STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265721	A. BUILDING _____ B. WING _____	05/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREGORY RIDGE HEALTH CARE CENTER	7001 CLEVELAND AVENUE KANSAS CITY, MO 64132

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 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** Based on observation, interview, and record review, the facility failed to protect one resident (Resident #1) from sexual abuse when Licensed Practical Nurse (LPN) A came onto the resident's unit and engaged in a sexual act with the resident. The facility failed to further protect Resident #1 when LPN A was allowed to continue his/her shift after the abuse allegation was made. Additionally, the facility failed to protect Resident #1 when, during the investigative process, the staff department heads were interviewing Resident #1 and placed him/her in a two-man hold (restraining the resident) when he/she wanted to leave the room and not watch the video any longer resulting in bruising on the resident's wrists and arms. The facility census was 114 residents. The Administrator was notified on 5/21/20 at 3:24 P.M., of the Immediate Jeopardy (IJ) which began on 5/16/20. The IJ was removed on 5/21/20, as confirmed by surveyor onsite verification. Record review of the facility Abuse, Neglect, Grievance Policy and Procedure, dated 11/28/16 and revised on 8/28/18, showed: -It is the policy of the facility that every resident has the right to be free from any physical or chemical restraints. -Mistreatment, neglect or abuse of residents is prohibited by the facility. -This facility will not employ individuals who have been convicted of abusing, neglecting or mistreating individuals. -The facility is committed to protecting our residents from abuse by anyone including, but not limited to facility staff, other residents, consultants or any other individuals. -Sexual Abuse - Causing a resident to touch an employee for sexual purposes. -Mental Abuse includes either verbal or nonverbal conduct which causes, or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. -During orientation of new employees the facility teaches sensitivity to resident rights, resident's needs and what constitutes physical, sexual, verbal and mental abuse. -On a periodic basis, staff will receive a review of the above topics. -Employees are required to immediately report any occurrences of potential neglect, abuse, sexual assault, misappropriation of property and injury of unknown source to a supervisor or the administrator. -The abuse, neglect, exploitation or sexual assault are reported immediately, but no later than two hours after the allegation is made to other officials including State Survey Agency in accordance with State law through established procedures. -The facility shall immediately call 911 to involve the police department when there is abuse. -Employees of this facility who have been accused of mistreatment will be immediately removed from contact with any residents and must leave the facility pending the results of the investigation and review by the administrator. -Employees accused of possible mistreatment shall not complete the shift and will immediately be sent home. Record review of the facility Behavioral Emergency Policy, dated 4/6/17, showed: -Provide safe treatment and humane care of the residents in a behavioral crisis. -Ensure that the resident is not being coerced, punished or disciplined for staff convenience. -There are only two reasons that staff will utilize approved Crisis and Aggression, Limitation and Management (CALM- best practice principles in de-escalation and physical intervention. Physical intervention or physical restraint can only be used where all other intervention strategies have been ineffective and there is immediate danger of physical harm to individuals and there is no danger, where doing so, of placing that staff member in immediate danger of physical harm). -Approved CALM hold techniques are never utilized for punitive reasons, discipline or for staff convenience. -Each resident who has an increased potential for aggressive behavior toward self or others, or shows a history of harm to self or others will have an assessment completed upon admission or prior to the use of approved supportive CALM take down techniques. -A resident who displays or is assessed as having physical/medical limitations and is assessed to be clinically inappropriate to use approved CALM supportive take down techniques will be placed on the Behavior Management/Care List with the acronym STOP (Supportive Techniques Oversight Protection). -Other supportive methods to control behaviors will be outlined in the plan of care individually for those residents in a behavior emergency crisis. -After every utilized CALM hold technique, the director of nursing (DON)/designee will complete a Registered Nurse Investigation of the occurrences regarding the resident's behavior and staff responses. -The physician and legal guardian must be notified and this should be a part of the individualized plan of care. -The licensed nurse will document the behavioral emergency (define behavior, interventions, reaction/response, plan and evaluation) in the resident's medical record. -Any resident who requires approved CALM hold techniques must have a complete skin assessment with vital signs monitored for 72 hours. -The physician and legal guardian will be notified of assessment findings and other concerns regarding the resident's behavior emergency crisis. 