STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175187	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Ridge Health & Rehabilitation	6501 W 75th Street Overland Park, KS 66204

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834 The facility identified a census of 83 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to prevent an incident of resident-to-resident sexual abuse when Resident (R) 1, who had a history of inappropriate sexual behaviors with a recent escalation, exposed his genitals to R2, a cognitively impaired resident unable to consent. This deficient practice resulted in a negative reaction from R2 and placed the residents at risk for impaired psychosocial well-being including fear and embarrassment, and risk for ongoing sexual abuse. Findings Included: - R1's Electronic Medical Record (EMR) documented diagnosis of obsessive-compulsive behavior (OCD - an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), unspecified dementia (progressive mental disorder characterized by failing memory, confusion), and cognitive communications deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. The MDS further documented R1 had other behavioral symptoms not directed toward others that occurred for one to three days of the observation period. The MDS documented R1 as independent for mobility and walking. The MDS further documented R1 used a wheelchair and could propel himself independently. The Functional Abilities Care Area Assessment (CAA), dated 01/09/24, documented R1 admitted to the facility after a recent stay at a psychiatric facility and had diagnoses of obsessive-compulsive behavior and dementia. R1's Care Plan with an initiated date of 01/03/24 documented R1 had a history of sexually inappropriate behavior in a previous facility where he exposed his penis and fondled a female resident. R1's Care Plan documented R1 as at risk for behaviors and had diagnoses of obsessive-compulsive behavior and dementia. R1's Care Plan with an initiated date of 01/12/24 directed staff to evaluate behavior patterns and try to remove causes for behavior. R1's Care Plan with an initiated date of 04/03/24 documented staff educated R1 on inappropriate behaviors. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A Provider Progress Note dated 01/04/24, documented R1 newly admitted from another facility. The note further documented R1 displayed new onset sexually inappropriate behavior. A Nurses Note dated 03/30/24, documented that while nurses were in R1's room taking care of R1's roommate, R1 began pleasuring himself and showed a Certified Nurse Aide (CNA) his genitals. A General Note from eRecord dated 04/01/24 documented R1 tried to enter another resident's room and was redirected. The note further documented that R1 had shown interest in the resident in that room. A Nurses Note dated 04/03/24, documented R1 exhibited sexual behavior in front of staff by pleasuring himself and then exposing himself to staff. The note further documented R1 inappropriately touched staff in activities and R1 was educated on inappropriate behavior. A Behavior Note dated 04/21/24 documented R1 attempted to follow a female resident into her room and was redirected by staff. A Nurses Note dated 04/24/24, documented R1 had behaviors of inappropriately touching himself in a public area. A Nurses Note dated 06/30/24 documented three staff sat at the nurses' station when they heard a female resident (R2) yell out and at that time it was witnessed that R1 stood to the right side of R2 as she sat in her Broda chair (specialized wheelchair with the ability to tilt and recline), and staff could only see the back of R2's Broda chair and R1's back. The note further documented as staff approached to investigate, they noted R1 had his pants pulled down part way with his penis exposed to R2. Staff intervened and removed R2 from the area and R1 pulled his pants up and sat down in a chair in the TV room where the incident occurred. The note further documented R1 was placed on one-to-one observation with staff, staff attempted to contact the resident's family, police were notified, and the executive director of the facility was contacted. A Complaint Investigation Witness Statement dated 06/30/24, documented Certified Medication Aide (CMA) R heard R2 scream while CMA R was at the nurses' station. The statement documented CMA R went into the TV room and saw R1 standing to the right side of R2 with his penis out. The statement documented when R1 noticed staff he pulled his pants up and sat down. R2 was moved to the nurses' station. A Complaint Investigation Witness Statement dated 06/30/24, documented R1 and R2 were watching TV in the activity room and Licensed Nurse (LN) G heard R2 yell out. The statement documented LN G went to investigate with two other staff and found R1 standing close to R2's face with his pants halfway down. The statement documented R1's penis was out and next to R2's face and mouth. Staff brought R2 to the nurses' station while R1 remained in the TV room and was placed on one-to-one supervision. A Complaint Investigation Witness Statement dated 06/30/24, documented LN H was at the nurse's station and heard R2 yell. The statement documented LN H looked in the direction of the yelling and observed R1 as he stood over R2 with his penis exposed. The statement further documented CMA R removed R2 from the TV room and placed her at the nurses' station. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 07/03/24 at 01:10 PM, R2 was in her room and laying in her bed awake looking upward toward the ceiling. R2 did not answer basic yes or no questions. She looked around and made some noises under her breath but did not respond with an answer. On 07/03/24 at 03:45 PM, CNA M stated the facility provided abuse, neglect, and exploitation education through an online training module and the education included sexual abuse. CNA M stated R2 was non-verbal and communicated through actions such as making faces if she was in pain or turning away if she did not like something while staff assisted with meals. CNA M stated R2 was dependent on staff for everything. CNA M stated that without staff intervention R2 would not have been able to stop R1. CNA M stated she saw in R1's EMR that he was sexually aggressive, and that staff had to redirect him from going into female resident's rooms CNA M stated staff usually kept an eye on R1 and if they did not see him, then they would go look for him. She stated she was aware that R1 had masturbated in front of staff before. CNA M stated the intervention to prevent R1 from sexually inappropriate behavior was for staff to redirect him. CNA M stated she considered what R1 did to R2 as abuse and harassment. On 07/03/24 at 03:50 PM LN I stated she worked at the facility for about three months but had not received any abuse training at this current facility. LN I stated R2 was non-verbal, but would smile sometimes. LN I stated she had never heard R2 say a word and that she has no way to communicate. LN I stated that she was not aware of any specific intervention in place for R1 prior to this incident that could have prevented his behavior and that she was not aware if R1 had been inappropriate with other residents before this incident. LN I stated R1 was placed on one-to-one supervision after the incident and that she would hope interventions would be put in place for R1 going forward. LN I stated that what R1 did to R2 would be a form of abuse. On 07/03/24 at 03:58 PM Administrative Nurse D stated R2 was able to answer yes and no questions; however, providing care for R2 was more about anticipating her needs and R2 could laugh, or cry, but that sometimes her cry sounded more like a laugh. Administrative Nurse D stated while R2 was in her Broda chair she was completely dependent on staff and could not get around on her own at all. Administrative Nurse D stated she was not aware of another incident where R1 exposed himself at the facility and stated she knows that R1 spent time with another female resident and that they would eat together, or watch TV together, but she never heard of there being anything that was sexually inappropriate between them. Administrative Nurse D stated the intervention for R1 to prevent sexually inappropriate behavior was for staff to redirect him if he was doing it. Administrative Nurse D stated she believed the incident between R1 and R2 would be a form of abuse as R2 was unable to consent. Administrative Nurse D stated R1 was sent out to a psychiatric facility for evaluation and treatment and that the facility was seeking placement for him at a facility with a male-only unit. She stated if R1 returned to the facility before placement was found, that he would be placed on one-to-one supervision until placement was found for him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 07/03/24 at 04:33 PM Administrative Staff A stated abuse, neglect, and exploitation education was provided for staff during orientation and annually for all staff. Administrative Staff A stated R2 had a BIMS of zero (indicating severe cognitive impairment), but she could give yes or no answers that were consistent. Administrative Staff A stated when he spoke with R2 about the incident, he asked if R1 had touched her, or her mouth, and R2 stated no. Administrative Staff A stated that he asked R2 each question twice and was told no each time. Administrative Staff A stated he was not aware that R2 could answer questions, that R2 was probably better at responding during the day than in the evenings, and that when R2 normally tried to speak it was garbled sounds. Administrative Staff A stated R2 could not have gotten away from R1 without staff intervention, but staff responded to the incident when they heard her scream. Administrative Staff A stated R1 had not exposed himself to other residents at this facility prior to this incident and he had not heard of R1 exposing himself to staff prior to this incident. Administrative Staff A further stated when R1 first arrived at the facility they had not seen any behaviors from him so staff were just observing him, and if they saw anything they would address it moving forward, but he was not aware of anything in the facility prior to this incident. Administrative Staff A stated the incident between R1 and R2 would be considered abuse. Administrative Staff A further stated R1 was placed on one-to-one supervision and sent out to a psychiatric facility. He stated the plan moving forward was to find placement in an all-male unit. He stated the facility was working with R1's guardian to help in the process, and if R1 had to return before placement was found, that R1 would remain on one-to-one supervision until he could be placed at another facility. The facility provided an Abuse Prevention Program policy with a review date of 03/22/24, documenting the facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the residents, family members, legal guardians, surrogates, sponsors, friends, visitors or any other individual. Identification of occurrences and patterns of potential mistreatment, abuse, neglect, and or misappropriation. The policy documented sexual abuse is non-consensual sexual contact of any type with a resident. The facility failed to prevent an incident of resident-to-resident sexual abuse when R1, exposed his genitals to cognitively impaired R2 who was unable to consent. This deficient practice placed the residents at risk for impaired psychosocial well-being including fear and embarrassment, and risk for ongoing sexual abuse. R2 screamed and demonstrated a negative reaction at the time of the abuse. The scope and severity were determined to be actual harm based on the reasonable person concept due to the circumstances of R2's cognitive impairment and inability to self-identify and express her feelings regarding the abuse.