

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Shawnee Gardens Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6416 Long Street Shawnee, KS 66216	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>45668</p> <p>The facility identified a census of 117 residents. The sample included eight residents, with one resident reviewed for abuse and neglect. Based on observation, record review, and interview, the facility failed to prevent an episode of resident-to-resident sexual abuse for cognitively impaired Resident (R) 2. On 02/08/25, facility staff witnessed R1 groping R2's nipples, breast, and buttocks while both were seated at the dinner table on the locked unit for cognitively impaired residents. R2 voiced she did not consent to R1 touching her. This placed R2 in immediate jeopardy and at risk for ongoing and/or unidentified abuse and feelings of fear for R2, based on reasonable person concept.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and a history of sexual behaviors related to psychiatric illness. <p>R1's Quarterly Minimum Data Set (MDS) completed 12/15/24 noted a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The MDS noted he had verbal and physical aggression one to three days weekly. The MDS noted he had rejection of care behaviors one to three days weekly. The MDS noted he was independent with transfers, bed mobility, bathing, toileting, and walking. R1's MDS noted no sexual behaviors.</p> <p>R1's Cognitive Loss/Dementia Care Area Assessment (CAA) completed 06/11/24 noted he had impaired cognition related to his medical diagnoses. The CAA noted he required reorientation, reminders, and reassurance to make sense of things. The CAA noted a care plan was implemented with interventions and monitoring to reduce the risks.</p> <p>R1's Behavioral Symptoms CAA was not triggered.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's Care Plan initiated on 10/25/23 noted he was admitted to the long-term care unit due to his medical diagnoses. The plan noted he exhibited sexually inappropriate behaviors related to his psychiatric illness (03/04/24). The plan instructed staff to explain and reinforce to R1 why his behaviors were inappropriate or unacceptable (03/04/24). The plan instructed staff to educate and collaborate with R1 to find successful coping and interaction strategies (03/04/24). The plan instructed staff to administer and monitor his medication's side effects and effectiveness (03/04/24). The plan revealed that R1 was moved to another unit due to exhibiting sexually inappropriate behaviors (related to a sexual behavioral episode with R2 on 02/08/24).</p> <p>R2's Care Plan initiated 06/15/24 revealed R2 had a deficit related to her severe cognitive impairment. The plan noted she had difficulty understanding others and making her needs known. The plan instructed staff to provide R2 with a calm and safe environment. The plan instructed staff to allow her to share her feelings and verbalize her feelings, perceptions, and fears. The plan noted she had a history of behavioral concerns related to other peers invading her personal space. The plan instructed staff to ensure other residents respected her personal space. The plan noted she exhibited wandering behaviors and had impaired safety awareness.</p> <p>R1's EMR under Assessments revealed a Social Service Assessment completed on 04/17/24 revealed he had a history of sexual behaviors, and a medication change was implemented for his Estradiol medication.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 07/10/24. The note revealed direct care staff reported they observed R1 seated in the dining room next to R2. The note revealed that R1 and R2 were inappropriately touching each other. The note indicated R2 was immediately moved away from R1 and both residents were kept separated for the rest of the shift.</p> <p>R2's EMR under Progress Note revealed an Alert Note completed 02/08/25. The note documented that R2 was in the dining room attempting to stand up at the table. The note indicated that R1 grabbed R2's breast and buttocks. The note indicated both residents were immediately separated. The note revealed that R1 was moved off the unit due to his sexual behaviors towards female residents. (Refer to F610)</p> <p>A Facility Incident Report #3462 completed on 02/08/25 revealed that R1 was observed by staff touching R2's breast and buttocks during meal service. The report indicated that R1 was moved away from R2 and placed on one-on-one supervision.</p> <p>A Staff Witness Statement completed 02/08/25 revealed that R1 sat at the dining room table next to R2. The statement revealed staff witnessed R1 grope R2's nipples and pulled her breast downward. The statement indicated that R2 was visibly upset and reported to staff she felt like she was being held against her will. The statement indicated that R2 continued to verbalize she was scared. The statement indicated R1 was supervised for the remainder of the evening.</p> <p>On 02/19/25 at 11:10 AM, R2 sat in walked around the locked memory care unit. R2 was unable to recall the incident that occurred on 02/08/25.</p> <p>On 02/19/25 at 11:55 AM, R1 walked from his room to the 2nd-floor dining area without staff assistance or supervision.