paper. Administrative Staff A stated the ID team had discussed possible interventions such as one to one monitoring for R9 but R9 lacked the funds for such measures. She stated there was no way for her to know if R9 had constant supervision. Administrative Staff A reported facility staff has received abuse training in the last calendar year and the training was scheduled again in the next month or so. The facility policy Abuse and Neglect effective 07/18/16 recorded the facility had the responsibility to ensure each resident had the right to be free from verbal, sexual, physical, and mental abuse. The policy recorded the facility would identify events, occurrences, patterns, and trends of potential or suspected abuse of residents. The policy further documented staff would protect residents from harm during an investigation of alleged abuse. The facility failed to implement measures to protect residents while investigating allegations and /or suspected sexual resident to resident abuse. The deficient practice placed all cognitively impaired female residents on both health care units in Immediate Jeopardy. The Immediate Jeopardy was determined to first exist on 01/23/2020 and was removed on 03/12/2020 at 05:43 PM when the facility implemented the following: All nursing staff were required to read and sign the Abuse, Neglect, and Exploitation policy before beginning his/her shift at the facility. Nursing staff were assigned additional online training regarding the reporting of abuse. R9's care plan was updated to include one to one caregiver and all interventions to address and prevent inappropriate sexual behaviors towards other residents. Care plan interventions for R9 were printed and shared with nursing staff to assure knowledge of all interventions to prevent R9 from entering other resident's rooms or having inappropriate sexual contact with other residents. CNA worksheets were updated to reflect R9s risk for sexually inappropriate behavior and the related interventions. A one to one caregiver was confirmed for R9 each day, for each shift. The deficient practice remained at a scope and severity of an E.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 44 residents. The sample included 20 residents. Based on interviews and record reviews the facility failed to electronically transmit completed Minimum Data Set (MDS) data to the Centers for Medicare & Medicaid Services (CMS) within 14 days after completion for two Residents (R)1 and R2. Findings included: - The Quarterly MDS dated [DATE] for R1 documented a completion date of 01/22/20. There was no submission to CMS documented. The Quarterly MDS dated [DATE] for R2 documented a completion date of 01/31/20. There was no submission to CMS documented. The Resident Assessment Instrument (RAI-guide for proper procedures on completing the MDS) manual directs staff to electronically transmit MDS assessments, to CMS, within 14 days after completion. On 03/16/20 at 11:57 AM Administrative Nurse E stated MDS transmissions had been missed after their completions. The facility's MDS Completion and Submission Timeframes policy dated January 2020 documented the facility submitted MDS assessments in accordance with current federal and state submission timeframes. The facility failed to electronically transmit completed Minimum Data Set (MDS) data to the Centers for Medicare & Medicaid Services (CMS) within 14 days after completion for two residents.
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** The facility identified a census of 44 residents. The sample included 20 residents. Based on observations, interviews, and

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) record review the facility failed to provide incontinence care as the comprehensive care plan directed for one Resident (R)27 sampled for Activities for Daily Living (ADLs). Findings included: - The [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five, which indicated severely impaired cognition. She required total staff assistance for her toileting needs. She was always incontinent (leakage of urine and bowel movements) of bowel and bladder. The Annual MDS dated [DATE] documented a BIMS score of five. She required extensive staff assistance with her toileting needs. She was always incontinent of bowel and bladder. The ADL Care Area assessment dated [DATE] documented R27 was incontinent of bowel and bladder. She wore a brief to protect her skin from impairment and received a medication which increased her urination. The Comprehensive Care Plan revised 01/23/20 documented R27 was offered toileting upon rising, before and after meals, at bedtime, and as necessary. On 03/11/20 at 09:45 AM R 27 sat in her room. A staff member removed R27's breakfast tray but did not assist R27 with toileting. On 03/11/20 at 12:53 PM a staff member assisted R27 from the dining room, after lunch, to the common area. R27 was not assisted with toileting. On 03/12/20 at 09:00 AM a staff member removed R27's breakfast tray from her bedside table. R27 was assisted to the common area at 10:00 AM and was not assisted with toileting. On 03/16/20 at 01:45 PM Certified Nurse Aide (CNA)M stated the facility staff followed the residents' care plans for toileting. The CNA's checked R27 for incontinence in the morning and once in the afternoon, as a rule. On 03/16/20 at 01:58 PM Licensed Nurse G stated R27 wore extra absorbent incontinence briefs. The facility staff toileted R27 as necessary. On 03/16/20 at 03:19 PM Administrative Nurse D stated the facility staff usually toileted residents before and after meals during the day. Some care plans had directions for specific toileting times. The facility's Perineal Care (washing of the genitals and anal area) dated 03/14/20 documented the resident's care plan was assessed for the special needs of the resident. The purposes of the procedure were to provide cleanliness and comfort to the resident, to prevent infections, and skin irritation and to observe the resident's skin condition. The facility's ADL Supporting policy dated March 2018 document residents who were unable to carry out ADLs independently received the services necessary to maintain good grooming and personal hygiene. The facility failed to provide incontinence care to R27, as directed by her comprehensive care plan. This had the potential for increased urinary tract infections, skin breakdown, discomfort, and embarrassment to R27.