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 _____	03/12/2020

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to prevent the diversion (the unauthorized removal) of a Scheduled II controlled medication (a medication with a higher potential of dependency and abuse) for one sampled resident (Resident #3) out of nine sampled residents. The facility census was 96 residents. Record review of the facility policy for Controlled Substances dated 1/2020 showed: -The facility staff was to comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of all Schedule II and other controlled substances. -All Schedule II narcotics were to be double locked at all times. -The Charge Nurse on duty was to maintain the narcotic keys at all times. -The Director of Nursing (DON) was to maintain a set up back-up keys for all drug storage areas including the keys to the narcotics storage containers. -The DON was to investigate all discrepancies in the narcotics counts and act accordingly. -The facility nursing staff were to count narcotics at the end of each shift. -The nurse coming on duty and the nurse going off duty were to count the narcotics together. -Unless otherwise directed by the DON, when a resident is no longer receiving a narcotic, the narcotic was to be destroyed and not returned to the narcotics box 1. Record review of Resident #3's Facility Admission Record showed he/she was admitted on [DATE] with the following Diagnoses: [REDACTED]. -Malignant [MEDICAL CONDITION] (a [MEDICAL CONDITION] of the final section of the large intestine which has spread to other areas of the body causing issues with bowel elimination and pain). Record review of the resident's Physician's Order Summary (POS) dated 2/1/20 showed: -The resident was receiving [MEDICATION NAME] HCL (a narcotic drug used for severe pain) 10 milligrams (mg) every morning for pain control. -The resident was receiving [MEDICATION NAME] HCL 10 mg every four hours as needed for pain control. Record review of the Facility Investigation Summary dated 2/17/20 showed: -During the narcotic count the morning of 2/17/20, it was discovered by Licensed Practical Nurse (LPN) A that two narcotic cards were missing from the 400 hall medication cart. -A new narcotic count was completed by the DON and Assistant Director of Nursing (ADON) and it was verified the narcotic count was correct on the narcotic count sheet. -LPN A continued to insist that two narcotic cards were missing, as he/she had worked two days prior, taking care of Resident #3, and at that time the resident still had two cards with [MEDICATION NAME] left in them. -LPN A could not figure out where Resident #3's two cards of [MEDICATION NAME] would have gone in just two days. -A complete narcotic count of all medication carts was completed at that time and all narcotic counts were correct. -During the investigation, the two narcotic count sheets for the missing cards were found with signatures of LPN C and LPN B, neither nurses who were not believed to have worked at the time they were signed. -The narcotic sheets were signed as having been destroyed on 2/12/20. -At that time it was believed that the signatures on the narcotic count sheets were not that of the nurses working at the time. -The DON checked the schedule, Agency Registered Nurse (RN) A was working and assigned to the care for the resident. -The ADON spoke with the pharmacy to see if they could determine who had requested refills on the resident's [MEDICATION NAME]. -The pharmacy said that an emergency fill was called in on 2/3/20 at 5:58 A.M., the note did not document which nurse had made that call. Record review of a phone interview with Agency RN A conducted by the facility DON dated 2/17/20 showed: -Agency RN A was asked if he/she was aware there were two missing narcotic cards from the 400 hall medication cart where he/she had worked. -He/she stated that the counts were correct on his/her shifts and potentially those cards were empty and pulled for the DON's review. -He/she was told the area where the empty cards would have been returned showed the narcotic cards nor the narcotic counts sheets were accounted for. -He/she thought maybe the cards and count sheets had been placed in the wrong area and reassured the DON the narcotic counts were correct on his/her shifts and that he/she knew nothing about missing narcotic cards. Record review of LPN B's written statement dated 2/17/20 showed: -Two narcotic sheets were found in the medication room and on those medication sheets were the words, destroyed 2/12/20 with two signatures. -One of the signatures was LPN B. -LPN B did not destroy any medications on 2/12/20 for the resident. -He/she believed his/her name was forged onto the narcotic sheets. -The signature