1. Record review of Resident #1's Face Sheet, dated 5/11/19, showed the resident was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. -Major [MEDICAL CONDITION] (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). -Anxiety Disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). -Impulse Disorder (a person has trouble controlling emotions or behaviors). -Post-Traumatic Stress Disorder ([MEDICAL CONDITION] - a disorder in which a person has difficulty recovering after experiencing or witnessing a shocking, scary, or dangerous event). Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning), dated 12/23/19, showed: -The resident had a Brief Interview for Mental Status (BIMS - is used to assess cognitive status in residents) score of 15 out of 15 (indicating the resident was cognitively intact). Record review of the resident's Care Plan, dated 12/23/19, showed: -Behavior: Risk for episodes of agitation/anger/behavior resulting in the need for Code Green (used to help get more staff on the unit to help with behaviors) to be called and CALM techniques will be used as needed. -Ascertain if the resident is on the STOP Program. -Remove from public area when behavior is disruptive and unacceptable as needed. -Administer medication as prescribed and monitor effectiveness. -Allow the resident to verbalize and ventilate feelings. -Provide 1 to 1 attention to resident as needed. -Redirect as able/needed to encourage positive behavior choices. -Identify causes for the behavior and reduce factors that may provoke the resident. -Discuss options for appropriate channeling of anger. -Assist in selection of appropriate coping mechanisms. -Provide reality orientation, remaining calm, encouraging, and non-judgmental. -If current interaction is not de-escalating the situation or the resident is becoming more upset, allow staff member with best rapport with the resident to intervene and attempt to resolve and calm the resident. -If experiencing hallucinations, allow the resident to express his/her thoughts/fears while maintaining eye contact and removing unnecessary external stimuli. -Attempt to ascertain what the resident would need/accept to calm down and provide if able. -If resident smokes, allow him/her to smoke with supervision to assist with de-escalation. -After situation resolves, place on 1 to 1 for protective oversight. -Notify physician, administrator, DON, family/guardian of need for CALM hold and results. -Send out to the hospital for evaluation/medication adjustment if ordered. Record review of the resident's Physician order [REDACTED]. -May have Behavioral Therapist consult as needed. 2. Record review of Resident #2's Face Sheet, dated 2/21/20, showed the resident was admitted to the facility on [DATE] and readmitted on [DATE], with the following Diagnoses: [REDACTED].

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) -[MEDICAL CONDITION] Disorder. -Attention-Deficit [MEDICAL CONDITION] Disorder (ADHD, a developmental disorder typically characterized by a persistent pattern of inattention and/or [MEDICAL CONDITION] - a physical state in which a person is abnormally and easily excitable or exuberant, as well as forgetfulness, loss of control or impulsiveness, and distractibility). -[MEDICAL CONDITION] (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others). -Mood (affective) Disorder (are illnesses that affect the way you think and feel and can be dramatic or extreme changes of mood). Record review of the resident's annual MDS, dated [DATE], showed: -The resident had a BIMS score of 15 out of 15 (indicating the resident was cognitively intact). 3. Record review of Resident #6's Face Sheet dated 12/25/19, showed the resident was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. -Major [MEDICAL CONDITION]. -Obsessive-Compulsive Disorder (OCD - is an anxiety disorder characterized by intrusive thoughts that produce uneasiness, apprehension, fear, or worry; by repetitive behaviors aimed at reducing the associated anxiety; or by a combination of such obsessions and compulsions). -Anxiety Disorder. -Auditory hallucinations (false perceptions of sound). Record review of the resident's quarterly MDS, dated [DATE], showed: -The resident had a BIMS score of 15 out of 15 (indicating the resident was cognitively intact). Record review of Resident #1's Nurse's Note, dated 5/16/20 7:00 P.M. to 7:00 A.M., showed: -At approximately 10:50 P.M., Resident #1 came to the Nurse's station and told LPN B to get his/her phone and go to Resident #1's room. -Resident made sexual allegations toward LPN A. -Resident #1 stated that they had oral sex and had been witnessed by another resident. -No bruising, bleeding or pain noted at this time. -Administrator notified. Record review of Resident #1's Nurse's Note, dated 5/17/20 at 7:00 A.M., showed: -Resident #1 was monitored by LPN B, all through the shift. -Resident #1 rested well, no concerns voiced during the rest of the shift. -No bruising, pain or genitalia bleeding noted. -Resident #1 went to bed at approximately 12:45 A.M. -Resident #1's safety made priority with frequent safety checks. Record review of Resident #1's Nurse's Note, dated 5/17/20 7:00 A.M. to 7:00 P.M., showed: -Reported to this charge nurse, LPN C, allegations continue from last night. -Direct supervisor and police were notified of the incident. -Police report was filed and Resident #1 was sent to the hospital for evaluation and treatment at 4:30 P.M. -Guardian notified as well as all responsible parties. -Resident remains in the hospital for further testing while results pending. Record review of the Registered Nurse (RN) Investigation Report, dated 5/16/20 at 11:05 P.M., showed: -Resident #1 reported to charge nurse, LPN