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 44 residents with a sample of 20. Based on observations, interviews, and record review, the facility failed to provide necessary respiratory care and services for Resident (R) 36. The facility failed to date and store oxygen tubing and nebulizer equipment for R36. Findings included: -The electronic medical record (EMR) for R36 revealed [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] revealed R36 had a Brief Interview for Mental Status (BIMS) score of 15 which indicates cognitively intact. R36 received oxygen therapy during the assessment period. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 03/03/20 revealed R36 was admitted to rehab following recent hospital stay for influenza A and was on continuous oxygen during the assessment period. The [MEDICAL CONDITION] care plan initiated 03/10/20 directed staff to change and date oxygen tubing weekly and store in plastic bag when not in use and to change and date nebulizer equipment weekly. The Orders tab of the EMR lacked an order to change and date oxygen tubing and/or nebulizer equipment weekly. An observation on 03/11/20 at 02:40 PM revealed nebulizer mask was in plastic container but was not dated. The plastic bag for storage was hanging on the nightstand and was dated 03/10/20 but no tubing observed inside the bag. An observation on 03/12/20 at 02:38 PM revealed portable oxygen tubing on back of wheelchair was wrapped around portable oxygen bottle and was not dated. Nebulizer mask was observed in plastic container, not dated with tubing on top of bedside table out of storage bag. An observation on 03/16/20 at 01:38 PM revealed nebulizer tubing and mask were in plastic tub and not dated. Plastic storage bag dated 03/10/20 was hanging on nightstand with no tubing inside. Oxygen tubing on back of wheelchair not dated and was wrapped around portable oxygen bottle. An interview on 03/16/20 at 01:50 PM with Licensed Nurse (LN) H revealed that night shift changed the oxygen tubing and when not in use, oxygen tubing stored in bag. LN H stated the nebulizer mask should be dated, sometimes on the bridge of the nose. An interview on 03/16/20 at 01:57 PM with Certified Nurse Aide (CNA) N revealed that oxygen tubing was changed once a week or whenever the resident needed it. CNA N stated tubing was usually changed on first shift and dated on a piece of tape secured to the tubing then stored in the bag. An interview on 03/16/20 at 03:21 PM with Administrative Nurse D revealed that oxygen tubing was changed every Sunday night, stored in plastic bag and dated. Administrative Nurse D stated there should be an order to change tubing weekly on Sundays. The Oxygen Administration policy revised January 2012 lacked direction on proper replacing, labeling, and storing of oxygen tubing and nebulizer equipment. The facility failed to replace, date, and store oxygen tubing and nebulizer equipment for R36. This deficient practice had the potential for transmission and/or development of infections among the residents and staff.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 44 with 20 residents in the sample. Based on observations, interviews, and record reviews, the facility failed to utilize a system for communication to the [MEDICAL TREATMENT] (a process of removing waste products and excess fluid from the body when the kidneys are unable to adequately filter the blood) center for Resident (R) 31. Findings included: - The [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] revealed R31 had a Brief Interview for Mental Status (BIMS) of eight which indicated moderate cognitive impairment. R31 received [MEDICAL TREATMENT] during the assessment period. The Fall Care Area Assessment (CAA) dated 02/28/20 revealed R31 had [MEDICAL CONDITION] and received [MEDICAL TREATMENT] treatments. An observation on 03/11/20 at 09:45 AM revealed R31 sat in his wheelchair in the lobby and waited for transportation to [MEDICAL TREATMENT]. There was no paperwork observed in his possession. During an interview on 03/16/20 at 08:32 AM, Licensed Nurse (LN)I stated the nurse performed a head-to-toe assessment with vitals and daily weight on R31 before [MEDICAL TREATMENT]. LN I stated the nurse assessed the [MEDICAL TREATMENT] catheter (a catheter used for exchanging blood to and from a [MEDICAL TREATMENT] machine and a patient) to ensure it was clean and dry. Upon return from [MEDICAL TREATMENT], the nurse obtained R31's vitals and offered him a snack, LN I stated the facility did not send any communication with R31 or call communication into the [MEDICAL TREATMENT] center. During an interview on 3/16/20 at 03:21 PM, Administrative Nurse D stated the facility sent a physician communication form with [MEDICAL TREATMENT] patients but were informed by the [MEDICAL TREATMENT] center the facility was to send a [MEDICAL TREATMENT] communication form. The [MEDICAL TREATMENT] Access Care policy dated 03/05/20 lacked direction on communication with [MEDICAL TREATMENT] centers. The facility failed to utilize a system for communication between the facility and the [MEDICAL TREATMENT] center for R31. This deficient practice had the potential for ineffective communication and possible unrecognized complications to R31's health.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Observe each nurse aide's job performance and give regular training.** The facility identified a census of 44 residents. The sample included 20 residents. Based on record reviews, observations and interviews the facility failed to complete annual performance reviews for the Certified Nurse Aides (CNAs). Findings included: - Review of the CNA employee files from April 2019 through 03/12/20 revealed a lack of documentation for annual performance reviews for the CNAs. On 03/16/20 at 01:45 PM CNA M stated she had competency skills testing when she was hired, but none since. On 03/16/20 at 03:19 PM Administrative Nurse D stated the facility had CNA competency skills testing during an employee's orientation period. The facility has not done annual skills testing. The facility's Nurse Aide Qualifications and Training Requirements policy dated May 2019 lacked documentation regarding the annual CNA competency performance reviews required by the Centers for Medicare & Medicaid Services (CMS). The facility failed to complete annual CNA performance reviews. This had the potential to ensure the residents were provided with competent care for the prevention of accidents and possible complications in their health.
