STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175135	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Post Acute Care Center	6500 Greeley Avenue Kansas City, KS 66104

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 31 residents. The sample included three residents with one resident reviewed for dementia (progressive mental disorder characterized by failing memory, confusion) care. Based on record review and interviews, the facility failed to provide dementia care and services for Resident (R) 1 when the facility failed to assess, identify, record, respond to, and reassess R1's specific behaviors and triggers to promote an environment which supported R1's individualized care needs. This deficient practice created an environment that affected R1's ability to maintain his highest practicable level of physical, mental, and psychosocial well-being. Findings included: - The Diagnoses tab of R1's Electronic Medical Record (EMR) documented R1 had diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought]) and dementia with other behavioral disturbances. The Significant Change Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. R1 hallucinated (sensing things while awake that appear to be real, but the mind created). R1 had wandering behavior one to three days in the assessment period. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of nine which indicated moderate cognitive impairment. R1 had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R1 had verbal behavioral symptoms directed towards others four to six days and other behavioral symptoms not directed towards others one to three days in the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/11/23, documented R1 triggered for cognitive loss related to low BIMS and wandering. The Behavioral Symptoms CAA dated 10/12/23, documented R1 triggered for behavior symptoms and problems. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan dated 04/06/20 and revised 06/04/21, documented R1 had difficulty keeping his hands to himself at times. The plan documented an intervention, dated 04/06/20, that directed if reasonable, staff discussed R1's behavior and explained why the behavior was inappropriate and/or unacceptable. An intervention, dated 01/05/24, directed R1 had an increase in verbal and physical approaches to staff and staff cued R1 regarding appropriate requests to staff for needs given. An intervention, dated 03/07/24, directed staff made sure R1 had their attention before starting cares with him as he did not like to be approached abruptly. An intervention, dated 03/07/24, directed staff encouraged R1 to verbally express what he was thinking or feeling instead of grabbing or hitting. An intervention, dated 03/07/24, directed if R1 grabbed people or made other physical contact, staff firmly and clearly told R1 that behavior was not acceptable and was not tolerated. R1's Care Plan revised 08/31/23, documented R1 was at risk for verbal and physical touch towards others. The plan documented an intervention, dated 03/15/24, that documented on 03/01/24, R1 was moving about in the lobby and nurse desk area when he approached a female resident [R2] who was standing at the desk; R1 reached out and poked or touched her on her belly area on her left side. Staff assisted R1 out of the area and there was no further interaction with R1 and R2. R1's Care Plan dated 01/31/22, documented R1 had cognitive loss that affected his memory. The plan documented staff gave R1 his medications per physician orders and helped him establish a regular daily schedule. R1 needed tasks divided into several steps to assist him so staff explained any activity or care procedure prior to beginning with R1. Staff reminded R1 who they were when providing cares, staff gave R1 one instruction at a time. Staff provided R1 cueing and prompting but allowed him as much independence as possible. Staff repeated instructions as needed in a calm tone and staff gave R1 choices when possible. R1's Care Plan lacked evidence of resident specific triggers related to behaviors for R1. The Notes tab of R1's EMR revealed the following: A Nurse's Note, on 02/04/24 at 07:11 PM, documented around 06:15 PM, R1 started grabbing the arms of staff walking nearby. R1 was assisted to his room and Haldol (antipsychotic medication used to treat major mental conditions which cause a break from reality) was given which was ineffective. A message was left for the doctor and R1's representative. A Behavior Note, on 02/06/24 at 10:11 AM, documented a Certified Medication Aide (CMA) explained to the nurse that R1 grabbed her between her legs. The other nurse attempted to talk to R1 about grabbing other people and staff members. R1 responded by saying he wanted cocaine. The nurse witnessed R1 wheel himself down the hall and attempt to go into a female resident's room. The nurse explained to R1 that was not his room and redirected R1 to his room. R1 appeared less agitated while in his room. The doctor and R1's representative were notified. A Nurse's Note, on 03/01/24 at 01:41 AM, documented R1 attempted to grab staff late in the evening and staff redirected R1. R1 went to his room and slept. A Nurse's Note, on 03/05/24 at 11:53 AM, documented R1 attempted to grab the writer that morning and staff provided redirection in which R1 was compliant. R1 went by the front door and the alarm sounded, he stated he wanted to go to the store. R1 was redirected and given snack items to eat. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note, on 03/14/24 at 08:00 PM, documented R1 pinched the buttocks of a female resident that was standing at the nursing station. Staff redirected R1 and immediately separated him and female resident. R1 placed on 15-minute checks. A Nurse's Note, on 03/15/24 at 06:33 AM, documented R1 was up and down majority of the night asking for honey buns and coffee. Staff redirected R1 to his room multiple times during the course of the night and he went to bed for short periods of time. A Nurse's Note, on 03/15/24 at 10:41 AM, documented R1's behaviors continued throughout the morning and R1 yelled in the hallways asking for honey buns. Staff redirected to his room with snacks given. A RISK Progress Note, on 03/15/24 at 11:54 AM, documented R1 poked a female peer on her left belly area on 03/01/24 and staff assisted him away from the lobby area. Staff continued ongoing observation for risk of R1 returning or interacting with female resident to provide immediate redirection as needed. In the facility's investigation report, dated 03/20/24, Administrative Staff A stated he was notified on 3/14/24 at 08:02 PM that at 08:00 PM, R1 wheeled up to R2 and pinched her buttocks. R1 was trying to get the attention of the nurse and R2 appeared to be a nurse as she stood around the nurses' station daily. This was witnessed by Certified Nurse Aide (CNA) M, who immediately separated the two. Administrative Staff A stated R1's representative and physicians were notified as well as Administrative Staff A and Administrative Nurse D. R1 was placed on 15-minute checks to ensure safety of the other residents. R2 was moved from 200-hall to the 100-hall to help protect her from R1 as he was on the 200 hall. A referral packet for R1 was sent to the hospital for psychiatric evaluation and treatment on 3/18/24 and R1 was admitted to the hospital on 3/20/24. On 04/10/24 at 12:03 PM, Licensed Nurse (LN) G stated when R1 had behaviors, staff used distraction and provided activities and with any difficult behaviors, staff removed R1 from the area and did things to keep his mind off of what upset him. On 04/10/24 at 12:05 PM, LN H stated if R1 had behaviors, staff tried to remove him from the incident. She stated R1 had inappropriate verbal behaviors directed towards staff mostly and staff tried to watch R1. On 04/10/24 at 12:09 PM, CMA R stated when R1 had behaviors, staff usually redirected him. She stated staff kept R1 away from R2 and told R1 to keep his hands to himself and that he cannot touch ladies. CMA R stated R1 liked to grab and hold onto others, mostly staff depending on his mood. She stated if she saw R1 having a behavior, she de-escalated him, got him into activities, and provided redirection. She stated R1's behaviors seemed to be getting worse the older he gets. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 12:33 PM, Administrative Nurse D stated before the 03/14/24 incident between R1 and R2, staff kept R1 and R2 separated or in areas where they were not around each other. She stated staff tried to redirect R1 as best as they could, used food as a redirection, and provided one-on-one supervision depending on the situation. Administrative Nurse D stated some days R1 was easy to redirect by talking with staff and sometimes staff gave him a honey bun as a redirection; it depended on the day which redirection strategy staff used. She stated prior to R1 transferred to the hospital, staff monitored him, made sure they knew where he was at all times, made sure R1 was not in R2's area, and offered interventions depending on the behaviors he had in that moment. Administrative Nurse D stated prior to the 03/14/24 incident, R1 yelled a lot and yelled out throughout the facility. On 04/10/24 at 12:43 PM, Administrative Staff A stated he was notified on 03/14/24 that R1 pinched R2 at the nurse's station when he was looking for a honey bun and he thought she was a nurse. He stated he reviewed the camera and said what he saw was a poke. On 04/10/24 at 01:56 PM, LN G stated one of R1's triggers was wanting something and not getting it. She stated somebody would walk by R1 and he would grab them, or he saw staff and next thing they knew, he was propelling up to them. LN G stated redirection helped at first with R1's behaviors but the last couple of weeks before he was transferred to the hospital, his behaviors were beyond that point. On 04/10/24 at 02:10 PM, CMA R stated a few of R1's triggers included if he could not get coffee when he wanted or when he could not get food he wanted since he was on a pureed (mechanically altered diet) diet. She stated she had received dementia and behavioral training in the last year. On 04/10/24 at 02:22 PM, CNA N stated R1's usually behaviors were he liked to eat snacks and go to the vending machine. She stated he did not have any triggers that she knew of but if there were any triggers, they were found on the care plan. She stated she had not received any behavioral health or dementia training. On 04/10/24 at 02:39 PM, Administrative Nurse D stated Relias (online training platform) was the main source for behavioral health and dementia training. She stated R1 did not necessarily have any triggers and from day-to-day, staff did not know what a trigger might be for him. Administrative Nurse D stated every day, staff tried to exhaust all leads to suit R1 and she did not know if his behaviors were because of his dementia so she did not know what triggered his behaviors. She stated the care plan had behaviors, behavioral interventions, and any known triggers for behaviors. Administrative Nurse D stated she expected staff to monitor residents for any behavior triggers to update the care plan. On 04/10/24 at 02:52 PM, Administrative Staff A stated he saw on Relias that some staff were assigned behavioral health and dementia training while others were not. He stated he believed all staff should be trained on how to interact with dementia residents. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Behavior Management and Psychotropic (medication that alters mood or thought) Medications policy, last revised December 2022, directed the plan of care addressed individualized focus, goals, and interventions directed towards managing the resident's target behaviors, non-pharmacological interventions, psychotropic medication use, and gradual dose reductions and/or supporting documentation for continued use. The policy directed residents with psychosocial and/or history of traumatic events were identified in the care plan with triggers, de-escalations, personnel preferences, and interventions. The facility failed to provide dementia care and services for R1 when the facility failed to assess, identify, record, respond to, and reassess R1's specific behaviors and triggers to promote an environment which supported R1's individualized care needs. This deficient practice created an environment that affected R1's ability to maintain his highest practicable level of physical, mental, and psychosocial well-being.