

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

PRINTED: 10/03/2023
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 09/21/2023
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 The following citations represent the findings of complaint investigations #KS00182935, KS00182864, KS00182867, and KS00182678.	F 000			
F 600 SS=G	The 2567 was sent electronically on 10/03/23. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 37 residents. The sample included four residents reviewed for abuse. Based on record review and interviews, the facility failed to prevent physical abuse when Certified Nurse Aide (CNA) M hit cognitively impaired Resident (R) 1, who had history of traumatic head injury, in the face on 09/08/23. This deficient practice resulted in impaired psychosocial well-being and placed R1 at risk for continued abuse.	F 600	Past noncompliance: no plan of correction required.		

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

TITLE

(X6) DATE

10/03/2023

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.

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

PRINTED: 10/03/2023
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 09/21/2023	
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 600	Continued From page 1 Findings included: - R1 admitted to the facility on 03/17/23 and discharged to the hospital on 09/17/23. The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with other behavioral disturbance, personal history of traumatic head injury, and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). The "Significant Change Minimum Data Set (MDS)" dated 08/14/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. R1 had inattention and disorganized thinking that was present and fluctuated during the review period. The "Delirium [sudden severe confusion, disorientation and restlessness] Care Area Assessment (CAA)" dated 08/27/23, documented R1 had a potential for alteration in delirium due to R1 triggering for inattention, such as being easily distracted with disorganized thinking. R1 was able to verbalize his needs but had difficulty understanding sometimes, due to his own perspective or delusional thinking and beliefs. The "Cognitive Loss/Dementia CAA" dated 08/27/23, documented R1 had a BIMS of five during assessment interview and had indicators of inattention and disorganized thinking noted. The "Care Plan" last revised on 09/09/23, directed staff R1 was at risk for verbal and			F 600			

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

PRINTED: 10/03/2023
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 09/21/2023
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 600	Continued From page 2 physical aggression towards others and non-compliant with care related to impaired memory, poor impulse control, traumatic brain injury, and bipolar disorder. The "Care Plan" documented an intervention, dated 04/17/23, that directed staff when R1 became agitated, staff intervened before agitation escalated, guided R1 away from the source of distress, and engaged calmly in conversation. If R1's response was aggressive, staff walked away calmly and approached later. The facility's "Investigation," dated 09/12/23, documented CNA M and two other CNAs were assisting R1 with care at approximately 06:00 AM on 09/08/23 during shift change rounds. CNA M stated R1 had spit on her and called her a "black [expletive]." CNA M asked R1 not to spit on her and he spit on her again. At that time, CNA M stated she put her hand on his face so he would not do it again and when she took her hand off his face, R1 spit on her again. At that time, she stated she walked out of the room. The witnessing CNAs (CNA O and CNA P) reported CNA M hit the resident and verbalized she did not care if she lost her job. Another resident witnessed CNA M in the hallway and reported CNA M stated she punched R1 in the face. CNA N sat at the nurses desk and witnessed CNA M come out of R1's room and down the hallway. CNA N asked CMA M what had occurred and CNA M stated R1 was just in her face and tried to punch her again, so she punched him in the face. CNA M gathered her belongings at that time while CNA N observed her until she left the building immediately after the incident. CNA N reported to Licensed Nurse (LN) G about the incident and LN G contacted Administrative Nurse D around 07:15 AM, regarding the incident. Administrative Nurse	F 600			

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

PRINTED: 10/03/2023
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 09/21/2023
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 600	Continued From page 3 D contacted Administrative Staff A and the police were contacted at approximately 08:30 AM regarding the incident. LN G completed a skin assessment on R1 with no injuries noted. LN G notified R1's representative and physician of the incident. Police arrived at 08:40 AM and interviewed R1, both witnesses, and CNA M when she arrived back to the building at 09:45 AM to provide her written statement of the incident. When police and Administrative Staff A met with R1, he was unable to recall any incident or altercation from that morning. There was no visible injury noted on R1 at that time. In a "Witness Statement" on 09/12/23, CNA M stated she went to get R1 out of bed with the help of two other aides. As they placed the sit-to-stand (mechanical lift) behind R1, he called CNA M a "black [expletive]" and spit in her face. She stated she wiped her face and asked R1 not to spit on her as they were trying to pull him up with the sling. CNA M stated R1 said "[expletive] you" and spit on her one more time in her face. She told R1 that she asked him not to spit on her and she put her hand on his face to turn his face so he would not do it again. CNA M stated when she took her hand off R1's face, he did it again and at that time she walked out of the room. She washed her face and glasses, sat down to cool off, then left. In a "Witness Statement" on 09/12/23, CNA O stated on 09/08/23, he arrived at the facility that morning and was approached by CNA M to assist R1 with activities of daily living (ADLs). He stated he went to R1's room to assist, and while they were trying to assist R1 to sit up, R1 spit on CNA M. CNA M hit R1 and verbalized she did not care if she lost her job. CNA P was also assisting R1.	F 600			

