STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	**105 N HIGHWAY 99 WESTMORELAND, KS 66549**

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F 000	INITIAL COMMENTS The following citations are the result of complaint survey KS00183247, KS00183278, and KS00182850. The 2567 was sent electronically on 10/24/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 31 residents with three residents reviewed for resident rights. Based on record review, observation, and interview, the facility failed to protect Resident (R) 1's right to dignity. This deficient practice placed R1 at risk for impaired psychosocial wellbeing.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of early on-set Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), convulsions (involuntary series of contractions of a group of muscles), and extrapyramidal (movement disorders as a result of taking certain medications) and movement disorder.

The "Annual Minimum Data Set (MDS)," dated 07/14/23, documented the Brief Interview for Mental Status (BIMS) could not be completed because R1 was rarely understood. Per staff interview, R1 had short term memory problems and long-term memory problems. The MDS documented R1 required extensive assistance of one to two staff for all activities of daily living (ADL) except eating for which R1 was totally

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dependent on one staff.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 07/14/23, documented R1 was severely impaired for making decisions regarding tasks of daily life. R1 displayed inattention which fluctuated in severity and R1 wandered four to six days during the observation period.

The "Psychosocial Well Being CAA," dated 07/14/23, documented R1 had little pleasure or interest in doing things.

R1's "Care Plan," revised 07/27/23, documented R1 had impaired communication related to Alzheimer's disease. The care plan documented R1 would be able to communicate basic needs. The care plan directed staff to use R1's preferred name, staff were to identify themselves to R1 with each interaction and make eye contact with R1. The plan directed staff to reduce distractions, use consistent simple directive sentences, provide R1 with necessary cues, and stop and return if R1 was agitated.

The "Facility Grievance Form," dated 10/02/23, documented Certified Nurse Aide (CNA) O had been informed by one of R1's representatives that CNA M was telling people that when CNA M put R1 to bed the previous night, or the night before that, R1 grabbed CNA M by her neck and forced CNA M to "make out" with R1.

CNA M's undated "Witness Statement," documented CNA M was assigned to work on the hallway where R1 resided. CNA M noticed R1 was starting to "get antsy" while seated in a recliner. CNA M went over to R1 as R1 was

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attempting to stand up by herself. CNA M assisted R1 to stand. CNA M stated R1 leaned over and kissed CNA M on the side of the neck and placed a hand on CNA M's lower buttock. CNA M stated she leaned away from R1 and told R1 they were going to go for a walk and moved R1's hand from her buttock. Licensed Nurse (LN) G came over to assist CNA M with ambulating R1 in the hallway and then back to the recliner. CNA M stated she did not tell any other staff member of the event.

CNA P's "Witness Statement," dated 10/02/23, documented CNA P said another CNA told her that R1 had grabbed CNA M's buttock and "made out" with CNA M's neck. CNA P stated she had never witnessed the behavior from R1.

CNA N's "Witness Statement," dated 10/02/23, documented CNA M told CNA N that R1 "groped" her and "made out" with her. The other staff that were working had already heard about it. CNA N noted an agency CNA then came and told CNA N the same story. CNA N stated she accidentally told R1's representative about the rumor. CNA N stated she realized telling the rumor to R1's representative was wrong.

CNA Q's "Witness Statement," dated 10/03/23, documented CNA Q stated CNA M was transferring R1 to a reclining chair. CNA M had her arms around R1 to stabilize her and R1 gave CNA M a kiss on the cheek. Later in the day, CNA M stated multiple times R1 had "groped" her and "tried to make out" with her.

CNA MM's "Witness Statement," dated 10/03/23, documented CNA MM stated CNA M came to her and told her that R1 had groped her and kissed

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her neck.

CNA NN's "Witness Statement," dated 10/03/23, documented CNA M made statements to CNA NN That R1 had groped her and was "making out" with CNA M's neck. CNA M talked about R1 in an inappropriate manner. CNA NN stated CNA M had made these comments in front of other staff.