F 0742 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 44 residents. The expanded sample included 20 residents. Based on observation, record

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F 0742 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) review, and interviews, the facility failed to provide the care needed to maintain Resident (R)9's highest practicable level of psychosocial well-being when the facility failed to implement and monitor effectiveness of specific, person centered interventions to address R9's increased depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) resulting from an involuntary discharge notice issued to R9 by the facility. Findings included: - R9's electronic medical record (EMR), recorded [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE] recorded R9 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact. The MDS, under the Mood section, recorded a total severity score of zero which indicated no symptoms of depression. The MDS documented R9 had no behaviors. The MDS recorded R9 received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and antipsychotic (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions) seven of the seven look back days. R9 had occasional pain, which he rated at a two on a zero to ten scale with ten being the worst. The MDS recorded a weight of 179 pounds (lbs.) with no weight loss. The MDS documented R9 had no plan to discharge to the community and preferred not to be asked about discharge with each assessment. The Significant Change MDS dated [DATE] recorded R9 had a BIMS score of 13 which indicated he was cognitively intact. The MDS, under the Mood section, recorded a total severity score of four which indicated depression as evidenced by R9 felt down, depressed, and hopeless. He also had a poor appetite, felt tired and/or lacked energy, and felt bad about himself. He had little interest or pleasure in doing things. The MDS documented R9 had no behaviors, but he hallucinated (sensing things while awake that appear to be real, but the mind created). The MDS recorded R9 received an antidepressant, antianxiety and antipsychotic seven of the seven look back days. R9 had occasional pain, which he rated at a five on a zero to ten scale with ten being the worst. The MDS recorded a weight of 170 lbs. and indicated R9 had unintentional weight loss. The MDS documented R9 had no plan to discharge to the community. The question regarding the resident's goal for discharge was left blank. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/23/19 documented R9 had occasional instances of short-term memory loss. The CAA for Activities of Daily Living (ADLs) recorded R9 was alert with forgetfulness. He made his needs known and scored 13 on his BIMS assessment. He propelled himself self in his wheelchair and required reminders on safety. He had significant changes with mood, weight loss, and incontinence. The CAA recorded he verbalized changes in his mood. The CAA for Behaviors documented R9 had increased anxiety and weight loss related to his possible discharge. The CAA for Mood recorded R9 had increased anxiety and sadness. The Nutritional Status CAA documented R9 had a significant weight loss. The Psychosocial Well-being CAA documented R9 reported stress and anxiety. The Activities CAA documented R9 felt more tired lately and needed more help and reminders regarding programs. R9's care plan titled Cognitive Loss/Dementia, dated 01/06/20, documented R9 had impaired decision and cognitive deficits related to [MEDICAL CONDITION] and dementia. It directed staff to provide daily orientation to routines, activity schedules, and therapy. It further directed staff to use environmental cues as needed for memory. The Behavior Problems care plan, dated 01/06/20, documented R9 had impaired behavior related to making inappropriate sexual comments and gestures. It directed staff to intervene as necessary to ensure safety of resident and others. It directed staff to remind him of the importance of being respectful and all acts should be consensual. It further directed staff to remind him he was not to initiate contact of any sort with others without permission and understanding of the companion. Staff were to help redirect him. The care plan directed staff to remind R9 that inappropriate touching and sexual comments were unacceptable and to redirect. The Psychosocial Well-being care plan, dated 01/06/20, documented R9's well bring was important to him and he wanted to be able to share an intimate relationship with a willing female resident. It directed staff to remind and redirect R9 as needed if at any time he approached any female resident or current companion that it is always to be consensual and that at no time is it appropriate to touch or initiate contact without permission and verbal agreement and understanding from the female. It further directed to provide R9 emotional support and validate his feelings and/or concerns as needed. It directed staff to facilitate development of consensual relationship with fell ow resident and promote one on one time. The care plan directed staff to assist the resident when he chose to have alone time with his consensual companion. It recorded staff were to encourage family involvement and support as needed and continue to educate regarding safety. The Mood State care plan, dated 01/06/20 documented R9 had a mood problem related to depression as evidenced by R9 self-report. It directed staff to administer R9's antidepressant medication and monitor for adverse effects. It further directed staff to observe and document effectiveness of mood enhancement medications, to monitor behaviors, and observe for patterns or triggers. The Mood State care plan recorded R9 had an alteration in mood related to anxiety. It directed staff to provide reassurance and comfort, give clear concise explanations of procedures, and to assist with decision making. The care plan recorded R9 had ineffective coping related to stress as evidenced by R9's self-reports of increased anxiety and difficulty making decisions. It directed staff to assess and document specific stressors, stimuli, and triggers. It directed to provide opportunities to express concerns, fears, feelings and expectations. The care plan directed staff to explore R9's attitudes and feelings about required lifestyle changes and to reduce stimuli in his environment that could be interpreted as threatening. It directed staff to administer mediations as ordered and to teach R9 the use of relaxation, exercise, and diversional activities as methods to cope with stress. The Discharge Planning care plan, dated 01/06/20, recorded R9 needed 24-hour supervision and required long term care environment. It directed staff to encourage R9 to move about the facility as long as he had no exit seeking behaviors and to make care choices as he was able. It further directed staff to orient R9 to facility layout and provide orientation to routine and daily scheduling including meals, programs, and therapy. It directed staff to identify self and role when approaching the resident . The Care Plan lacked interventions which identified specific or suspected triggers and lacked direction to staff regarding person-centered measures aimed at relieving R9's self-reported stress, anxiety, and depression. The care plan lacked interventions which directed staff on how to provide resident specific support in the event of anxiety, stress, and/or