on the narcotic sheets were not that of LPN B. Record review of LPN C's written statement dated 2/17/20 showed: -Two narcotic sheets were found in the medication room and on those medication sheets were the words, destroyed 2/12/20 with two signatures. -One of those signatures was LPN C. -LPN C did not destroy any medications on 2/12/20 for the resident. -He/she believed his/her name was forged onto the narcotic sheets. -The signature on the narcotic sheets was not that of LPN C. Record review of the Facility Interview with Agency RN A on 2/18/20 completed by the Corporate Nurse Director of Regulatory Compliance showed he/she: -Was asked if he/she was aware of any missing narcotics cards. -Stated he/she was unaware of what could have happened to the missing narcotics cards and that the counts were correct when he/she worked. -Was asked to think back to the shift of 2/16/20 and whether or not he/she had administered any narcotics on his/her shifts. -Stated that he/she recalled administering narcotics to a variety of residents during his/her shifts, but could not recall exactly how many times. -Stated that he/she documented all narcotics that were administered. -Was asked if he/she remembered counting the narcotics cards with anyone in between the evening and night shift as he/she had worked a double shift. -Stated that he/she did not count in between shifts as he/she was not passing off the narcotic keys and had never been directed to count unless he/she was passing off the narcotics keys. -Was directed that he/she should have counted the narcotics cards in between shifts even if he/she was not passing off the narcotics keys. -Was asked if he/she knew the process for counting the narcotics cards, making sure to count each narcotic card against how many medications had been administered and then also count the number of cards in the narcotics box. -Said he/she was aware of the facility process to ensure count of narcotics against administered narcotics. -Was asked if he/she knew what to do with empty narcotics cards and he/she stated that the empty narcotic cards were to go to the DON's mailbox, but other nurses were not always placing the narcotics cards where they belonged. -Was told that the procedure was actually to keep the empty cards in the narcotics books so that the DON could retrieve them once he/she arrived at work each day. -Said he/she was not aware of the policy to keep the empty narcotic cards in the narcotic books. -Was asked if he/she was aware that two narcotics cards were located on 2/12/20, showing that narcotics had been destroyed and it was believed that those narcotics cards had been falsified as the signatures did not belong to the nurses who showed had signed as destroying them. -Said he/she did not work on 2/12/20 and was not aware the signatures appeared to be falsified. -Was told that no one saw the 2/12/20 narcotics sheets in the medications room from 2/12/20 to 2/17/20, the cards were not discovered until 2/16/20, and both nurse managers stated that they did not participate in and/or authorize the destruction of those narcotics and the signatures on the cards were falsified. -Denied knowledge of any of the above. -Was then told that he/she was being suspended pending the completion of the investigation, and notified the police may call him/her as there was a suspicion that he/she had actually misappropriated those narcotics cards and falsified the destruction, dating it back to 2/12/20. -Voiced understanding. Record review of Agency RN A's written statement dated 2/18/20 at 12:01 P.M., showed: -He/she worked 2/16/20 and completed a narcotic count when coming onto work. -He/she administered a variety of narcotics during his/her 16 hour shift. -He/she was not aware that he/she should have counted the narcotics half way through his/her 16 hour shift. -He/she was not aware of any missing narcotics. During an interview on 3/9/20 at 9:45 A.M., LPN A said: -He/she did not realize the narcotic count was off until after his/her day had started and Agency RN A had left for the

