STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265830	A. BUILDING _____ B. WING _____	05/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KANSAS CITY CENTER FOR REHABILITATION AND HEALTHCA	12942 WORNALL ROAD KANSAS CITY, MO 64145

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

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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** Based on interview and record review, the facility failed to protect four sampled resident's (Residents #1, #2, #3 and Resident #4) out of four sampled residents, when the facility staff failed to implement monitoring and interventions for residents with known behaviors. Resident #1 touched Resident #2's chest area resulting in Resident #2 screaming, and Resident #3 pushed Resident #4 out of his/her wheelchair resulting in Resident #4 sustaining a hematoma (bleeding under the skin due to trauma) to his/her forehead and required emergency treatment. The facility census was 88 residents. Record review of the facility's policy titled, Abuse Prevention Training, dated 11/2017, showed: -Prohibiting, preventing, identifying, recognizing and reporting all forms of abuse, neglect, misappropriation of resident property and exploitation. -Dementia management and understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond; These may include: --Aggressive and or catastrophic reactions of resident. --Wandering or elopement type behaviors. --Resistance to care. --Outbursts or yelling out. --Difficulty in adjusting to new routines. -Identifying person-centered thinking, planning and practice skills to contribute to a community culture of prevention and identification of abuse, neglect and exploitation. -Conflict resolution and anger management skills, including resolving conflicts between staff and residents, visitors and resident and resident to resident conflicts. Record review of the facility's policy titled, Preventing and Prohibiting Resident Abuse, dated 11/2017, showed staff are directed to do the following: -Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect. -Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. -Utilizing resident assessment data to identify potential issues and apply appropriate interventions for the monitoring of residents with behaviors that may lead to conflict or neglect. 1. Record review of Resident #1's facility face sheet showed he/she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. -Cerebral infarction (stroke). -[MEDICAL CONDITION] (paralysis of one side of the body). -Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool facilitys use for care planning), dated 1/2/19, showed: -Brief Interview of Mental Status (BIMS) score of 4 which shows severe cognitive impact. -Extensive assistance from staff required for transfers, dressing and toileting. -Limited assistance from staff required for bed mobility. -Supervision of the resident for eating and ambulating in a wheelchair. -No behaviors were listed as occurring during this assessment period. Record review of the resident's facility records of behaviors dated between 2/15/19 to 9/6/19 showed: -On 2/15/19, he/she had tried to approach female residents in a sexual manner, he/she had brought out his/her private parts and urinated in the hallway or dining room in front of other residents. -On 6/13/19, he/she had continued to back his/her wheelchair into others, where he/she had attempted to invade personal space of both residents and staff. -On 8/23/19, he/she was observed in the TV room reaching out with his/her hand and attempted to rub other residents' leg. -On 9/6/19, he/she was observed by a Certified Nursing Assistant (CNA) in the TV room attempting to touch another resident's legs when the CNA called out to not touch other residents, he/she stopped and was repositioned to another area. Record review of the resident's care plan, dated 9/25/19, showed: -Resident exhibited behavior symptoms such as putting him/herself on the floor, refusing medications, socially inappropriate/verbally aggressive/abusive, physically aggressive/abusive. -Was administered [MEDICAL CONDITION] medications. -The facility was to call the his/her responsible party when he/she refused medications, or when he/she had behaviors to speak with the resident. -Distract resident with activities of interest. -Initiated psychology evaluation as needed. -The Medical Director was notified of inappropriate behavior. -No specific interventions noted for resident sexually inappropriate behaviors. Record review of the resident's facility records of behaviors, dated between 12/27/19 to 2/20/20, showed: -On 12/27/19, he/she was in wheelchair next to another