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	175559	A. BUILDING _____ B. WING _____	C 06/19/2018

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WESTERN PRAIRIE SENIOR LIVING LLC	**510 E SAN JACINTO AVENUE ULYSSES, KS 67880**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation KS#130529.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 51 residents. The sample included 4 residents reviewed for care plan accuracy. Based on observation, record	F 657		

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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review, and interview the facility failed to revise a care plan regarding behaviors for 2 of 4 sampled residents. (#2, #4)

Findings included:

- Resident #2's quarterly (MDS) Minimum Data Set assessment, dated 3/16/18, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 10, indicating moderately impaired cognition, a mood severity score of 13, indicating moderate depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and no behaviors. The MDS recorded the resident required extensive assistance from 1 staff for locomotion and bathing, limited assistance from 1 staff for walking, dressing, toilet use, personal hygiene, supervision with 1 staff assistance for transfers, and was independent with bed mobility and eating. The MDS recorded the resident's balance was not steady, had no functional limitation in (ROM) Range of Motion, used a walker and wheelchair for mobility. The MDS recorded the resident received antidepressant medications (class of medications used to treat mood disorders and relieve symptoms of abnormally exaggerated feelings of sadness, worthlessness and emptiness).

The resident's 6/18/18 quarterly MDS was the same as the 3/16/18 MDS except: the resident had a BIMS score of 3, indicating severe cognitive impairment, fluctuating inattention behavior, and a mood severity score of 10, indicating moderate depression.

The 1/3/18 Cognitive Loss/Dementia (progressive

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mental disorder characterized by failing memory, confusion) (CAA) Care Area Assessment recorded the resident had a mood severity score of 16, indicating moderately severe depression, an increase from his/her prior score of 6. The CAA recorded the resident made himself/herself understood, had no problems understanding others, had some short term memory loss, no signs or symptoms of delirium (sudden severe confusion, disorientation and restlessness) and took Lexapro (medication used to treat depression) for his/her depression. The CAA recorded the resident had a BIMS score of 11, indicating moderately impaired cognition with a prior BIMS score of 13, and was oriented to person and place.

The 4/16/17 care plan, reviewed on 6/6/18 with no changes, recorded the resident had behaviors and depression related to his/her admission with mood problems including: refused (ADLs) Activities of Daily Living, threw things, tried to cut other resident's wander guards (tracking device designed to prevent persons at risk from leaving a facility unless they are accompanied by staff) off, refused to give urine samples for testing, refused vital signs and neurological checks after falls, kicked his/her wheelchair over, threw the urinal at staff, and cut a (CNA) Certified Nurse Aide with scissors. The care plan directed staff to administer medications, as ordered by the physician, monitor and document for side effects and effectiveness, explain to the resident what tasks he/she was to do, monitor, document, and report (PRN) as needed any signs or symptoms of depression, risks for harming others: increased anger, labile mood (an emotional response that doesn't match the situation) or agitation, feeling threatened by others or thoughts of harming

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someone, possession of weapons or objects that could be used as weapons. The care plan directed staff to ensure the resident had no scissors in his/her room, as the resident had attempted to cut wander guard bracelets off other residents, and had cut staff.

The care plan failed to address the behaviors the resident had with opposite gender residents or direct staff how to address the interactions if observed.

The 4/5/18 at 4:05 PM, nurse's note recorded at approximately 3:30 PM, Resident #2 propelled himself/herself into Resident #4's room, transferred himself/herself to Resident #4's bed and sat on the bed laying across the middle of Resident #4's body. The note recorded both residents had the door open and Resident #2 repeatedly told Resident #4 "I love you", "I will check on you". The note recorded Resident #2 could not independently get up from Resident #4's bed, a nurse aide had to transfer him/her from Resident #4's bed into his/her wheelchair. The note documented the residents both consented.

The 4/13/18 at 6:52 PM, nurse's note recorded Resident #2 was in the hall propelling his/her wheelchair backwards, running into things in the hall, when staff asked the resident where he/she was headed, Resident #2 stated he/she was headed to see his/her girlfriend/boyfriend. The note recorded when the nurse intervened, told Resident #2, "No", he/she grabbed the nurse's hand, pushed him/her to the side, and stated "I knew you would say that." The note recorded the nurse talked to Resident #4 and he/she reported to the nurse that he/she had told Resident #2

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"No" he/she did not want the resident to come to his/her room.

The 4/14/18 at 4:28 PM, nurse's note recorded Resident #4 allowed Resident #2 into his/her room and talked with him/her. The note recorded Resident #4 used the call light, and reported Resident #2 was trying to kiss him/her, and he/she did not want Resident #2 to kiss him/her. The note recorded staff stopped Resident #2, and let him/her know that he/she needed to leave Resident #4's room. Resident #2 became agitated and tried to hit nurse aides as they were trying to get him/her out of Resident #4's room.