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 02/19/25 at 11:03 AM, Certified Nurse Aide (CNA) M stated cognitively impaired residents should be monitored closely due to the potential risk of injuries and abuse. CNA M stated residents with noted behaviors should be monitored closely around other residents and said male residents with sexual behaviors should not be left unsupervised around female residents. CNA M stated R1 should not be seated next to or be around female residents unsupervised.</p> <p>On 02/19/25 at 01:04 PM, Licensed Nurse (LN) G stated R1 was recently moved from the locked unit due to sexual behaviors towards females. LN G stated the direct care staff documented behavioral monitoring under the Tasks section of the EMR. LN G stated R1 recently moved to the unit, so he was not sure if the monitoring section was under Tasks for the resident. LN G stated staff were expected to keep an eye on R1 while he was out walking around. LN G stated all staff had access to the care plan and the care plans should reflect his repeated behaviors toward females, monitoring, coping strategies, and interventions to prevent his behaviors. LN G said suspected abuse allegations were reported immediately to the director of nursing and facility administrator. LN G stated staff would immediately separate the perpetrator from other residents and ensure everyone was safe.</p> <p>On 02/19/25 at 02:40 PM, Administrative Nurse D stated R1 was immediately separated from R2 and placed on one-on-one supervision. Administrative Nurse D stated R1 was moved to another hall. Administrative Nurse D said R1 had medication changes occurring and was not a risk to the females in the new hallway. Administrative Nurse D said she expected staff to monitor R1's behaviors and document them under the Psychotropic Medication Monitoring section of his MAR. She stated events should be documented there. She stated staff were expected to immediately separate the suspected perpetrator from all potential victims.</p> <p>The facility's Abuse, Neglect, and Exploitation policy revised 11/2017 indicated the facility will provide safety and dignity for all residents by implementing proper procedures for enforcing resident rights. The policy noted the facility will protect residents of suspected abuse and all potentially affected residents from incidents of abuse.</p> <p>The facility failed to ensure cognitively impaired R2 remained free from abuse when the facility failed to prevent an episode of resident-to-resident sexual abuse. This placed R2 at risk for ongoing and/or unidentified abuse and mistreatment based on the reasonable person concept, this deficient practice resulted in feelings of fear for R2 and placed R2 at risk for further psychosocial harm, intimidation, and neglect.</p> <p>The facility failed to identify and implement preventative interventions related to Resident (R)1's sexual behaviors upon moving him to a new unit. This deficient practice placed 19 female residents at risk for sexual abuse.</p> <p>On 02/19/25 at 03:31 PM, Administrative Staff A was provided a copy of the IJ template and notified of the facility's failure to prevent the sexual abuse of R2, the facility additionally placed 19 other female residents at risk for sexual abuse after moving R1 to another unit without addressing his sexual behaviors.</p> <p>The facility provided an acceptable plan for the removal of the immediacy on 02/19/25 at 04:30PM which included the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. R1 was immediately placed on one-on-one supervision until psychiatric evaluation can be completed. 02/19/25</p> <p>2. The facility identified all at-risk residents on the new unit. 02/19/25</p> <p>3. Staff were provided in-service upon hire, annually, and post-allegation on abuse, neglect, and exploitation with comprehensive testing. 02/19/25</p> <p>4. Safe survey conducted on female residents of new unit. 02/19/25</p> <p>5. Psychiatric evaluation will be completed.</p> <p>The Surveyor verified the implementation of the IJ removal plan while onsite on 02/19/25 at 04:45 PM. The deficient practice remained at a G after removal of the immediacy based on reasonable person concept.</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>45668</p> <p>The facility identified a census of 117 residents, with eight residents sampled, including two residents reviewed for abuse. Based on observation, record review, and interviews, the facility failed to implement effective preventative interventions related to Resident (R)1's sexual behaviors to protect the female residents in the facility including R2 (See F600). This failure placed 19 female residents at risk.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and a history of sexual behaviors related to psychiatric illness. <p>R1's Quarterly Minimum Data Set (MDS) completed 12/15/24 noted a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The MDS noted he had verbal and physical aggression one to three days weekly. The MDS noted he had rejection of care behaviors one to three days weekly. The MDS noted he was independent with transfers, bed mobility, bathing, toileting, and walking. R1's MDS noted no sexual behaviors.