resident sitting on the sofa in TV room, he/she reached for another resident, had attempted to grab at him/her when the nurse intervened and he/she lashed out at nurse. He/She needed to be monitored when in any area with resident of the opposite gender, so he/she did not get close to touch the other residents. -On 12/28/19, he/she had to be redirected away from a resident of the opposite gender this morning, when he/she appeared trying to touch a resident of the opposite gender inappropriately. -On 2/3/20, he/she had increased sexually inappropriate behavior on the unit with other residents of the opposite gender, he/she was sent to the hospital psychiatric unit for evaluation and treatment for [REDACTED]. -On 2/20/20, he/she was in the TV lounge when two residents of the opposite gender yelled for the nurse, he/she was wearing shorts, had pulled and was stroking his/her genitalia, the two residents of the opposite gender stated he/she had done this all the time. Record review of the resident's significant change Minimum Data Set (MDS-a federally mandated assessment tool used for facilities for care planning), dated 3/4/20, showed he/she: -Had BIMS score at 99, which indicates that the resident was incapable of completing the assessment. -Required extensive assistance with Activities of Daily Living (ADL's - transferring, toileting, bathing, getting dressed and continence). -Required supervision once he/she is in the wheelchair for ambulation. -Required supervision for eating. -Behavior was not documented as exhibited. Record review of the resident's progress notes, dated 4/15/20, showed his/her physical examination note from the physician assessed the resident with sexually inappropriate behavior. Record review of the resident's facility records of behaviors, dated 5/9/20, showed he/she was found in another resident of the opposite gender room masturbating. Record review of the resident's nursing progress notes, dated 5/10/20, showed he/she was found in another resident room masturbating on 5/9/20, the physician was notified and he/she remained on one to one staff supervision. Record review of the resident's facility records of behaviors, dated 5/14/20, showed the physician had ordered the medication [MEDICATION NAME] (a medication to restrict the resident sexual propensity). Record review of the resident's Physician Orders, dated 5/14/20, showed the resident received medications that included [MEDICATION NAME] Tablet 2.5 milligram (mg) ([MEDICATION NAME] Acetate) give one tablet by mouth every day shift for sexual behavior. Record review of the resident's nursing progress note, dated 5/23/20, showed he/she had grabbed the chest area of Resident #2 and he/she was moved away from the other resident. 2. Record review of Resident #2's facility face sheet showed he/she was admitted to the facility of 7/3/18, with [DIAGNOSES REDACTED]. -Depression. -Pseudobulbar Affect (involuntary and uncontrollable reaction of laughter or crying that is disproportionate to an event). -Anxiety (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). -Obsessive Compulsive Personality Disorder (a personality disorder characterized by excessive concern with orderliness, perfectionism, attention to details, mental and interpersonal control and a need for control over the environment). Record review of the resident's Care Plan, dated 7/16/18, showed he/she: -Had a self care performance

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 0742 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) deficit related to [MEDICAL CONDITION] and dementia. -Had a mood problem related to [MEDICAL CONDITION]. -Was monitored/documented/reported any risk for harm to self, suicidal plan, past attempt at suicide, risky actions, intentionally harm self, refusing to eat or drink, refusing medications or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Record review of the resident's quarterly MDS, dated [DATE], showed he/she: -Had a BIMS score of 10 (moderately cognitively impaired). -Was independent for bed mobility, needed stand by assist for transfers (cueing) and assistance for toileting. Record review of the facility's investigation regarding the allegation Resident #1 had touched Resident #2's chest area, dated 5/23/20 showed: -On 5/23/20, Agency CNA A entered the main room of the unit and stated, Resident #2 told him/her that he/she (Resident #1) keeps touching me. -Agency CNA A removed the Resident #2 and called the nurse. -Resident #1 was not able to articulate if the event had occurred or not. -Resident #1 was redirected to his/her room and placed on a one to one staffing pattern. -Resident #2 was assessed and found to be without