depression. R9's EMR documented a 30 Day Notice of Involuntary Discharge issued to R9 and his representative on 11/5/19. A note, under the Interdisciplinary Note (ID) Note tab, dated 11/06/19 recorded Administrative Staff A met with R9 to discuss the 30 Day Notice of Involuntary Discharge provided to him. R9 asked Administrative Staff A what he could do to change that final decision. Administrative Staff A suggested to R9 that he do all he could to control behaviors that resulted in inappropriate verbalizations and/or physical contact with staff members. A note, under the ID Note tab dated 11/14/19 documented R9 requested to speak with Social Service X. He asked for an update to the notice of discharge. Social Service X provided the update. R9 again asked about timeline for the process and Social Service X explained that it would be open ended until determination of a decision. The note documented Social Service X provided active listening as R9 had concerns he upset his family. R9 stated he was thankful for the support he received. Social Service X encouraged R9 to feel free to contact her as needed whenever R9 had questions or felt the need to talk. Social Service X encouraged R9 to continue self-care. A note, under the ID Note tab, dated 11/17/19 documented LN L asked R9 how he was doing. R9 stated that he was doing well, and asked LN L to come to R9's room and visit. LN L informed R9 LN L had to go see another resident. R9 voiced understanding and propelled himself back to his room. The note lacked documentation LN L followed up with R9 to assess R9's needs. The note lacked documentation staff provided comfort and/or visitation to R9 as R9 requested. A behavioral health Progress Note under the consults tab, dated 11/19/19 documented R9 was seen for the goal of reducing stress and anxiety. The session content recorded health concerns and situational circumstances. The note recorded the recommendation to staff to continue to provide comfort and support. A note, under the ID Note tab, dated 11/25/19 recorded R9 extended his hand to CNA Q, as if to shake it, and stated Hi, my name is (R9). The note recorded CNA Q responded she knew R9's name. R9 then asked CNA Q my place or yours? CNA Q told R9 that comment was not appropriate. CNA Q asked R9 if he wanted to go to his room and R9 responded no I just want you to come to my room. CNA Q stated again that's not appropriate. CNA Q then asked R9 if she could help him with something, and R9 responded I just want to spend time with you. CNA Q excused herself from R9. The note lacked documentation staff followed up with comfort, support, or offered R9 individualized time as R9 requested. The note lacked evidence the nurse assessed R9's well-being or needs at that time. A late entry note, under the ID note tab, dated 12/01/19 documented Social Services X and Administrative Nurse D met with R9 to review the comments he made to CNA Q on 11/25/19. The note documented R9 did not remember making the comment and stated, if you say this happened, then I guess it did. Social Service X and Administrative Nurse D reminded R9 that it was important to try not to make these types of comments and why. R9 stated he was sorry for the incident. Social Service X then provided reassurance that updates would be provided about the discharge investigation. A note under the ID Note tab dated 12/01/19 documented R9 remained in bed the whole day, asleep. R9 did not get up to eat at all. R9 was only up to toilet and take medications. R9 denied any

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F 0742 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 8) discomforts. No inappropriate behaviors observed or reported. A note under the ID Note tab, dated 12/11/19 documented Social Service X met with R9 prior to his doctor's appointment. The note recorded R9 looked haggard and when asked how he was doing, he stated, I'm tired. I didn't sleep well last night. At least I don't think I did. Social Service X checked with R9 about his mood and R9 said, I really can't tell you. Social Service X offered suggestions for how R9 might feel and R9 agreed he felt anxious and scared. Social Service X provided reassurance that this was normal, and this was also part of the reason for the multiple doctor appointments. The note recorded R9 seemed more confused and had difficulty speaking or finding words to express himself. The note documented Social Service X met with R9 later in the day. R9 was in bed, but awake. R9 told Social Service X he had a headache and had been in bed off and on all afternoon. Social Service X reminded R9 of self-care strategies discussed previously and then encouraged him to have a good dinner since he had not eaten much that day. A note under the ID Note tab dated 12/12/19 documented R9 expressed to LN J feeling increased anxiety. R9 stated he needed something to calm him down. The note recorded notification of the physicianand obtained a new order for an antianxiety medication. The note recorded LN J notified Social Service X and Administrative Nurse D to follow up with R9 the next day. A note under the ID Note tab dated 12/13/19 documented Social Service X met with R9 to check on him following his difficulty the previous day with increased anxiety. R9 stated he had a bad day and was in bed resting. When asked why it was a bad day, R9 said he had been nervous all day. The note recorded Social Service X also notified R9 that the pre-hearing (regarding the involuntary discharge) scheduled for 12/27/19 had been rescheduled for 1/3/20. Social Service X explained to R9 there would be another facility there to meet him on Tuesday 12/17/19 and Social Service X would be present for support. A note under the ID Note tab dated 12/17/19 documented R9 complained of increased anxiety and increased tremors. Staff administered As needed medication and R9 reported he felt better. A note under the ID Note tab dated 12/18/19 recorded on 12/17/19 Social Service X met with representatives from a nursing center regarding possible placement as needed depending on outcome of R9's discharge appeal. Social Service X reminded R9 about the reason for the meeting and R9 was willing to meet. Social Service X made a follow up visit to R9 on 12/18/19 and reminded R9 why the other facility staff met with him. R9 stated understanding, but also stated he did not want to move. Social Service X reminded R9 of pre-hearing date of 01/03/2020. Social Service X asked R9 how he felt and R9 indicated he had some increased anxiety, but staff had been helpful when R9 asked. Social Service X reminded R9 to continue self-care activities as possible and notify staff if he had questions or needed support. A nutrition alert note under ID Note tab dated 12/29/19 documented R9's weight at168.6 lbs. The note recorded R9 continued weight loss and inadequate oral intake . An unlocked note under the ID Note tab dated 12/31/19 documented Social Service X met with R9. The note lacked further information. A note under the ID Note tab dated 01/01/20 recorded R9 refused to get up. R9 did not want to eat and stated he just felt tired. R9 called to use the bathroom and took all of his medications. R9 denied any needs and nursing staff offered R9 food and fluids. A note under the ID Note tab dated 01/02/20 documented Administrative Staff A met with R9 in his room and reminded him that tomorrow was the prehearing conference. The note recorded R9 immediately reacted with