Licensed Nurse (LN) G's "Witness Statement," dated 10/04/23, documented LN G was on the memory unit when R1 started to get restless. CNA M assisted R1 to her feet with a gait belt. R1 leaned her head on CNA M's shoulder. CNA M laughed and said, "Oh, [R1] you're so nice." LN G stated she went over to assist CNA M with ambulating R1. R1 leaned into CNA M again and gave CNA M a quick kiss on the jaw line. LN G, CNA M, and R1 laughed. CNA M stated, "Well let's keep walking." R1 leaned into CNA M for a few steps, and then continued to walk down the hallway.

The "Facility Incident Report," dated 10/10/23, documented on 09/25/23 at around 04:23 PM CNA M and LN G walked with R1. R1 leaned heavily on CNA M as R1 had difficulty with her balance. R1 kissed CNA M on the neck twice and grabbed the back of CNA M's shirt to help steady herself. CNA M and LN G walked R1 from the memory care living room down the hallway and back to the living room recliner. According to multiple staff witness statements, CNA M told staff R1 groped CNA M and "made out" with her neck. R1's representative wanted a complete investigation by the facility to prove that nothing else had happened. The facility interviewed all of the staff that were there during this time period.

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All witness statements showed CNA M made statements exaggerating the kiss and the pulling of back of her shirt. The facility reviewed video footage and identified CNA M had not put R1 to bed without another staff member with her. From the investigation, witness statements, and video footage, the facility deducted that CNA M exaggerated inappropriately about an innocent kiss. The investigation included employee training and/or in-service which covered the prevention and reporting of abuse, neglect, and exploitation as well as protection of privacy and procedure for reporting to family completed on 10/02/23.

On 10/10/23 at 10:30 AM, observation revealed R1 laid in bed listing to music.

On 10/10/23 at 10:35 AM, CNA NN stated that R1 was completely dependent on staff for all her cares, even eating. CNA NN stated that R1 would kiss staff on the cheek or hand in appreciation of her cares. CNA NN stated R1 was completely non-verbal, and that was how she demonstrated her gratitude and affections for the staff caring for her.

On 10/10/23 at 10:45 AM, CNA PP stated that she never misunderstood R1's affection for sexual behavior or action and said that anyone that did was not thinking right. CNA PP stated R1 would give quick pecks on the cheek or neck in appreciation for cares due to being non-verbal and having early onset Alzheimer's. CNA PP stated that she had heard the rumors that CNA M had said about R1, and she did not think it was nice.

On 10/10/23 at 11:30 AM, Administrative Staff A stated CNA M had been dismissed from working

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at the facility following the investigation. Administrative Staff A stated CNA M denied ever spreading rumors about R1. Administrative Staff A stated the witness statements from other CNAs all had the same story. Administrative Staff A stated CNA N should have never disclosed the rumors to R1's representative and CNA N was educated on all communication with the family needed to go through the nurse. Administrative Staff A stated R1's representative was upset with the facility that this had occurred and wanted a complete investigation into the situation and stated that he was going to turn the incident into the police for investigation. Administrative Staff A stated CNA M should not have spread rumors or discussed the resident's cares in a negative or unnecessary manner. Administrative Staff A stated CNA N should not have reported the rumors to R1's family members.

On 10/10/23 at 02:45 PM, R1's representative stated they were upset that staff spread rumors about their loved one. R1's representative said the facility should take care of R1 and not allow anything bad to happen to her.

The "Resident Rights Policy," dated 10/01/23, documented each resident residing in the facility has the right and will be afforded the right to a dignified existence, self-determination, and communication with and access to person and services inside and outside the facility without interference, coercion, discrimination or reprisal. No staff member or contracted provider will hamper, compel, treat differently or retaliate against a resident for exercising Resident Rights. It is the responsibility of all who work at the facility to advocate and protect the rights of each resident. All staff members are trained on this

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F 550	Continued From page 7 Resident Right Policy at the time of employment, before providing care to residents and at least annually to ensure full understanding and competency. The facility failed to protect R1's right to dignity. This deficient practice placed R1 at risk for impaired dignity and decreased psychosocial wellbeing.	F 550		