injury. -The responsible party, physician and police were notified. -The facility had substantiated the event had occurred. During an interview on 5/25/20 at 9:30 A.M., Agency CNA B said he/she: -Had never witnessed Resident #1 being sexually inappropriate. -Had never been given any report Resident #1 was sexually inappropriate. -Was not really sure how to look at the resident's care plan for guidance. During an interview on 5/25/20 at 10:15 A.M., the Administrator said: -Resident #1 had previous events involving masturbation. -The physician had prescribed [MEDICATION NAME] a few weeks ago for Resident #1, but now this happened. -He/She had facility managers responsible for monitoring and reporting any resident behaviors during meals and during rounds while at the facility. -He/She provided no documentation facility manager monitoring or description of what the monitoring should have been. -The staff on the locked unit received training upon hire and annually on how to manage dementia (a group of thinking and social symptoms that interferes with daily functioning, an impairment of at least two brain functions such as memory loss and judgment) behaviors. -The locked unit had consistent staff most of the time. -The staff were expected to monitor the residents behaviors every shift on the locked unit. During an interview on 5/25/20 at 11:00 A.M., Agency CNA A said: -He/She recalled the incident with Resident #1 and Resident #2, and said: -It was about 1:30 P.M., when he/she had heard Resident #2 scream that he/she was touched on his/her chest area. -He/She asked another facility staff person to sit with Resident #2, and he/she called the Director of Nursing (DON). -He/She had not witnessed Resident #1 do that before. -He/She had seen Resident #1 masturbate. -When Resident #1 masturbated, he/she closes his/her curtain. -He/She had not seen Resident #1 masturbate in public areas. -He/She said the facility didn't do any type of training, except to have him/her go with another CNA to train on the unit. -He/She had been working at the facility about a month. -He/She had online training where a small portion of the training dealt with behaviors. -He/She thought facility staff were able to look at the residents care plans, but wasn't really sure how to do this. -He/She did not say where or how he/she should monitor resident behavior. During an interview on 5/25/20 at 12:30 P.M., Agency CNA C said: -The staff on the locked unit are not qualified to be back there dealing with the resident behaviors. -He/She had heard through report Resident #1 masturbated a lot in other resident rooms of the opposite gender and touched residents of the opposite gender inappropriately. -He/She was not told to or how to monitor resident behavior. -He/She was not told about what interventions to do for the resident behavior. -He/She was contract agency staff and the staff that work on the locked unit were from a contract agency. -He/She received report on the residents from the prior shift CNA, but was not sure how to find the residents' care plans. During an interview on 6/5/20 at 1:31 P.M., Physician #1 said: -He/She would expect the staff to follow their policy and procedure regarding behavioral monitoring. -He/She had prescribed a medication, [MEDICATION NAME], for Resident #1, in hopes that this may mitigate his/her behaviors. -He/She agreed that the facility staff should monitor the behaviors of the residents to provide appropriate interventions. 3. Record review of Resident #3's facility face sheet showed he/she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. -Unspecified [MEDICAL CONDITION] (delusions, hallucinations, disorganized speech, grossly disorganized speech, grossly disorganized or catatonic behavior). -[MEDICAL CONDITION] ([MEDICAL CONDITION] caused by an outside force, usually a violent blow to the head). -Stroke. -[MEDICAL CONDITION] (brain disease that alters brain function or structure). Record review of the resident's Care Plan, dated 12/5/18, showed: -Resident exhibits behavior symptoms such as choosing not to take his/her prescribed medication. -Resident has actual/potential to demonstrate physical behaviors such as hitting the wall, resident to resident altercations, putting cigarettes out on wall, etc., related to anger. -Analyze key times, places, circumstances, triggers and what de-escalates behavior and document. -Monitor and document observed behavior and attempted interventions. -When resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. Record review of the resident's quarterly MDS, dated [DATE], showed he/she: -Had a BIMS score of 7 (severe cognitive impairment). -Required supervision with Activities of Daily Living (ADL's - transferring, toileting, bathing, getting dressed and continence). -Was independent with eating. -Behaviors were not identified as exhibited. Record review of residents facility progress notes, dated 5/24/20, showed: -Nurse received report from CNA staff that the resident was hearing voices and he/she flipped another resident out of their chair. -Placed on 1:1 supervision and removed from situation. -Resident sent to emergency room for psychological evaluation. -No documented aggresive behaviors for the resident prior to the progress note. Record review of the resident medical record showed no behavioral monitoring. 