acknowledgement and understanding of what was being referred to. Administrative Staff A asked R9 if he wished to be present for the phone conference. R9 stated, No, I don't think so, I am not really feeling strong enough. A note under the ID Note tab dated 01/02/20 recorded R9 refused to eat and was tired all the time from walking around. It further recorded staff voiced concerns that R9 lacked motivation, even with strong encouragement. The note recorded R9 voiced he had no appetite lately, but would try to eat that night. A note under the ID Note tab dated 01/07/20 recorded R9 stopped Social Service X in the hallway to report that R9 had a rough 24 hours. R9 shared that he felt weak, tired, had heartburn last night, and generally didn't feel well. When asked why he felt that way, he responded, I'm not sure. R9 also stated he felt jittery. Social Service X assisted R9 to see the charge nurse and requested the nurse check on R9. Social Service X also spoke with the Behavioral Health Therapist . The note recorded the therapist would see R9 that day and weekly. A note under the ID Note tab dated 01/29/20 recorded R9 complained of increased anxiety. Staff administered medication for the anxiety. R9 went to bed & refused to eat the evening meal. The note documented R9 stated he felt better, but still declined to eat at that time. A Nutrition Alert under the ID Note tab dated 01/31/20 recorded R9 weighed 168.6 lbs. The note recorded R9 had some anxiety noted and had a pattern of not eating well when he had increased anxiety. A note under the ID Note tab dated 02/04/20 documented R9 called Social Service X and requested a visit. During the meeting, R9 voiced concerns that he did not understand why he was given the discharge notice. Social Service X again revisited the concerns as they were noted by staff and comments that R9 made to staff. R9 stated, If I did this, I certainly didn't do it with any malice or intent. He also stated that these comments must have been made off the cuff. The note documented R9 questioned why anyone would be threatened by anything he said. Social Service X reviewed past incidents with R9 and reminded R9 those incidents had been discussed with him. The note documented Social Service X confirmed that R9 apologized to some of the people who made the reports. R9 indicated he did not remember this. Social Service X reviewed recent correspondence after the pre-hearing was held and agreed to follow up in regard to what R9 could expect with the hearing scheduled for 3/13/20. A Behavioral Health Progress Note under the consults tab, dated 02/04/20 documented R9 was seen for the goal of reducing anxiety and depression. The note recorded the session content consisted of situational circumstances and the unknown or not knowing or understanding pending legal matters. The note recorded R9 reported worry and anxiety as soon as he awoke and panic attacks in the afternoons. The note documented recommendation to staff to continue comfort and support. A note under the ID Note tab dated 02/04/20 recorded R9 complained of increased anxiety two times during the shift and requested as needed medication. R9 reported the medication was effective. A note under the ID Note tab dated 02/17/20 recorded Social Service X met with R9 at R9's request. R9 continued to report he had no idea why he received the notice of discharge and shared his anxiety about it was increasing. Social Services X again reminded R9 of the reports that were made regarding his comments to staff. He stated again he did not remember making the comments. R9 also stated he had increased anxiety about the hearing and wondered what to expect, whether he had to be present, and what to expect from the decision. The note documented Social Service X reviewed self-care activities with R9 and encouraged him to continue a normal routine when possible and seek support as needed A note under the ID Note tab dated 03/02/20 documented Social Service X received a phone call from R9. R9 asked What is next in all of this? Social Service X confirmed R9 was talking about the upcoming hearing. Social Service X reminded R9 the hearing remained scheduled for 3/13/2020. R9 asked if there was anything he could do at that time and Social Service X recommended R9 contact his family representative for further options if available. Social Service X offered to visit R9, but R9 declined. A note under the ID Note tab dated 03/03/20 recorded R9 complained of increased anxiety. The note recorded staff administered medication with effectiveness noted. A note under the ID Note tab dated 03/10/20 at 04:50 PM recorded R9 suffered increased anxiety related to having a very stressful day. Staff received new orders for antianxiety medication administered the medication. R9 ate supper and rested in his room for the rest of the shift. During observation and interview with R9 on 03/10/20 at 05:10 PM, R9 agreed to talk with the surveyor. R9 laid back on his bed. He appeared restless and uncomfortable as evidenced by frequent weight shifting and repositioning. R9 stated he liked the facility, his nurses, and the other residents at the facility. He reported he had been feeling very anxious and scared for several months because of the notice. He also said he had been feeling tired and disinterested. He expressed concern in speaking about the notice or about his feelings and stated that in the past, when he spoke about things it caused problems. R9 verbalized he did not want to cause any issues. He stated he would answer any questions and do what he needed to do, but did not really want to talk or think about the discharge and how it made him feel. R9 shared he felt uncertain about the future and uncertain about what may happen if he lost the appeal. He stated, I guess they just shuffle me off to another nursing home. R9 stated he did not remember if he discussed these feelings with anyone in the facility. R9 then said that if they say I did, then I guess I did. R9 verbalized he had been having trouble remembering things and getting things right. He again expressed concern about saying anything and stated he did not want to say the wrong thing. R9 said that happened in the past and it had come back to bite him. R9 became tearful, and stated he felt very blah and was just stressed over the hearing on Friday. He then requested to end the interview. On 03/12/20 at 12:11 PM CMA R stated R9 had been depressed and crying. CMA R said she had not received any specific instruction or training regarding R9 recent change in mood. She said she just reported it to the nurse when she observed it. CMA R stated she was aware there had been talk about R9's specific behaviors, but she had not really witnessed it. The nurse informed staff that there was an occurrence involving R9. Social services usually dealt with those type of behaviors. CMA R stated there had been a big change in R9 and it was usually more noticeable after they take him off to talk to him. She clarified they were management people. After those times, he usually did not want to come out of his room, like he was embarrassed. CMA R stated she did not know what else they do for the behaviors. She stated she only knew they take him off and talk to him. CMA R said she administered medications, so she knew R9 was on some medications for his anxiety. CMA R said R9 started asking for more anxiety medication. She stated once in a while R9 would ask for a pain