B, that he/she was allegedly sexually assaulted by LPN A in his/her room. -Resident #1 was helping LPN A with his/her personal laptop when LPN A reached out and slid his/her hand under Resident #1's night clothes and caressed his/her body. -Resident #1 smacked LPN A's hand away and told him/her no. -Resident #1 continued to work on LPN A's laptop when Resident #2 entered Resident #1's room and asked LPN A to go to the store for him/her. -LPN A left Resident #1's room and went to the store for Resident #2. -LPN A returned from the store and entered Resident #1's room and watched Resident #1 work on the laptop. -LPN A was standing on the left side with his/her back to the door obstructing his/her view of the hallway. -Resident #1 states LPN A unzipped his/her pants and produced his/her genitalia and instructed Resident #1 to give me head (oral sex). -Resident #1 stated he/she told LPN A no, but LPN A then put the resident's head down and forcefully opened his/her jaw. -He/She opened his/her mouth, because he/she did not want any bruising, that is when LPN A put his/her genitalia in Resident #1's mouth. -LPN A started to ejaculate in the resident's mouth then LPN A said Oh[***]and went to the bathroom to finish in the toilet. -He/She still had seminal fluid in his/her mouth and swallowed it. -LPN A then left Resident #1's room and the unit. -Resident #1 stated he/she felt sick to his/her stomach, but did not puke. -Resident #1 went to LPN B and asked him/her to come to his/her room, because LPN A was just in there and put his/her thing in my mouth and that is his/her sperm in the toilet. -Resident #2 witnessed it and told CNA A about what he/she had just seen. -Resident #1 stated that LPN A has been fingering him/her when he/she is awake and asleep. -He/She has not told anyone due to [MEDICAL CONDITION]. -He/She does not know what gave him/her the courage to report the behavior now. -LPN B assessed Resident #1 for bruising, none was found on the face or body and no bleeding from the genitalia area. -The investigation began. -The administrator, Assistant Director of Nursing (ADON), the regional office, and guardian were notified of the alleged sexual abuse. -The police were notified on 5/17/20 at 9:00 A.M. -Police were on site 5/17/20 at 4:30 P.M. -Resident #1 was sent to the hospital on [DATE] at 4:30 P.M. -Call received from the hospital at 9:00 P.M., stating Resident #1 had evidence of sexual abuse. -Resident #1 returned back to the facility on [DATE] at 1:00 A.M. Record review of Resident #1's Police Report, dated 5/17/20 at 3:13 P.M., showed: -The police were called to the facility in regard to a sexual assault. -Upon arrival LPN C was contacted by the police officer. -LPN C was informed by LPN B that Resident #1 was sexually assaulted by LPN A. -LPN C advised he/she was told by Resident #1 that LPN A had fingered him/her and forced him/her to perform oral sex on him/her on 5/16/20. -The officer contacted Resident #1 who stated the following: --On 5/16/20 around 10:30 P.M. or 11:00 P.M., LPN A brought a laptop to his/her room for him/her to download MP3 music off of. --LPN A stated he/she wanted Resident #1 to download an anti-virus software on his/her laptop in exchange for the music, in which Resident #1 agreed to. --LPN A was sitting down at a desk while Resident #1 stood next to LPN A slightly leaning over LPN A to download the software. --While Resident #1 was leaning over, LPN A reached behind Resident #1 and up through the bottom of his/her clothing, placing his/her fingers inside his/her genitalia. --Resident #1 told LPN A to stop, in which he/she did. --LPN A then stood up and stated he/she was going to the store to get something for another resident. --LPN A returned approximately five minutes later to Resident #1's room. --LPN A then stood in front of Resident #1, who was sitting at his/her desk, and unzipped his/her pants. --At this time, LPN A told Resident #1 to give him/her a hand job in which he/she stated no. --LPN A then grabbed Resident #1 by the head with both of his/her hands and pushed his/her head onto his/her genitalia forcing him/her to perform oral sex on him/her for approximately 30 seconds. --During this time, Resident #1 stated LPN A ejaculated in his/her mouth, which he/she then swallowed. --Resident #1 stated LPN A then went to the restroom. --Before leaving the room, LPN A stated to Resident #1 to be quiet and stay out of the hallway because it will make him/her look guilty, and to not tell anyone. --LPN A then pushed Resident #1 onto the bed and exited the room. --Resident #1 advised this has been going on for approximately three weeks, but has been too scared to say anything. --Resident #1 stated there has been nights where he/she has woke up during the night with LPN A over him/her and his/her legs spread apart. --LPN C advised LPN A is not currently working at the facility while the facility conducts their own investigation of the incident. --Resident #1 advised that Resident #2 may have witnessed the incident. --Resident #1 and his/her guardian agreed to get a Sexual Assault Nurse Examiner (SANE - a forensic nurse conducts assault evidentiary exams for sexual assault, rape and abuse) exam completed. --The facility agreed to save the camera footage of the hallways for the date and time of the incident. Record review of Resident #1's Hospital Report, dated 5/17/20, showed: -The resident was admitted to the emergency room at 5:38 P.M. -The resident presents to the emergency department for a SANE exam. -The resident has had a staff member that has been forcing him/her to perform oral sex and stated the staff