4. Record review of Resident #4's facility face sheet showed he/she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. -Anxiety. -Depression. -Dementia. -Unspecified [MEDICAL CONDITION]. Record review of the resident's quarterly MDS, dated [DATE], showed he/she: -Had a BIMS score at 99, which indicates that the resident was incapable of completing the assessment. -Required extensive assistance with Activities of Daily Living (ADL's - eating, transferring, toileting, bathing, getting dressed and continence). Record review of the resident's Care Plan, dated 3/28/19, showed: -Resident exhibited behavior symptoms such as socially inappropriate/verbally aggressive/abusive, physically aggressive/abusive, hallucinations, delusions, wandering behavior and does not like to be touched and is combative with staff. -The facility staff should determine the cause of behavior and remove resident to another location if interfering with interest or safety of other residents. -He/She was distracted with activities of interest. Record review of the facility investigation regarding the allegation that Resident #3 grabbed Resident #4's wheelchair and tipped him/her out of the chair, dated 5/24/20, showed: -On 5/24/20, Resident #3 was observed by staff to rise from his/her wheelchair and approached the wheelchair of Resident #4, grabbed a hold of Resident #4's wheelchair and dumped Resident #4 out. -Resident #4 was sent to the emergency room and found to have a hematoma on his/her forehead. -He/She later returned to the facility. -Resident #3 was sent to the emergency room and was then admitted to the psychiatric unit. -The police, responsible party and physician were notified. -Upon return from the hospital, a new plan of care would be established by the Interdisciplinary Team for Resident #3. During an interview on 5/25/20 at 9:15 A.M., the Administrator said: -Resident #3 had a history of [REDACTED]. -On 1/18/20 Resident #3 tried to lunge toward other residents, but the root cause was pain from an abscessed tooth causing agitation. -Resident #3 was currently at the hospital for a psychiatric evaluation. -Upon return to the facility the resident will be placed on one to one supervision until an alternative placement is found. -He/She thought Resident #3's behavior was just random. During an interview on 5/25/20 at 10:00 A.M., Certified Medication Technician (CMT)/Staffing Coordinator D, said: -Resident meal trays were being passed about 11:35 A.M. when all of a sudden Resident #3 rose from a seated position in his/her wheelchair, walked over to Resident #4 and tipped Resident #4's wheelchair forward, and Resident #4 hit the floor. -He/She jumped between the two residents. -Resident #4 had a big goose egg on his/her head. -He/She took Resident #3 to his/her room when, Resident #3 told him/her that the voices in his/her head told him/her to do it. -He/She had education about how to deal with the behaviors on the locked unit. -He/She was unable to describe the education provided to him/her to deal with the resident behaviors on the locked unit. -He/she was unable to report interventions for aggresive behaviors. During an interview on 6/5/20 at 1:31 P.M., Physician #1 said: -He/She would expect the staff to follow their policy and procedure regarding behavioral monitoring. -He/She said that the staff had notified him/her about the behavior of Resident #3. -He/She said that he/she thought that the staff was monitoring the behaviors. -He/She agreed that the staff should monitor the behaviors of residents to provide appropriate interventions. During an interview on 6/8/20 at 2:33 P.M., the DON said: -Agency staff had the same expectation as the facility staff. -The staff were expected to document behaviors in the electronic documentation system PCC (Point Click Care). -The staff had access to the care plans for the residents, but the electronic system is so new to them, they may not have known to look in PCC. -The staff should monitor and know about resident behaviors. MO 538 & MO 540