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F 0742 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 9) pill, due to a bad headache. She said she was not sure if he was using his pain medication more than before. CAM R stated she would not say R9 had more pain, he was just sad now. CMA R stated facility staff were not doing anything new to help him with his emotional support and the changes in his mood. On 03/12/20 at 12:22 PM CNA N stated he worked with R9 almost every day he worked. CNA N stated he was not sure what he was supposed to say regarding the situation with R9. CNA N stated he had not really witnessed any behaviors from R9, but was aware from other staff that there had been occurrences. CNA N said R9 was forgetful, but that was common from all the residents. CNA N stated the staff were all very fond of R9 and loved him. CNA N said the whole situation that happened with R9, with the discharge, had really messed with R9 emotionally. CNA N stated R9 would cry and be upset frequently, which was not normal for R9. CNA N stated he was aware of a few incidents of inappropriate behavior R9 had towards staff and a few other residents. CNA N said R9 was redirectable, but if R9 was redirected the wrong way, he would have what CNA N called a bad day. CNA N stated he knew when R9 had a bad day because R9 would not want to get out of bed. CNA N said on R9's bad days R9 would repeatedly apologize to the staff. CNA N said he was unaware of any specific interventions regarding R9's behavior and mood changes. CNA N stated staff had not received any special training or new interventions regarding the changes in R9's mood or behaviors. On 03/12/20 at 01:01 PM LN I stated staff had not received any specific training or instructions regarding caring for R9's mood or behaviors. LN I stated R9 had bad days, and on those bad days R9 talked about being anxious and nervous. LN I said R9 would go back to bed. LN I reported R9 had been more tearful recently. On 03/12/20 at 01:20 PM LN G stated staff had not received any specific training or information related to R9. LN G stated staff were very worried about him. R9 was nervous and anxious all the time. LN G stated that began when he received the notice of eviction. LN G said R9 seemed a bit better now, but she was sure he was probably still upset. LN G said staff had not received any communication regarding interventions or supporting needs when the facility issued the notice. LN G said there should have been an in-service or some training to direct staff about what was going on. On 03/16/20 at 03:00 PM Social Service X stated since R9 received the discharge notice he reported increased anxiety. Social Service X said R9 started calling her to check and look for updates. She said one day the previous week he called three or four times in one day. R9 wanted to know if there was anything else he could do to stop the discharge. Social Service X stated she spent a lot of time communicating with R9 and also encouraged R9 to talk to his family. Social Service X stated she thought R9 was active in programs (activities) with no change from his normal routine. She said R9 was more tired recently and took more naps. Social Service X stated increased sleeping and napping could be a sign of depression. She said R9 had anxiety before, but it had certainly heightened due to the recent events. She stated she discussed multiple non-pharmacological interventions with R9 and made suggestions, but R9 was usually not interested. Social Service X stated she had done some informal training with some of the staff regarding R9's mood and behaviors. She said she asked staff to monitor and check on R9 frequently. The facility policy Behavior Assessment, Intervention and Monitoring dated 01/2019 documented the facility would thoroughly evaluate new and changing behavioral symptoms in order to identify underlying causes and address modifiable factors. It listed examples of emotional, psychiatric and/or psychological stressors. Examples listed included, depression, boredom, loneliness, and fear. The policy directed interventions would be individualized and part of an overall care environment that strove to understand, prevent, or relive the resident's distress. The facility failed to provide individualized care and interventions to respond to R9's mental health needs. The facility failed to identify and apply person-centered interventions to alleviate the acute stress, anxiety, and depression for R9 after he received an involuntary discharge notice. The deficient practice resulted in R9's impaired psychosocial well-being at the level of harm as evidenced by increased anxiety, increased need for antianxiety medication, depression, guilt, and weight loss . **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R9's electronic medical record (EMR), recorded [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set ((MDS) dated [DATE] recorded R9 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated he was cognitively intact. R9 had no behaviors, but he hallucinated (sensing things while awake that appear to be real, but the mind created). He used a wheelchair for mobility and required limited assistance of one person for locomotion. The MDS recorded R9 received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and antipsychotic (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions) seven of the seven look back days. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/23/19 documented R9 had occasional instances of short-term memory loss. The CAA for Activities of Daily Living (ADLs) recorded R9 was alert with forgetfulness. He made his needs known and scored 13 on his BIMS assessment. He propelled himself self in his wheelchair and required reminders on safety. He had significant changes with mood, weight loss and incontinence. The CAA recorded he had verbalized changes in his mood. The Mood State care plan, dated 01/06/2020 documented R9 had a mood problem related to depression as evidenced by R9 self-report. It directed staff to administer R9's antidepressant medication and monitor for adverse effects. It further directed staff to observe and document effectiveness of mood enhancement medications and to monitor behaviors and observe for patterns or triggers. Review of the orders, under the orders tab revealed the following physician orders: [MEDICATION NAME] (antidepressant) 15 milligrams (mgs) daily, dated 07/31/19; [MEDICATION NAME] (medication used to treat heartburn) 20 mgs capsule once daily dated 12/28/18; [MEDICATION NAME] (antipsychotic) 50 mg tablet at bedtime dated 10/10/19; [MEDICATION NAME] 100 mgs tablet at bedtime for [MEDICAL CONDITION] /hallucinations dated 11/26/19. Review of the August 2019 electronic Medication Administration Record [REDACTED]. Review of the September 2019 eMAR revealed the [MEDICATION NAME] was documented as not administered on 09/2, 9/3, 9/15 and 9/16 due to the medication was not available. Review of the November 2019 eMAR revealed the [MEDICATION NAME] was documented as not administered on 11/19 due to the medication was not available. The [MEDICATION NAME] was documented as not administered on 11/9, 11/10, and 11/11 due to the medication was not available. Review of the December 2019 eMAR revealed the [MEDICATION NAME] was documented as not administered on 12/26,12/27 and 12/28 due the medication was not available. On 03/11/20 at 11:05 AM R9 sat in his wheelchair, alone, in the common room, and read the