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

PRINTED: 10/03/2023
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 09/21/2023
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 600	Continued From page 4 In a "Witness Statement" on 09/12/23, CNA P stated on 09/08/23 at about 06:05 AM, CNA M, CNA O, and herself went in R1's room to try and change him and get him up. R1 refused and CNA M was determined to get him up so R1 spit in CNA M's face. CNA P stated CNA M grabbed R1's face and pushed it down on the pillow and R1 swung at CNA M. She stated CNA M hit R1 in the jaw. CNA P stated that was enough and they walked out of the room. In a "Witness Statement" on 09/12/23, CNA N stated on 09/08/23 at 06:10 AM, she sat at the nurses station giving information to the new hire when she heard CNA M walking down the hall towards them, yelling that she was done. CNA N asked CNA M what happened, while she was in the dining room collecting her belongings. CNA M replied R1 spit in her face three to four times and tried to punch her again, so she punched him in the face. CNA N stated she watched CNA M leave the building. CNA N stated she immediately reported to the charge nurse what had happened. On 09/21/23 at 02:14 PM, CNA N stated on 09/08/23, there was a new CNA working so she was sitting down talking about the residents. CNA M came out of R1's room screaming she was done and cussing. As CNA M walked closer to the desk, she stated R1 spit in her face two more times so she hit him in the face. CNA N stated after CNA M left the facility, she reported it to the nurse. On 09/21/23 at 02:19 PM, LN G stated on 09/08/23, she was getting report when CNA N opened the door and said she needed to tell her something. CNA N waited until CNA M left and	F 600			

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

PRINTED: 10/03/2023
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 09/21/2023
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 600	Continued From page 5 reported CNA M hit R1. LN G stated she notified Administrative Nurse D, who notified Administrative Staff A, who was on her way into the facility. LN G checked on R1. On 09/21/23 at 02:29 PM, Administrative Nurse D stated on 09/08/23, LN G notified her that the CNAs reported R1 had been in CNA M's face. and called her a name, then she hit him. She stated she immediately called Administrative Staff A to let her know. CNA M returned to fill out a witness statement. Administrative Nurse D stated CNA M was terminated, and staff received education on abuse, neglect, and exploitation (ANE). On 09/21/23 at 02:35 PM, Administrative Staff A stated on 09/08/23, Administrative Nurse D notified her of the incident while she was on her way to work. She stated when she arrived at the facility, she asked what happened, but CNA M was already gone. She gathered statements and the nurse checked on R1 who was fine. Administrative Staff A stated she talked to CNA O and CNA P and notified the police who arrived and talked to everyone again. She stated CNA M did come back to the facility for a statement and talked to the police as well. Administrative Staff A stated CNA M did not tell her or the police that she hit R1. Based on the situation being witnessed by two CNAs, CNA M was terminated at that time. She stated ANE education was completed that day with everyone working and everyone that came in to work filled out the ANE form before they worked. CNA M was unavailable for interview on 09/26/23 at 04:54 PM.	F 600			

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

PRINTED: 10/03/2023
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 09/21/2023
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 600	Continued From page 6 On 09/27/23 at 08:36 AM, CNA P stated on 09/08/23 she arrived to work around 05:54 AM and R1 was soiled with urine. She stated CNA M, CNA O, and herself were in R1's room trying to get him up. R1 was lying in bed and after they could not get the sling under R1, he spit in CNA M's face. She stated CNA M put her hand on R1's jaw then pushed his head into his pillow. They tried to get the sling underneath R1, and he tried to spit in CNA M's face again. CNA P stated CNA M used her right hand and hit R1. She stated R1 seemed upset and had said to CNA M, [expletive] if he could get up, he would punch her. At that time, CNA P told CNA M they needed to leave the room to give him time to calm down. CNA P stated she reported the incident within 10 minutes. The facility's "Recognizing Signs and Symptoms of Abuse/Neglect/Exploitation" policy, last revised October 2021, directed abuse was defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The facility failed to prevent physical abuse when CNA M hit R1 in the face on 09/08/23. The scope and severity were determined to be actual harm based on the "reasonable person" concept due to the circumstances of R1's mental illness and inability to self-identify and express his feelings. The facility put the following corrections into place by 09/12/23: CNA M was suspended then terminated on 09/08/23. All staff working on 09/08/23 were in-serviced on ANE and any additional staff, including agency	F 600			

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

PRINTED: 10/03/2023
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 09/21/2023
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 600	Continued From page 7 staff were in-serviced prior to the start of their next shift. R1's care plan was updated on 09/09/23. R1 was seen by psychiatry on 09/12/23. All corrective actions were completed prior to the onsite survey therefore the citation was deemed past noncompliance.	F 600			