member had been sticking his/her fingers in his/her genitalia. -He/She is not his/her own guardian. -The resident will be discharged back to the facility. Record review of Resident #1's Nurse's Note, dated 5/17/20 7:00 P.M. to 7:00 A.M., showed: -At approximately 9:00 P.M., the hospital notified the facility that Resident #1 was not coming back to the facility. -Resident #1 wanted to get placement in a sister facility. -The hospital nurse notified LPN B that there was evidence of sexual abuse and it was not safe for Resident #1 to return to the facility. -The hospital nurse was referred to the administrator. -At 11:15 P.M., hospital nurse called LPN B and stated that Resident #1 was able to come back to the facility if the alleged nurse, LPN A, was not working. -Resident #1 was safe to come back to the facility, administrator was notified. Record review of Resident #1's Nurse's Note, dated 5/18/20 at 1:00 A.M., showed: -The resident returned back to the facility by ambulance. -Resident in pleasant mood. -New order per hospital physician standard STD (an infection transmitted through sexual contact, caused by bacteria, viruses, or parasites) cultures within two weeks. -Follow up with facility physician. -Administrator and DON notified of the resident's return to the facility. -At 6:30 A.M., resident rested well during night, no acute distress noted, and no concerns voiced during shift. -No time given, resident demonstrated brief violent outburst upon returning from unit meeting with administrative staff. -Resident easily redirected and medication compliant without any further behaviors or concerns. -Resident noted to be tearful while lying in bed and did not come out of his/her room throughout the evening. -Resident able to validate feelings and advises this charge nurse, he/she needs to make a phone call to gain permission to smoke on 1 to 1 supervision. -He/She was tearful because of being back at the facility and the sexual abuse. He/She did not feel safe staying at the facility. -Request was denied. Will continue on 1 to 1 monitoring. Record review of Resident #1's Resident Statement, dated 5/16/20, showed: -To whom it may concern LPN A had been fingering him/her when he/she is asleep. LPN A had also been making him/her give LPN A oral sex for everything that LPN A buys him/her. Record review of LPN A's Employee Written Statement, dated 5/19/20, showed: -On Friday 5/15/20, Resident #1 asked him/her to help get an ear piece to a resident on two south and to ask that resident if Resident #1 could get the computer

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) so Resident #1 could download some music. -The computer was not usable because the computer had [MEDICAL CONDITION]. -LPN A promised Resident #1 to help him/her with one of his/her computers from home the next day. -On Saturday 5/16/20, LPN A brought the computer and notified LPN B that he/she would be in Resident #1's room to work on the computer. -LPN A was in Resident #1's room for about three minutes, while Resident #1 was in and out of his/her room constantly. -When this was done, LPN A went to the store for some energy drinks for Resident #2. -LPN A came back from the store and gave Resident #2 the energy drinks that he/she asked LPN A to go and buy for him/her and then took an ice cream bar for Resident #1. -By then Resident #1 was working on the computer, LPN A stepped in to see if Resident #1 was downloading on the computer. -While LPN A was standing with his/her back to the door, Resident #2 walked into Resident #1's room with some candy and stood for a while looking as Resident #1's head was down. -Resident #1 lifted his/her head and asked what to Resident #2. -Resident #2 left Resident #1's room. -LPN A stayed for a little while and walked out of Resident#1's room, spoke with LPN B and went to the kitchen and filled his/her water bottle. -LPN A left the women's unit and returned later with the midnight census, left for three north and returned on three south unit with some medications. -LPN A saw Resident # 1 on the hallway standing and LPN A asked Resident #1 to step into his/her room, which he/she did. -LPN A left the unit and did not return the rest of the night until the early hours between 3:30 A.M. and 4:30 A.M. That is when the nurse notified him/her of Resident #1's complaint. -At this time LPN A was getting ready for his/her morning routine and end of shift at 7:00 A.M. -He/She was called by the administrator while at home and suspended pending investigation. Record review of Resident #2's Written Statement, dated 5/18/20, showed: -He/She does not know what time it was on Saturday night 5/16/20, when he/she had asked LPN A to go to the store for him/her to get an energy drink. -He/She had asked LPN A to go to the store for him/her. -LPN A said he/she would think about it. -About 10 minutes later LPN A went to the store. -LPN A brought Resident #2's drink to his/her room and left. -Resident #2 went to Resident #1's room about 15 to 20 minutes later. -Resident #2 walked into Resident #1's room and saw LPN A standing with his/her back to Resident #2. -Resident #2 saw Resident#1's head at LPN A's crotch. -Resident #2 called Resident #1's name and Resident #1 looked around LPN A and wiped his/her mouth and said what. -Resident #2 then went and told CNA A. -Resident #2 and CNA A went to Resident #1's room and LPN A was in Resident #1's bathroom. -Resident #1 wiped his/her face and was smiling. Record review of CNA A's Employee Statement, dated 5/17/20, showed: -Resident #2 asked him/her if he/she could take some money back to Resident #1. -When Resident #2 came back