On 6/20/18 at 1:18 PM, observation revealed Resident #2 finished lunch, attempted to move his/her wheelchair away from the table and Administrative Nurse D assisted Resident #2 away from table and back to his/her room. Observation revealed as Resident #2 was being moved away from the table he/she motioned with his/her finger to Resident #4, gesturing him/her to come toward Resident #2, but Resident #4 did not come over.

On 6/20/18 at 1:36 PM, Administrative Nurse D stated the relationship between Resident #2 and Resident #4 was kind of off and on, Resident #4 wanted to break up with Resident #2, and then wanted to hold Resident #2's hand and kiss at times. Administrative Nurse D verified there was nothing in either resident's care plan regarding the relationship.

On 6/21/18 at 8:17 AM, Administrative Nurse D stated the relationship with Resident #2 and Resident #4 was "not really" sexual behaviors, it had been a mutual relationship. Administrative

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Nurse D stated he/she felt Resident #2 was cognitive enough to know what he/she was doing, and with Resident #4, it was not a behavior, he/she was aware of what he/she was doing. Administrative Nurse D stated he/she did not feel there was anything that needed to be put in either resident's care plan.

The facility's November 28, 2017 Care Plan policy documented a care plan would be developed for each resident that included measurable objectives to meet a resident's medical, nursing, mental and psychosocial needs, and are consistent with the resident's desires and preferences.

The facility failed to revise Resident #2's care plan (whose cognition declined to severely impaired) in a timely manner to include interventions regarding the behaviors of sexual nature with Resident #4, or provide direction for staff on how to care for the situation of unwanted resident to resident contact.

- Resident #4's admission (MDS) Minimum Data Set assessment, dated 1/3/18, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 11, indicating moderately impaired cognition, a mood severity score of 11, indicating moderate depression, and hallucinations (sensing things while awake that appear to be real, but the mind created). The MDS recorded the resident required total assistance from 1 staff for locomotion, extensive assistance from 2 staff for bed mobility, transfers, walking, dressing, toilet use, bathing, extensive assistance from 1 staff for locomotion on the unit, independent with for personal hygiene and eating.

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The MDS recorded the resident's balance was not steady, had no functional limitation in (ROM) Range of Motion, and used a walker and wheelchair for mobility.

The quarterly MDS, dated 6/8/18, recorded the resident had a BIMS score of 15, indicating intact cognition, a mood severity score of 2, indicating minimal depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The MDS recorded the resident required total dependence from 1 staff for locomotion, extensive assistance from 2 staff for bed mobility, transfers, dressing, toilet use, bathing, independent for personal hygiene eating. The MDS recorded the resident's balance was not steady, had no functional limitation in ROM, used a wheelchair for mobility. The MDS recorded the resident received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications.

The 1/10/18 care plan recorded the resident had limited physical mobility due to weakness related to a history of frequent falls prior to admission and Neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness). The care plan directed staff to encourage the resident to walk to the restroom during the day, and use a wheelchair for long distances if his/her legs got weak. The care plan recorded the resident required assistance from 2 staff with a gait belt and walker with transfers and

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walking.

The care plan failed to address the behaviors the resident had with opposite gender residents or direct staff how to address these interactions if observed.

The 3/16/18 at 4:52 PM, nurse's note recorded the (SSD) Social Services Designee had a lengthy visit with Resident #4, the resident reported a love interest with one of the opposite gender residents on the hallway, but assured the SSD it was nothing to worry about. The note recorded the SSD told the resident he/she was not worried.

The 4/5/18 at 4:05 PM, nurse's note recorded at approximately 3:30 PM, Resident #2 propelled himself/herself into Resident #4's room, transferred himself/herself to Resident #4's bed and sat on the bed laying across the middle of Resident #4's body. The note recorded both residents had the door open and Resident #2 repeatedly told Resident #4 "I love you", "I will check on you". The note recorded Resident #2 could not independently get up from Resident #4's bed, a nurse aide had to transfer him/her from Resident #4's bed into his/her wheelchair. The note documented the residents both consented.

The 4/12/18 9:51 AM, nurse's note recorded the SSD along with the (DON) Director of Nursing visited with Resident #4 that morning concerning another resident and their mutual "boyfriend/girlfriend" relationship. The note recorded Resident #4 claimed to the SSD and DON that he/she would like that relationship to end, but was nervous about the confrontation, the

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SSD agreed to serve as mediator so that all would understand that the relationship would end peacefully and without further events.

The 4/12/18 at 4:21 PM, nurse's note recorded facility staff notified Resident #4's family member of conversation with Resident #4 that morning regarding the resident wanted to break up with Resident #2. The note recorded Resident #4 did not want to "break up" with Resident #2 until the next day, and he/she wanted staff to be present. Staff explained to Resident #4's family member that staff had explained to Resident #4 about not allowing Resident #2 to kiss him/her or hold his/her hand as that gave Resident #2 mixed messages. The note recorded staff reported to Resident #4's family member that, staff were to keep Resident #2 out of Resident #4's room.