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 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) day. -He/she had completed the shift change count with Agency RN A and did not notice a discrepancy at that time. -After the day had started, he/she began to realize that Resident #3 should have had two more narcotic cards for [MEDICATION NAME] 10 mg. -He/she notified the DON. -During the morning narcotic count at 7:30 A.M., on 2/17/20, he/she discovered that two narcotic cards were missing for the resident on the 400 hall medication cart. -A full narcotics count was completed by the DON and ADON comparing the narcotic cards with the narcotic sheets. -He/she was certain that two narcotic cards of [MEDICATION NAME] 10 mg were missing. -Two narcotic sheets for the resident's medications were found in the medication room signed as destroyed on 2/12/20, however, LPN A was sure that the signatures were not those of the nurses listed as having destroyed the narcotics, as the signatures on the narcotic sheets looked nothing like the signatures of these nurses that LPN A was used to seeing. -The Agency RN A frequently worked in the facility had been the nurse assigned to the 400 hall cart for the previous 16 hour evening/night shift. -He/she notified the DON of the discrepancy. -Narcotic counts were done at the end of each shift with the on-coming nurse and the off-going nurse. -If there was a discrepancy in the narcotic count, the nurses performing the narcotic count was to immediately notify the DON. During an interview on 3/9/20 at 12:55 P.M., the DON said: -When he/she arrived at work on 2/17/20, LPN A said there were two narcotic cards missing for the resident. -He/she and the ADON completed a full audit of all the narcotic cards, medications and narcotic sheets to see if there was a discrepancy. -LPN A told the DON that he/she was sure that there were two narcotic cards missing for Resident #3. -LPN A told the DON that the last time he/she worked, there were two more cards of [MEDICATION NAME] 10 mg for Resident #3 and they were no longer in the narcotic cart. -It was not until later that the two narcotic sheets were found showing they had been destroyed. -At this point, the DON and LPN A felt that the signatures on those sheets showing the narcotics had been destroyed, were falsified as they did not appear to be the signatures of those nurses. -The DON spoke with both of those nurses and both denied having destroyed any narcotics on the date listed for that resident as the resident was still getting the [MEDICATION NAME] 10 mg daily. -The DON would have expected that Agency RN A would have counted appropriately in between his/her 16 hour shifts. -He/she believed that Agency RN A misappropriated those narcotics. During an interview on 3/18/20 at 8:35 A.M., Agency RN A said: -He/she worked a 16 hour shift on 2/16/20. -He/she gave a variety of narcotics during his/her shift but did not recall exactly all the residents who received narcotics. -On the morning of 2/17/20 after he/she had left the facility, the DON contacted him/her stating that there were two missing narcotic cards and sheets for Resident #3. -He/she told the DON that the count had been correct and questioned whether those cards had potentially been destroyed and the narcotic sheets not placed in the DON's box as per protocol. -Once the DON re-contacted him/her to let him/her know that they found the two missing narcotic sheets, but the signatures did not appear to be that of the nurses whose signatures were there, and those nurses denied wasting any narcotics, he/she stated that he/she was not working on 2/12/20 and knew nothing about the signatures. -He/she did not take the narcotic cards and did not falsify the signatures of the two nurses. During an interview on 3/24/20 at 2:00 P.M., LPN C said: -He/she did not waste any narcotics on 2/12/20 and did not even have access to the narcotic cart that day. -The nursing staff do not normally do the narcotic destruction without the DON's approval and the cards and sheets were to be given to the DON prior to any destruction. -He/she did not understand why anyone would have destroyed any narcotics for Resident #3 as the resident was still taking [MEDICATION NAME] 10 mg and those medications would not have been destroyed with the resident still needing them. -The signature on the narcotic sheets were not LPN C's signature. Attempts to contact LPN B, who no longer worked at the facility, were made on 3/18/20 at 10:30 A.M., 1:00 P.M., and 2:45 P.M.; on 3/20/20 at 8:15 A.M., 10:15 A.M., and 1:30 P.M.; on 3/23/20 at 7:35 A.M., 10:00 A.M., and 2:15 P.M.; On 3/24/20 at 10:55 A.M., 12:15 P.M., and 2:55 P.M.; and on 3/25/20 at 7:45 A.M., and 12:30 P.M. Messages were left each time with no returned call. MO 005