newspaper. On 03/16/20 at 11:59 AM Certified Medication Aide (CMA) R stated when a nurse or CMA gave a medication, they documented it on the MAR. When a medication was not available, she looked in the overflow drawer in the medication cart. If the medication was not there, CMA R stated she told the nurse and the nurse called the pharmacy to order the medication. Medication was usually delivered the same day or the next day. If the medication was still not available, it would be documented as unavailable and whether it was ordered. There were times medications were not received. On 03/16/20 at 12:30 PM Licensed Nurse (LN) H stated if there was no medication in the medication cart for a resident, she checked the medication room for availability and if the medication was not there, she told the charge nurse or called the pharmacy herself to reorder the medication. She stated she called right away if a medication was not available. The pharmacy the facility used is open 24 hours. The pharmacy usually delivered medication the same day or the next day. On 03/16/20 at 03:19 AM Administrative Nurse D stated when a resident had a medication due that was not available the nurse or CMA checked the E-kit for medication availability, and if it was still not available the nurse or CMA called the pharmacy to order the medication. A resident should not go without a medication for more than eight to 12 hours. The pharmacy used by the facility is a 24- hour pharmacy. The pharmacy delivers twice a day and on weekends as needed. It usually took no more than eight to 12 hours for a medication to be delivered. A missed medication report was done daily which documented medication not given. An investigation was done to find out why a medication was not given. The facility policy Administering Medications revised April 2019 stated medications were administered in accordance with prescriber orders. The facility failed to ensure medications were available to administer to R9 as ordered by the physician. This deficient practice placed R9 at risk for possible unwarranted and unrecognized medical complications. The facility identified a census of 44 residents. The sample included five residents for medication review. Based on observations, record reviews, and interviews the facility failed to ensure medications were available for administration as ordered by the physician for Resident (R) 10 and R9. Findings included: - The electronic medical record (EMR) for R10 included [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. R10 required one person staff assistance with Activities of Daily Living (ADLs). The Care Area Assessment (CAA) for Cognition dated 12/20/19 documented R10

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	175441	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) responded to yes/no questions and staff anticipated and met her needs. The ADLs Care Plan dated 02/20/2020 documented R10 took multiple medications. The Black Box Warning Care Plan dated 02/20/2020 documented staff monitored R10 for behaviors and adverse effects from medications. The EMR revealed the following orders: calcium [MEDICATION NAME] (a nutritional supplement) one daily dated 12/11/19, losartan (medication used for high blood pressure) 50 milligrams (mgs.) daily dated 12/11/19, vitamin B complex (a nutritional supplement) one daily dated 12/11/19, vitamin C (a nutritional supplement) 500 mgs. one half tablet daily dated 12/11/19, vitamin E (a nutritional supplement) 400 units capsule daily dated 12/11/19, [MEDICATION NAME] (a medication used to treat anxiety) 10 mgs. three times a day dated 12/11/19, [MEDICATION NAME] (a medication used to treat [MEDICAL CONDITION]) 0.25 mgs. twice a day dated 12/11/19 and discontinued on 01/27/20, and folic acid (a supplement) 400 micrograms (mcgs.) daily dated 06/24/19 and discontinued on 10/02/19. Review of the Medication Administration Record [REDACTED]. Documentation in the EMR revealed the medications were not administered as they were not available. On 03/11/20 at 11:15 AM R10 sat in the living room in her wheelchair. She watched a slide show with the activity director and other residents. She sat upright in her wheelchair and smiled and laughed with others. She showed no non-verbal signs of distress. On 03/16/20 at 11:59 AM Certified Medication Aide (CMA) R stated when a nurse or CMA gave a medication, they documented it on the MAR. When a medication was not available, she looked in the overflow drawer in the medication cart. If the medication was not there, CMA R stated she told the nurse and the nurse called the pharmacy to order the medication. Medication was usually delivered the same day or the next day. If the medication was still not available, it would be documented as unavailable and whether it was ordered. There were times medications were not received. On 03/16/20 at 12:30 PM Licensed Nurse (LN) H stated if there was no medication in the medication cart for a resident, she checked the medication room for availability and if the medication was not there she told the charge nurse or called the pharmacy herself to reorder the medication. She stated she called right away if a medication was not available. The pharmacy the facility used is open 24 hours. The pharmacy usually delivered medication the same day or the next day. She reviewed the MAR for R10 and confirmed the medications were not given as ordered. On 03/16/20 at 03:19 AM Administrative Nurse D stated when a resident had a medication due that was not available the nurse or CMA checked the E-kit for medication availability, and if it was still not available the nurse or CMA called the pharmacy to order the medication. A resident should not go without a medication for more than eight to 12 hours. The pharmacy used by the facility is a 24- hour pharmacy. The pharmacy delivers twice a day and on weekends as needed. It usually took no more than eight to 12 hours for a medication to be delivered. A missed medication report was done daily which documented medication not given. An investigation was done to find out why a medication was not given. The facility policy Administering Medications revised April 2019 stated medications were administered in accordance with prescriber orders. The facility failed to ensure medications were available to administer to R10 as ordered by the physician. This deficient practice placed R10 at risk for possible unwarranted and unrecognized medical complications.