to the room, he/she was shocked because of what he/she had just witnessed. -Resident #1 was sitting in a chair and LPN A was standing very close to Resident #1 and Resident #2 heard sounds and motions of Resident #1 giving LPN A oral sex. -CNA A asked how did he/she know if that is what he/she was really doing and Resident #2 said Resident #1 looked up wiping his/her mouth. -While CNA A talked to Resident #2 and tried to calm him/her down, Resident #1 had went to LPN B before CNA A and Resident #1 told on his/herself. Record review of LPN C's Employee Statement, dated 5/17/20, showed: -Upon arriving at the facility for his/her shift, Resident #1 asked if he/she could come to his/her office. -Resident #1 came into his/her office and started telling him/her about an incident that occurred last night with him/her and a staff member (LPN A). -Resident #1 stated that he/she had asked LPN A to use his/her old computer to download music on. -LPN A brought up the computer. As he/she was setting up the computer LPN A spread his/her legs apart and attempted to finger him/her. -Resident #1 stated he/she slapped LPN A's hand away and told LPN A, he/she can handle it from here. -LPN A left the room and the resident's unit. -LPN A returned to Resident #1's room. As he/she was sitting in a chair, LPN A unzipped his/her zipper and told him/her to give LPN A a hand job. -When Resident #1 told LPN A no, LPN A held Resident #1's face and head and told him/her to open his/her mouth and LPN A put his/her genitalia in Resident #1's mouth. -All the lights were on and the door was open. -Resident #1 was assessed for any bruising or pain, which Resident #1 denies. -No bruising noted. Record review of Resident #6's Written Statement, dated 5/18/20, showed: -Starting approximately 2 weeks ago and continuing each night that LPN A would go into Resident #1's room at night and LPN A worked until Saturday 5/16/20. -Resident #6 stated, I stand in my doorway a lot and about 2 weeks ago I witnessed LPN A come onto the unit on Thursday, Friday, Saturday and Sunday. -Resident #1 calls LPN A into his/her room, at first Resident #6 thought that they were just talking. -Resident #1 had been showing up with money. -On two occasions with a $10 and a $20 dollar bill after seeing LPN A go into Resident #1's room. -Resident #6 asked Resident #1 where he/she got that money. -Resident #1 would say, My little secret, my little secret. -It is always right after LPN A left Resident #1's room. -Sometimes when LPN A went into Resident #1's room, the door was open and sometimes the door was shut. -He/She never saw Resident #1 and LPN A. They were always behind the wall out of eyesight. -It was always quiet when the door was open, never any talking when the door was open. -When the door was shut, LPN A was usually in Resident #1's room for about 10 minutes. -On Sunday, 5/17/20, Resident #1 came to Resident #6 and told him/her that oral sex was forced. -Resident #1 told Resident #6 that LPN A pushed his/her head down and gave LPN A oral sex. Record review of the ADON's Employee Written Statement, dated 5/20/20, showed: -He/She interviewed Resident #1 on 5/18/20 at 9:30 A.M., regarding alleged rape on 5/16/20. -Resident #1 stated he/she had asked LPN A if he/she could use LPN A's laptop to download music. -LPN A came to Resident #1's room and while assisting with computer setup LPN A made inappropriate sexual advances. -Resident #1 stated LPN A entered his/her room while he/she was bent over in her closet, LPN A came over and lifted his/her night clothes and inserted three of his/her fingers into Resident #1's genitalia and wiggled then around for about 10 - 15 seconds. -LPN A then left Resident #1's room and went to the store for another resident. -LPN A came back into Resident #1's room stood next to Resident #1 while he/she was typing and LPN A unzipped his/her pants pulled out his/her genitalia and told Resident #1 to suck his/her genitalia. -Resident #1 refused, LPN A forcefully placed Resident #1's (face) near his/her genitals, used his/her hand to open Resident #1's mouth and inserted his/her genitalia. -LPN A moved his/her hips in a back-and-forth motion until he/she ejaculated a little in Resident #1's mouth and the rest in trash can. -LPN A then left the room and Resident #1 notified LPN B immediately. -When he/she asked Resident #1 why he/she did not notify staff of the first incident, Resident #1 said he/she was having a [MEDICAL CONDITION] flashback of previous rape in the past that caused him/her to be scared. During an interview on 5/18/20 at 4:10 P.M., Resident #1 said: -Between 10:00 P.M. and 11:00 P.M., Resident #1 was in his/her room when LPN A entered Resident #1's room with his/her laptop. -Resident #1 had told LPN A that he/she could download an anti-virus program on LPN A's laptop since it was an older computer. -LPN A left Resident #1's room and went to the gas station down the road for another resident. -When LPN A returned, he/she sat down in Resident #1's chair and asked Resident #1 if he/she would show him/her how to download the anti-virus program for the future. -Resident #1 was dressed in his/her night clothes. -Resident #1 was leaning over to show LPN A how to download the program. -Resident #1 asked LPN A to please move out of his/her chair. -Before LPN A moved out of the chair, LPN A reached up Resident #1's night clothes and was rubbing his/her body. -Resident #1 asked LPN A what he/she was doing and LPN A removed his/her hand from under the night clothes. -LPN A got up out of the chair and the resident sat down in the chair. -Then LPN A unzipped his/her