

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2023
NAME OF PROVIDER OR SUPPLIER BONNER SPRINGS NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 520 E MORSE STREET BONNER SPRINGS, KS 66012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000			
F 744 SS=D	The following citations represent the findings of complaint investigation #KS0080465 and #KS00180484. The 2567 was sent on 06/14/23. Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 39 residents. The sample included three residents reviewed for diagnoses of dementia (a cognitive decline that affects ones' ability with everyday activities, coupled with changes in mood, perception, sleep). Based on record review, observation, and interview the facility failed to ensure Resident (R)1 received appropriate treatment and services to attain or maintain their highest level of practicable physical, mental, and psychosocial wellbeing when the facility failed to implement interventions for R1's dementia related behaviors toward female residents and monitor for effectiveness of the interventions. This placed R1 at risk for impaired physical and psychosocial wellbeing. Findings included: - R1's Electronic Medical Record (EMR), under the "Diagnoses" tab recorded additional diagnoses of bipolar disorder (a mental health	F 744			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/14/2023

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 744	Continued From page 1 condition that causes extreme mood swings that include emotional highs and lows), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Admission Minimum Data Set" (MDS) dated 03/24/23 documented R1 had a Brief Interview for Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS recorded R1 had difficulty concentrating, feelings of depression, and felt tired or having low energy. The MDS lacked documentation R1 had any behaviors during the seven day review period. The "Cognitive Care Area Assessment" (CAA) dated 03/24/23 documented R1 had an altered level of consciousness and difficulty focusing attention. R1 slept hard during the day and would stay up at night. R1 mentioned a need to catch a flight out of Kansas City and would change the subject or lose focus when being asked something. The CAA recorded a care plan would be developed to address these areas. The "Care Plan" initiated on 04/15/23 recorded the resident had a potential to be sexually inappropriate related to impaired memory, and poor impulse control. The "Care Plan" documented on 04/15/23, R1 entered a female resident room and (per allegation) touched her breast. The "Care Plan" revised on 05/27/23, recorded R1 placed his hands on a female resident's neck and shoulder area and was whispering in her ear. The new intervention recorded R1 was immediately re-directed across the room to another table awaiting lunch and R1 complied	F 744			

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F 744	Continued From page 2 without difficulty. R1 received his ordered medication for sexual behaviors and was placed on one-on-one until further directions from administration. R1's EMR documented a physician order dated 04/17/23 (and reordered on 05/27/23) for medroxyprogesterone acetate (Depo-Provera: a hormone that lowers testosterone and sexual drive-in men) 150 milligrams (mg) per 1 milliliter (ml). The order directed staff to administer an Intramuscular (into the muscle) shot of 150 mg at bedtime every 14 day(s) for inappropriate hypersexuality. Review of the "Medication Administration Record" (MAR) for April 2023 recorded R1 first received the physician ordered Depo Provera injection on 04/18/23. The MAR for MAY 2023 recorded a code on 05/01/23 and 05/15/23 noting the resident did not receive the scheduled Depo Provera and directed the reviewer to "see progress notes." Record review of the "Nurse Progress Notes" lacked documentation explaining why the shot was not administered on 05/01/23 and/or 05/15/23. A "Nurses Note," dated 05/27/23 at 02:08 P.M. documented a Depo injection was given to R1. The Advanced Registered Nurse Practitioner (ARNP) was informed the medication was received and given by the nurse. The "Facility Investigation" recorded R1 had a history of inappropriately touching female residents. On 05/27/23 at 11:42 A.M. residents	F 744			

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F 744	Continued From page 3 were in the dining room just before lunch time; another resident witnessed R1 walk up to R2, rub R2's back and the back of R2's neck and whisper in R2's ear. Staff immediately separated the two and nothing further occurred. The investigation documented: R1 was given a Depo shot that day and was on 1:1 and being monitored for any further sexual behavior. R1's EMR reflected he received the physician ordered behavioral modifying medication (Depo-Provera) on 4/18/23, and again on 05/27/23, having missed doses on 05/01/23 and 05/15/23. Observation on 06/01/23 at 11:08 A.M. revealed R1 ambulated to the dining room and sat at a table. He did not approach any female residents. At 11:11 A.M. a female resident sat beside R1 at lunch however there was no discussion between them. On 06/01/23 at 11:08 A.M. R1 gave short yes or no answers, and said "what? what?" Interviewed on 06/01/23 at 11:40 A.M. Certified Nursing Assistant (CNA) M stated an awareness of R1's behaviors and witnessed R1's sexual inappropriateness on two occasions. CNA M stated R1 mostly would touch himself inappropriately during cares. CNA M stated staff would advise R1 the behavior was inappropriate and when asked to stop R1 would say, "I didn't do anything." CNA M said she did not think R1 was aware R1 was doing it. CNA M said she had not witnessed R1 be inappropriate with other residents and R1 never grabbed at CNA M or other female staff.	F 744			

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F 744	Continued From page 4 On 6/1/23 Administrative Nurse D, stated she was unaware R1's behavioral medication was not given as scheduled and stated she expected staff to follow the residents care plan for his dementia related behaviors including administration of medications and monitoring for effectiveness of interventions. On 6/1/23 at 12:57 p.m. Administrative Staff A stated staff responded appropriately regarding the encounter and staff would receive education on continued monitoring of dementia behaviors and/or triggering issues. The facility's "Behavioral Assessment, Interventions and Monitoring " policy revised August 2021 documented: Behavioral symptoms would I be identified through behavioral screening tools and the comprehensive assessment; The facility would comply with regulatory requirements related to the use of medications to manage behavioral changes; New onset or changes in behavior would be documented regardless of degree of risk to the resident or others; The interdisciplinary team (IDT)would thoroughly evaluate new or changing behavior symptoms in order to identify underlying causes ...; Care Planned interventions would be individualized and part of an overall care environment ...: and The IDT team would monitor improvement or worsening in the individuals behaviors , mood, and function, The facility failed implement interventions for R1's dementia related behaviors toward female residents and monitor for effectiveness of the interventions. This placed R1 at risk for impaired physical and psychosocial wellbeing.	F 744			