The 4/13/18 2:42 PM, nurse's note recorded after lunch, Resident #4 went to Resident #2's room to break up with him/her, Resident #4 was informed the DON was busy and would not be able to go with him/her until later that day. The note recorded Resident #4 denied asking the nurse to "sit outside just in case Resident #2 goes crazy", but the nurse waited outside of Resident #2's room listening to the residents' conversation. The note recorded the nurse asked Resident #2 if staff had talked to him/her, he/she denied anyone talked to him/her. The note recorded Resident #4 then told Resident #2 that they had to break up and he/she said, "that's fine", Resident #4 continued telling Resident #2, "they don't want us seeing each other, they have all these rules and regulations to follow." The note recorded Resident #4 told Resident #2 that "they asked where this relationship is going and he/she told them it wasn't going anywhere because they are

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both in the nursing home", but they could still be friends. The note recorded Resident #2 kissed Resident #4's hand and he/she said "They don't want us kissing or even kissing my hand", Resident #2 asked him/her who "they" are, Resident #4 reported "they" were Administration. The note recorded Resident #2 replied with "Oh what the hell", Resident #4 told Resident #2, "we can still be friends."

The 4/14/18 4:59 PM, nurse's note recorded Resident #4 allowed Resident #2 to come in his/her room and visit, even after stating "I don't want Resident #2 in my room". The note recorded Resident #2 then tried to kiss Resident #4, the nurse talked to Resident #4 and he/she explained that he/she did not think Resident #2 would act that way, this nurse explained that when Resident #4 allowed Resident #2 to come into his/her room that sent mixed signals to Resident #2.

The 4/20/18 at 3:43 PM, nurse's note recorded at 12:15 PM, Resident #4 went to talk to Resident #2, the nurse requested staff to remove Resident #4 from the room and come talk to the nurse. The note recorded when asking Resident #4 what was going on he/she stated, "Well when Resident #2 saw me yesterday, he/she just lit up. I don't know how much longer he/she has here, and I don't feel like it's my place to take that happiness away from him/her. So I was thinking Administration could just take down all the restrictions and let it be how it used to be." The note recorded the nurse informed Resident #4 that in doing so, it could possibly send the wrong message to Resident #2, Resident #4 stated, "Well, as long as he/she does not come try to hold my hand, kiss me, or get on my bed, I'll be okay with it but I would like to see what Administration thinks about

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the whole situation."

The 4/20/18 at 4:37 PM, nurse's note recorded the SSD was alerted that Resident #4 had made contact with Resident #2, and when approached and interrupted by a nurse aide, Resident #4 announced that he/she was rethinking his/her decision to have nothing to do with Resident #2. The note recorded Resident #4 asked staff to speak with the SSD, Resident #4 explained that he/she felt withholding attention from Resident #2 may be robbing him/her of happiness in what little time he/she had left. The note recorded the SSD explained that other's happiness was not Resident #4's responsibility, that SSD thought it was a bad idea (because he/she asked), and that staff were not going to continue getting into the middle of this relationship issue, because Resident #4 was making ill advised decisions. The note recorded the SSD did emphasize that Resident #4 would not be judged or treated unfairly based on whatever the resident decided, and it was important that both residents involved were adults, of sound mind, and were making their own choices.

On 6/20/18 at 1:18 PM, observation revealed Resident #2 finished lunch, attempted to move his/her wheelchair away from the table while Resident #4 propelled his/her wheelchair over toward Resident #2's table. Observation revealed Resident #2 was unable to move himself/herself away from the table, Administrative Nurse D assisted Resident #2 away from table and back to his/her room. Observation revealed as Resident #2 was being moved away from the table he/she motioned with his/her finger to Resident #4, gesturing him/her to come toward Resident #2, Resident #4 did not come over.

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F 657	Continued From page 11 On 6/20/18 at 1:36 PM, Administrative Nurse D stated the relationship between Resident #2 and Resident #4 was kind of off and on, Resident #4 wanted to break up with Resident #2, and then wanted to hold Resident #2's hand and kiss at times. Administrative Nurse D verified there was nothing in either resident's care plan regarding the relationship. On 6/21/18 at 8:17 AM, Administrative Nurse D stated the relationship with Resident #2 and Resident #4 was "not really" sexual behaviors, it had been a mutual relationship. Administrative Nurse D stated he/she felt Resident #2 was cognitive enough to know what he/she was doing, and with Resident #4, it was not a behavior, he/she was aware of what he/she was doing. Administrative Nurse D stated he/she did not feel there was anything that needed to be put in either resident's care plan. The facility's November 28, 2017 Care Plan policy documented a care plan would be developed for each resident that included measurable objectives to meet a resident's medical, nursing, mental and psychosocial needs, and are consistent with the resident's desires and preferences. The facility failed to revise Resident #4's care plan in a timely manner to include interventions regarding the behaviors of sexual nature with Resident #2, or provide direction for staff on how to care for the situation of unwanted resident to resident contact.	F 657		