pants. -The resident asked LPN A what he/she was doing and LPN A told the resident he/she was going to give him/her oral sex and LPN A pulled out his/her genitalia -Resident #1 said he/she told LPN A no and would not open his/her mouth. -The resident said LPN A took both of his/her hands and pushed on the resident's jaw just hard enough to get the resident to open his/her mouth, but not hard enough to cause bruising. -LPN A put his/her genitalia into the resident's mouth and started moving the lower part of his/her body back and forth while holding the back of the resident's head. -That is when Resident #2 came into Resident #1's room to return six cents Resident #2 owed Resident #1. -Resident #2 saw Resident #1 pull his/her head up from LPN A's crotch. -LPN A went into Resident #1's bathroom and finished what he/she was doing and left the room. -Resident #1 went down to the nurse's station upset and told LPN B to get his/her phone and to come to his/her room with him/her. -Resident #1 told LPN B that LPN A had forced him/her to have oral sex and showed LPN B a mucus like substance in the toilet and said it was LPN A's mucus like substance. -Resident #1 wanted LPN B to take a picture of the substance in the toilet. -Resident #1 told LPN B to get the administrator on the phone because he/she want to talk to him/her about the incident. -He/She never got to talk to the administrator. -LPN B tried to get Resident #1 out to the vending area so LPN A could talk to him/her, but he/she was too scared to go out and talk to LPN A. -Resident #1 said he/she was shaking and crying because LPN A was still in the facility and he/she was scared of LPN A. -He/She does not feel safe living at the facility. -Everywhere he/she looks, he/she sees LPN A's face. -He/She cannot sleep or eat and has no one to talk to about the incident. -He/She just wants to go somewhere he/she is safe. -The police came to the facility finally on Sunday, 5/17/20 and that is when the facility sent him/her to the hospital for a rape exam. -He/She has signs of sexual trauma and was bleeding in his/her genitalia. -He/She said that while sitting in the chair that same day LPN A spread his/her legs open and stuck 3 fingers in his/her genitalia area, that is how he/she got scratched and why he/she was bleeding. Observation on 5/18/20 at 4:10 P.M., showed: -Resident #1 was very emotional and crying during the interview. -He/She had no visible bruises at that time on his/her face, arms, or body. During an interview on 5/19/20 at 10:08 A.M., LPN A said: -He/She brought in his/her old

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	265721	A. BUILDING _____ B. WING _____	05/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREGORY RIDGE HEALTH CARE CENTER	7001 CLEVELAND AVENUE KANSAS CITY, MO 64132

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	(continued... from page 3) laptop for Resident #1 to download anti-virus on. -Resident #1 then would use the laptop to download music on his/her MP3 player. -Resident #2 had begged him/her to go to the store for him/her to get an energy drink for him/her. -He/She bought two waters for him/her, an ice cream bar for Resident #1 and an energy drink for Resident #2. -He/She went to Resident #1's room and stood by the table with his/her back towards the door. -He/She was watching what Resident #1 was doing to the laptop, so he/she could know how to download the anti-virus program in the future. -Resident #1 had his/her head looking down while working on the laptop. -Resident #2 came into Resident#1's room to give Resident #1 a piece of candy. -Resident #1 raised his/her head and asked Resident #2 what. -He/She filled his/her water bottle and went downstairs to another unit. -He/She brought around the midnight census around midnight and then went back downstairs for the rest of his/her shift. -He/She did not find out about the alleged assault until around 3:00 A.M., from LPN B. -He/She did not have Resident #1 ever give him/her oral sex. -He/She had not ever put his/her fingers in Resident #1's genitalia. -He/She was not suspended until after he/she finished his/her shift. During an interview on 5/18/20 at 3:16 P.M., witness Resident #2 said: -On Saturday night he/she w
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 follow facility abuse and neglect policy to report timely to the State Agency (SA) sexual abuse of one sampled resident (Resident #1) out of nine sampled residents. The facility census was 114 residents. Record review of the facility Abuse, Neglect and Grievance Policy and Procedure, dated 11/28/16 and revised on 8/28/18, showed: -Sexual Abuse was defined as any touching, directly or through clothing, of a consumer for sexual purpose, or in a sexual manner, this includes but is not limited to the following: Kissing, touching genitals, buttocks, or breast. Causing a consumer to touch employee for sexual purposes, promoting or observing for sexual purpose any activity or performance involving consumers including play, motion picture, photography, dance, or other visual or written representation. This also includes failure to intervene or attempt to stop or prevent inappropriate sexual activity or performance between consumers. -Employees are required immediately to report any occurrences of potential mistreatment including alleged violations, mistreatment, neglect, abuse, and sexual assault, injuries of unknown sources and misappropriation of resident property the staff observe, hear about or suspect to a supervisor or the administrator. -If such incidents occur after hours the administrator or designee and the director of nursing (DON) or designee will be notified at home or by cell phone and informed of any such incident. -Employees are required immediately to report any occurrences of potential mistreatment including alleged violations, mistreatment, neglect, abuse, sexual assault, injuries of unknown sources and misappropriation of resident property, no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious injury, to the administrator of the facility and to other officials (including State Survey Agency) in accordance with State law through established procedures. -The facility shall immediately call 911 to involve the police department when there is physical abuse, sexual abuse or a crime is committed in the facility. 