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to appropriately report an allegation of sexual abuse for one sampled resident (Resident #1) out of nine sampled residents when facility staff failed to report the allegation immediately to their direct line of administration. The facility census was 96 residents. Record review of the facility policy for Reporting Abuse revised on 11/2017 showed: -It was the responsibility of the facility employees to promptly report any suspected incident of abuse to facility management. -The facility did not condone any type of abuse of a resident by any individual. -Sexual abuse was defined as, but not limited to, sexual harassment, sexual coercion or sexual assault. -Employees were to immediately report any suspected abuse to their direct supervisor, Abuse Coordinator, and/or Administrator. 1. Record review of Resident #1's Facility Admission Record showed he/she was admitted on [DATE] with the following Diagnoses: [REDACTED]. -[MEDICAL CONDITION] ([MEDICAL CONDITION]-a narrowing of the arteries in the body causing poor circulation throughout the body). -[MEDICAL CONDITIONS]. Record review of the resident's Nursing Care Plan dated 2/25/20 showed: -The resident had the potential for anxiety due to respiratory issues and [MEDICAL CONDITION]. -The facility staff was to monitor for signs and symptoms of anxiety. -The facility staff was to offer support, encourage him/her to vent frustrations/fears and treat as indicated. -Educate the resident as to support groups available to assist with medical issues and anxiety. Record review of the resident's discharge Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 2/25/20 showed he/she: -No Brief Interview for Mental Status (BIMS-a test used to determine the cognitive level of a person at the moment the test was performed). -Was assessed as having no memory problems. -Had no behaviors. -Required extensive assistance for all daily activities except for eating. Record review of the resident's Nurse's Notes showed no documentation related to the resident's allegation of being raped. During an interview on 3/9/20 at 12:15 P.M., Hospital Registered Nurse (RN) A said: -The resident arrived into the Hospital emergency room around 8:15 A.M., on 3/9/20. -The resident had shown multiple medical issues including a low body temperature, low blood sugar and a history of being unresponsive earlier in the morning. -After the resident had been a patient in the Hospital emergency room for a few hours, he/she shared with Hospital RN A that he/she had been taken out into the cold at the facility and raped by three African American persons. -The resident did not answer any more questions for the emergency room staff. During an interview on 3/9/20 at 1:30 P.M., the resident said: -Around 3:00 A.M., on 3/9/20 three African American persons worked at the facility, came in his/her room around 3:00 A.M., and took him/her out of his/her room outside to rape him/her. -He/she fought back with a small pair of scissors he/she had in his/her pocket. -He/she crammed the scissors into one of the assailant's stomach, and pulled the scissors down hard. -The scissors caused the one assailant to have a scar on his/her stomach. -After he/she cut the one assailant, another assailant beat the[***]out of me hitting me in my chest and stomach. -His/her roommate saw the whole incident. -The same assailants raped a nurse at the facility also. -One of the assailants was wearing a Dodgers t-shirt. -The assailants were driving a van that had MO Pets written on the side. Note: The assessment of the resident in the Emergency Department did not show any signs of assault such as bruising or cuts. The Emergency Department physicians did not elect to do a rape kit due to the resident not showing any signs of assault. During an interview on 3/9/20 at 3:00 P.M., Certified Nursing Assistant (CNA) A said: -The resident turned on his/her light early the morning of 3/9/20. -The resident was upset and crying. -The resident was talking about having been raped and described three assailants who had raped him/her. -CNA A told the resident that there were no people working there or in the facility who met that description and reassured the resident he/she was safe. -CNA A did not tell anyone in Administration because he/she thought the resident was dreaming. During an interview on 3/10/20 at 10:25 A.M., Registered Nurse (RN) A said: -The resident told him/her that he/she had been raped sometime in the night. -He/she heard the resident yelling and went into his/her room. -When RN A asked the resident why he/she had been raped saying, that guy raped me. -When RN A asked the resident who he/she was talking about, the resident pointed to the sink in his/her room. -The resident then closed his/her eyes and went back to sleep. -RN A said he/she did not report the rape allegation to Administration because the resident had medical issues and had to be sent to the hospital and he/she got busy and forgot to report it. During an interview on 3/11/20 at 2:00 P.M., the Director of Nursing (DON) said: -He/she had suspended RN A and CNA A as they had not appropriately reported an alleged rape. -He/she did not know why they did not report immediately as the facility staff members knew that was the facility policy. -He/she would have expected the facility staff members to have reported the alleged rape. MO 690