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 44 residents. The sample included five residents for medication review. Based on observations, record reviews, and interviews the facility failed to ensure the Consultant Pharmacist (CP) identified medications not administered as ordered by the physician for Resident (R)10. Findings included: - The electronic medical record (EMR) for R10 included [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. R10 required one person staff assistance with Activities of Daily Living (ADLs). The Care Area Assessment (CAA) for Cognition dated 01/01/2020 documented R10 responded to yes/no questions and staff anticipated and met her needs. The ADL Care Plan dated 02/20/2020 documented R10 took multiple medications. The Black Box Warning Care Plan dated 02/20/2020 documented staff monitored R10 for behaviors and adverse effects from medications. The EMR revealed the following orders: losartan (medication used for high blood pressure) 50 milligrams (mgs.) daily dated 12/11/19, duloxetine (medication used to treat depression), donepezil (a medication used to treat dementia) 23 mgs daily, and folic acid (a nutritional supplement) 400 micrograms (mcgs.) daily dated 06/24/19 and discontinued on 10/02/19. Review of the Medication Administration Record (MAR) tab of the EMR revealed lack of documentation the following medications were administered in October 2020: donepezil four of 31 shifts, folic acid four of 31 shifts, duloxetine four of 31 shifts, and losartan four of 31 shifts. The record revealed no documentation on these dates why the medications were not given. On 03/11/20 at 11:15 AM R10 sat in the living room in her wheelchair. She watched a slide show with the activity director and other residents. She sat upright in her wheelchair and smiled and laughed occasionally. She showed no non-verbal signs of distress. On 03/16/20 at 11:59 AM Certified Medication Aide (CMA) R stated when a nurse or CMA gave a medication, they documented it on the MAR. No initials in the box meant the medication was not given since it was not initialed as being done, it was presumably not done. On 03/16/20 at 12:30 PM Licensed Nurse (LN) H stated blank spaces in the MAR meant the medication were not given. She reviewed the MAR and confirmed the medications were not given as ordered. On 01/22/20 at 11:48 AM Administrative Nurse D stated a blank space in the MAR meant the medication was not given, or the medication aide had not signed it was given. On 03/17/20 CP GG was unavailable for interview. The facility policy Medication Regimen Review revised April 2007 stated the CP visits the facility monthly and makes recommendations to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. The facility failed to ensure the CP identified medications were not administered as ordered by the physician. This deficient practice placed R10 at risk for unnecessary medication administration, thus leading to possible harmful side effects.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 44 residents. The sample included five residents for medication review. Based on observations, record reviews, and interviews the facility failed to ensure medications were administered as ordered by the physician for Resident (R) 10. Findings included: - The electronic medical record (EMR) for R10 included [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. R10 required one person staff assistance with Activities of Daily Living (ADLs). The Care Area Assessment (CAA) for Cognition dated 01/01/2020 documented R10 responded to yes/no questions and staff anticipated and met her needs. The ADL Care Plan dated 02/20/2020 documented R10 took multiple medications. The Black Box Warning Care Plan dated 02/20/2020 documented staff monitored R10 for behaviors and adverse effects from medications. The EMR revealed the following orders: losartan (medication used for high blood pressure) 50 milligrams (mgs.) daily dated 12/11/19, duloxetine (medication used to treat depression), donepezil (a medication used to treat dementia) 23 mgs daily, and folic acid (a nutritional supplement) 400 micrograms (mcgs.) daily dated 06/24/19 and discontinued on 10/02/19. Review of the Medication Administration Record (MAR) tab of the EMR revealed lack of documentation the following medications were administered in October 2020: donepezil four of 31 shifts, folic acid four of 31 shifts, duloxetine four of 31 shifts, and losartan four of 31 shifts. The record revealed no documentation on these dates why the medications were not given. On 03/11/20 at 11:15 AM R10 sat in the living room in her wheelchair. She watched a slide show with the activity director and other residents. She sat upright in her wheelchair and smiled and laughed occasionally. She showed no non-verbal signs of distress. On 03/16/20 at 11:59 AM Certified Medication Aide (CMA) R stated when a nurse or CMA gave a medication, they documented it on the MAR. No initials in the box meant the medication was not given since it was not initialed as being done, it was presumably not done. On 03/16/20 at 12:30 PM Licensed Nurse (LN) H stated blank spaces in the MAR meant the medication were not given. She reviewed the MAR and confirmed the medications were not given as ordered. On 01/22/20 at 11:48 AM Administrative Nurse D stated a blank space in the MAR meant the medication was not given, or the medication aide had not signed it was given. The facility policy Administering Medications revised April 2019 stated medications were administered in accordance with prescriber orders. The facility failed to ensure that medications for R10 were administered as ordered by the physician. This had the potential for unnecessary medication administration, thus leading to possible harmful side effects.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 11) The facility identified a census of 44 residents. The sample included 20 residents. Based on observations interviews, and record reviews the facility to ensure the use of standard infection precautions for the proper storage and handling of supplemental oxygen tubing for one Resident (R)7 of two residents sampled for respiratory care. Findings included: - The [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. She did not have shortness of air with exertion, at rest, or when she laid flat. She did not use supplemental oxygen. The Quarterly MDS dated [DATE] documented a BIMS score of 13, which indicated intact cognition. She did not have shortness of air with exertion, at rest, or when she laid flat. She did not use supplemental oxygen. The Activities for Daily Living (ADL) Care Area assessment dated [DATE] documented R7 required staff assistance for her ADLs due to muscle weakness. The Comprehensive Care Plan revised 04/25/19 documented R7 was administered supplemental oxygen per the physician order. The oxygen tubing was stored in a plastic bag when not in use. The physician's orders [REDACTED]. to administer supplemental oxygen) as needed for oxygen saturation levels (measure of how much oxygen the blood carried as a percentage of the maximum it could carry) below 90%. On 03/10/20 at 10:40 AM R7 sat upright in her bed without supplemental oxygen use. She had no signs of respiratory distress. The oxygen tubing with attached nasal cannula laid on the floor under her bed. On 03/16/20 at 08:14 AM R7 sat upright in her bed as she used supplemental oxygen per nasal cannula at two liters per minute. She had no signs of respiratory distress. She stated she did not use the oxygen unless she felt short of breath. On 03/16/20 at 01:58 PM Licensed Nurse G stated oxygen tubing was changed weekly. The tubing was stored in a plastic bag when not in use. Oxygen tubing found on the floor was replaced. On 03/16/20 at 03:19 PM Administrative Nurse D stated oxygen tubing was stored in a plastic bag when not in use. Oxygen tubing found on the floor was replaced prior to use. The facility's Oxygen Administration policy dated January 2012 documented the nasal cannula was a tube placed approximately one-half inch into the resident's nose. It was held in place by an elastic band placed around the resident's head. The policy lacked documentation for the storage of oxygen tubing not in use. The facility failed to ensure the use of standard infection precautions for the proper storage and handling of supplemental oxygen tubing for R7. This had the potential for unwarranted respiratory infections.