1. Record review of Resident #1's Face Sheet, dated 5/11/19, showed the resident was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. -Major [MEDICAL CONDITION] (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). -Anxiety Disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). -Impulse Disorder (a person has trouble controlling emotions or behaviors). -Post-Traumatic Stress Disorder ([MEDICAL CONDITION] - a disorder in which a person has difficulty recovering after experiencing or witnessing a shocking, scary, or dangerous event). Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning), dated 12/23/19, showed: -The resident had a Brief Interview for Mental Status (BIMS - is used to assess cognitive status in residents) score of 15 out of 15 (indicating the resident was cognitively intact). Record review of the resident's Resident Statement, dated 5/16/20, showed: -To whom it may concern Licensed Practical Nurse (LPN) A has been fingering him/her when he/she is asleep. LPN A has also been making him/her give LPN A oral sex for everything that LPN A buys him/her. Record review of the resident's Nurse's Note, dated 5/16/20 7:00 P.M. to 7:00 A.M., showed: -At approximately 10:50 P.M., the resident came to the nurse's station and told LPN B to get his/her phone and go to the resident's room. -The resident made sexual allegations toward LPN A. -The resident stated that they had oral sex and had been witnessed by another resident. -No bruising, bleeding or pain noted at this time. -Administrator notified. Record review of the resident's Nurse's Note, dated 5/17/20 at 7:00 A.M., showed: -The resident was monitored by LPN B, all through the shift. -The resident rested well, no concerns voiced during the rest of the shift. -No bruising, pain or genitalia bleeding noted. -The resident went to bed at approximately 12:45 A.M. -The resident's safety made priority with frequent safety checks. Record review of the resident's Nurse's Note, dated 5/17/20 7:00 A.M. to 7:00 P.M., showed: -LPN B reported to this charge nurse, LPN C, allegations continue from last night. -Direct supervisor and police were notified of the incident. -Police report was filed and Resident #1 was sent to the hospital for evaluation and treatment at 4:30 P.M. -Guardian notified as well as all responsible parties. -The resident remains in the hospital for further testing while results pending. Record review of the facility Registered Nurse Investigation Report dated 5/20/20, showed: -On 5/16/20 at approximately 11:05 P.M., Resident #1 reported to LPN B that he/she was allegedly sexual assaulted by LPN A in his/her room. -Investigation began, administrator, Assistant Director of Nursing (ADON), regional office, physician, guardian and police were notified. -The police were notified on 5/17/20 at 9:00 A.M. and entered the facility on 5/17/20 at 4:30 P.M. -It did not say what day or time the administrator, ADON, regional office, physician or guardian were notified of the sexual abuse. Review of the DHSS database for complaint and self-report investigations showed the facility did not report sexual abuse to the State Survey Agency, DHSS, until 5/17/20 at 12:44 P.M., more than eight hours after the resident reported the alleged sexual assault. During an interview on 5/18/20 at 4:10 P.M., the resident said: -On 5/16/20, between 10:00 P.M. and 11:00 P.M., the resident was in his/her room when LPN A entered the room with his/her laptop. -The resident had told LPN A that he/she could download an anti-virus program on LPN A's laptop since it was an older computer. -LPN A left the resident's room and went to the gas station down the road for another resident. -When LPN A returned, he/she sat down in the resident's chair and asked the resident if he/she would show him/her how to download the anti-virus program for the future. -The resident was dressed in his/her night clothes. -The resident was leaning over to show LPN A how to download the program. -The resident had asked LPN A to please move out of his/her chair. -Before LPN A moved out of the chair LPN A reached up the resident's night clothes and was rubbing his/her body. -The resident asked LPN A what he/she was doing and the LPN A removed his/her hand from under the nightgown. -LPN A got up out of the chair and the resident sat down in the chair. -Then LPN A unzipped his/her pants. -The resident asked the LPN A what he/she was doing and LPN A told the resident he/she was going to give him/her oral sex and the LPN A pulled out his/her genitalia. -The resident said he/she told LPN A no and would not open his/her mouth. -The resident said LPN A took both of his/her hands and pushed on the resident's jaw just hard enough to get the resident to open his/her mouth, but not hard enough to cause bruising. -LPN A put his/her genitalia into the resident's mouth and started moving the lower part of his/her body back and forth while holding