STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175200	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kenwood View Healthcare and Rehabilitation Center	900 Elmhurst Blvd Salina, KS 67401

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 - Minimal harm or potential for 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** 43204 The facility identified a census of 73 residents with three residents reviewed for abuse and neglect. Based on record review, observation and interview, the facility failed to ensure Resident (R) 1 remained free from verbal abuse and/or mistreatment from staff. This deficient practice placed R1 at risk for fear, intimidation and neglect. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), and seizures (violent involuntary series of contractions of a group of muscles). The Annual Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS documented R1 was dependent of staff for all her activities of daily living (ADL). R1 had impairment to both sides of her upper extremities, and both sides of her lower extremities. R1 was dependent on a wheelchair for locomotion. The Functional Abilities Care Area Assessment (CAA), dated 01/25/24, documented R1 required staff assistance with all her ADL. The CAA documented R1 was at risk for further decline in functional abilities, falls, contractures (abnormal fixation of a joint or muscle), isolation, pressure injuries and incontinence. The Communication CAA, dated 01/25/24, documented R1 had difficulty expressing her ideas and understanding others. The CAA documented R1 was at risk for missed messages, isolation, and depression. R1's Care Plan documented R1 was completely dependent on staff for all her ADL. The plan directed staff to anticipate and meet R1's needs. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nurse Aide (CNA) N's Witness Statement, dated 04/01/24, documented at around 03:30 AM CNA N and CNA M went into R1's room to do rounds. CNA N and CNA M performed R1's normal routine. When turning R1 to the wall, R1's arm got caught under her and she yelled out, My arm several times. CNA N and CNA M got R1's arm unstuck and then rolled R1 the other direction. CNA N noted when staff finished cleaning R1 up and laid her on her back, R1 stated, You almost broke my neck. CNA M started yelling and pointing his finger in R1's face. CNA M stated, We did not almost break your [expletive] neck. We have been yelled at and cussed at all night and don't [expletive] deserve this [expletive]. We don't get paid enough and we aren't robots. CNA N documented that CNA M then pulled R1's call light out of the wall, plugged it back in and tossed the call light in the chair, and told R1 not to call again and left the room. CNA N told R1 she was sorry, and that she would report the situation to the nurse. CNA N stated she left the room and reported the situation to Licensed Nurse (LN) G. LN G's Witness Statement, dated 04/01/24, documented at 05:00 AM CNA N reported to her that CNA M had treated R1 in an unprofessional manner. CNA N described to LN G CNA M had pushed a chair in R1's room, had spoken to R1 in a harsh manner, and pointed his finger in R1's face. LN G documented CNA N told the two CNA staff were changing R1 and turned R1 and her arm was stuck underneath her. The aides turned R1 to the left side. LN G documented CNA N told her R1 said they were going to break her neck and she would fall. LN G documented CNA N told her CNA M got upset and started yelling at R1 that she would get him in a lot of trouble and that was when the chair was shoved and the finger pointing started. CNA N asked LN G to go talk to R1. LN G asked R1 what had happened. R1 stated she was upset because she thought the aides would break her neck when they turned her, or she would fall. R1's face was red and R1 said, she was afraid and that she thought CNA M was mentally unstable and she had thought that for a long time. LN G left R1's room and went to talk to CNA N. CNA M's Witness Statement, dated 04/01/24, documented CNA N and he were doing rounds and met in R1's room; they turned the lights on and let R1 know everything they were going to do. They started to do cares on R1, then pulled the pad not knowing it was not fully under R1 and it pulled R1's body over and R1 laid on her wrist. CNA M documented they quickly rolled R1 back over to get her arm out and then rolled R1 the other way. R1 said the two staff tried to break her neck. CNA M documented that after they were we finished, he told R1 if she made an accusation like that, the staff could get in trouble when it was not true. CNA M recorded R1 was screaming and yelling, and he told R1 he was done getting yelled at and finished with her. CNA M documented he then tripped on the call light, knocked into R1's chair, grabbed up the mess and left R1's room. CNA M documented he let LN G know what had happened. The Facility Incident Report, dated 04/05/24, documented at approximately 08:00 AM on 03/31/24 LN G notified Administrative Nurse D of a potential incident between R1 and CNA M. LN G told Administrative Nurse D that CNA M's conversation with R1 was reported as unprofessional. LN G stated the incident was reported and witnessed by CNA N. The investigation was started, and CNA M was suspended pending results of the investigation. Administrative Nurse D spoke with R1 on 03/31/24 and R1 stated she could not recall any specific incident or any staff members she had issues with. A skin assessment was completed on R1 and no new variances were noted. Administrative Nurse D spoke with CNA N and obtained her witness statement and obtained a witness statement from LN G. A meeting was held with CNA M and his witness statement was obtained. Law Enforcement was also notified. A follow up with R1 was completed throughout the week and R1 showed no indications of psychosocial affects. On 04/16/24 at 10:30 AM, observation revealed R1 sat in a high-backed wheelchair watching television. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/24 at 10:30 AM, R1 stated she was upset with CNA M, but she was not afraid because CNA M did not work there anymore. R1 stated she got good care at the facility. On 04/16/24 at 01:00 PM, Administrative Nurse D stated that she expected her staff to report any allegations of abuse to her or Administrative Staff A immediately and if they could not be reached, they should reach out to other facility administrative staff until someone answered and report the situation. Administrative Nurse D stated CNA M should have been sent out of the facility immediately after the incident. Administrative Nurse D stated she re-educated LN G and CNA N on ANE policy and immediate notification. Administrative Nurse D stated CNA M had finished his shift that started on 03/30/24 and ended at approximately 07:00 AM on 03/31/24. On 04/16/24 at 01:30 PM, CNA N stated CMA M was very angry at R1 and was out of control. CNA N stated R1 was scared at the time of the incident. On 04/16/24 at 01:55 PM, Administrative Staff A e-mailed and stated that the all-staff education had not been started after the incident, but education would be started that day. The facility's Abuse, Neglect, and Exploitation Policy, revised 11/06/2017, documented it is the facility's policy to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing residents' rights to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility will not use verbal, mental, sexual, or physical abuse; corporal punishment; or involuntary seclusion. The facility must ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported. The facility must have evidence that all alleged violations are thoroughly investigated. The facility must prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. If the alleged violation is verified, appropriate corrective action must be taken. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, within five working days of the incident. The facility failed to ensure R1 remained free from staff abuse and/or mistreatment. This deficient practice placed R1 at risk for fear, intimidation and neglect.