the back of the resident's head. -That is when Resident #2 came into the resident's room to return six cents Resident #2 owed the resident. -Resident #2 saw the resident pull his/her head up from LPN A's crouch. -LPN A went into the resident's bathroom and finished what he/she was doing and left the room. -The resident went down to the nurse's station upset and told LPN B to get his/her phone and to come to his/her room with him/her. -The resident told LPN B that LPN A had forced him/her to have oral sex and showed LPN B a mucus like substance in the toilet and said it was LPN A's mucus like substance. -The resident wanted LPN B to take a picture of the substance in the toilet. -The resident told LPN B to get the administrator on the phone because he/she want to talk to him/her about the incident. -He/She never got to talk to the administrator. -LPN B tried to get the resident out to the vending area so LPN A could talk to him/her, but he/she was too scared to go out and talk to LPN A. -The resident said he/she was shaking and crying because LPN A was still in the facility and he/she was scared of LPN A. -He/She does not feel safe living at the facility. -Everywhere he/she looks, he/she sees LPN A's face. -He/She cannot sleep or eat and has no one to talk to about the incident. -He/She just wants to go somewhere he/she is safe. -The police came to the facility finally on Sunday 5/17/20 and that is when the facility sent him/her to the hospital for a rape exam. -He/She had signs of sexual trauma and was bleeding. -He/She said that while sitting in the chair that same day LPN A spread his/her legs open and stuck 3 fingers in his/her genitalia area, that is

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) how he/she got scratched and why he/she was bleeding. During an interview on 5/18/20 at 4:37 P.M., Certified Nursing Assistant (CNA) A said: -He/She did not see the incident that happen on 5/16/20, between 10:00 P.M. - 11:00 P.M. -He/She was sitting in Resident #2's room and told Resident #2 that he/she could take the six cents back to Resident #1. -He/She did not go with Resident #2 even though he/she was on 1 to 1 monitoring at the time. -Resident #2 came back to his/her room upset and told him/her that he/she had just seen Resident #1 giving LPN A oral sex. -He/She tried to calm Resident #2 down. -He/She went to look in Resident #1's room to see if LPN A was still in the room, but did not see LPN A in the room. -Resident #1 left his/her room and went and told LPN B what had just happened before he/she could tell LPN B what Resident #2 had told her. -He/She sent a text message to the administrator, but the administrator did not reply until 6:44 A.M. on 5/17/20. -The text message from the administrator said for CNA A to call him/her in the afternoon on 5/17/20. -CNA A sent a text message back to telling the administrator that he/she wanted to tell him/her about the alleged sexual assault and to see if the administrator wanted him/her to write a statement. -The administrator never responded to the last text message sent. During an interview on 5/18/20 at 4:53 P.M., LPN B said: -He/She was sitting at the nurse's desk when Resident #1 came to him/her and told him/her to get his/her cell phone and to come to his/her room now. -He/She got his/her phone and went to the resident's room. -The resident told LPN B that he/she had just had oral sex with LPN A and that his/her mucus-like substance was still in his/her toilet and wanted him/her to take a picture. -He/She did not take a picture of the mucus-like substance that was in the toilet. -He/She went and talked to Resident #2 about what he/she saw in Resident #1's room. -This incident happened around 10:50 P.M. on Saturday 5/16/20 -He/She called the administrator around 11:00 P.M. and left a voice message for the administrator to call LPN B at the facility. -The administrator called back around 11:20 P.M. and told LPN B to get written statements from everyone involved in the incident and to make sure that LPN A did not come back onto the Women's Unit the rest of the shift, which ended at 7:00 A.M. on 5/17/20. -Neither the administrator, DON or ADON came to the facility while he/she was on shift. -The AS is to be called with in two hours and the administrator, DON or ADON are the ones to call per facility policy. During an interview on 5/18/20 at 4:05 P.M., the ADON said: -Any abuse incidents should be reported to the SA within two hours. -The police should be called anytime a crime is committed. -LPN B notified the administrator not sure of the time on Sunday 5/17/20. -The ADON did not say when the sexual abuse was reported to SA. During an interview on 5/19/20 at 1:52 P.M., the Administrator said: -He/She was notified around 5:00 A.M. to 6:00 A.M. on 5/17/20 of the alleged sexual assault the night before on 5/16/20. -He/She notified LPN A at the end of his/her shift around 7:00 A.M., that he/she was suspended pending the outcome of the investigation. -He/She was called around 11:00 P.M. on 5/16/20 and was notified about a resident to resident altercation by LPN B, but was never told about the alleged sexual assault. -If he/she would have been told about the alleged sexual assault he/she would of come to the facility and took care of business, but nothing was said to him/her. -He/She said that he/she called the SA within the two hour time frame. -He/She asked what time the report said he/she called the SA. -The surveyor told the administrator that the report was made to the state agency on 5/17/20 at 12:44 P.M. -He/She said I know I called in to report the incident before that. MO 263 & MO 275