</p> <p>R1's Cognitive Loss Care Area Assessment (CAA) completed 06/11/24 noted he had impaired cognition related to his medical diagnoses. The CAA noted he required reorientation, reminders, and reassurance to make sense of things. The CAA noted a care plan was implemented with interventions and monitoring to reduce the risks.</p> <p>R1's Behavioral Symptoms CAA was not triggered.</p> <p>R1's Care Plan initiated on 10/25/23 noted he was admitted to the long-term care unit due to his medical diagnoses. The plan noted he exhibited sexually inappropriate behaviors related to his psychiatric illness (03/04/24). The plan instructed staff to explain and reinforce to R1 why his behaviors were inappropriate or unacceptable (03/04/24). The plan instructed staff to educate and collaborate with R1 to find successful coping and interaction strategies (03/04/24). The plan instructed staff to administer and monitor his medication's side effects and effectiveness (03/04/24). The plan revealed that R1 was moved to another unit due to exhibiting sexually inappropriate behaviors (02/08/24). The plan lacked information related to his sexual behaviors towards female residents, required supervision around female residents, and required monitoring while out of his room on the unit.</p> <p>R1's Care Plan revealed a resolved intervention that noted R1 was separated from a female resident on 07/10/24 due to inappropriate touching.</p> <p>R1's EMR under Physician Orders revealed an order (started 03/04/24) for him to receive one milligram of Estrace (Estradiol- lowers hormonal imbalances) every morning by mouth for sexual behaviors. No changes to this order have been documented since its start date.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's EMR under Progress Notes revealed a Nursing Note completed on 03/04/24. The note revealed direct care staff observed R1 as he sat on a female resident's rollator walker seat. The note revealed that R1 had his head between the female resident's breasts as she pushed him down the hallway for lunch. The note indicated staff separated the residents and asked them to sit away from the female residents during meals. The note revealed that R1 was to be supervised at all times while outside of his room and around other residents.</p> <p>R1's EMR under Assessments revealed a Social Service Assessment completed on 04/17/24 revealed he had a history of sexual behaviors, and a medication change was implemented for his Estradiol medication.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 07/10/24. The note revealed direct care reported they observed R1 seated in the dining room next to R2 (severely cognitively impaired resident). The note revealed that R1 and R2 were inappropriately touching each other. The note indicated R2 was immediately moved away from R1 and both residents were kept separated for the rest of the shift.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 07/14/24. The note revealed that R1 walked up to a female resident and began patting her on the shoulder. The note revealed the resident became distressed and attempted to push his hand away from her. The note revealed staff had to ask R1 to leave the female resident alone.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 12/07/24. The note revealed that R1 punched a female residents' hand as she attempted to throw food at him. The note revealed she was moved to another table.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 02/02/25. The note revealed staff observed R1 approach a female resident while she lay in the common area recliner. The note revealed that R1 began touching the female residents outer arm. The note revealed the female resident attempted to push his arm away and R1 resisted. The note revealed that R1 pushed the female residents arm downward and continued touching her arm. The note revealed staff immediately separated both residents. The note indicated staff sat with the female resident during meal service due to concerns for her safety.</p> <p>A Facility Incident Report #3462 completed on 02/08/25 revealed that R1 was observed by staff touching R2's breast and buttocks during meal service. The report indicated that R1 was moved away from R2 and placed on one-on-one supervision.</p> <p>A Staff Witness Statement completed 02/08/25 revealed that R1 sat at the dining room table next to R2. The statement revealed staff witnessed R1 groped R2's nipples and pulled her breast downward. The statement indicated that R2 was visibly upset and reported to staff she felt like she was being held against her will. The statement indicated that R2 continued to verbalize she was scared. The statement indicated that R1 was supervised for the remainder of the evening.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 02/08/25. The note revealed R1 was moved off the secured unit and moved to the Sunflower Hall. No information related to R1's sexual behavior episode on 02/08/25 was completed in his progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's EMR under Tasks revealed no entries related to behavioral monitoring.</p> <p>R1's EMR under Treatment Administration Report (TAR) revealed no monitoring related to his sexual behaviors or noting of his previous sexual behavioral episodes.</p> <p>R1's EMR under Medication Administration Report (MAR) revealed psychotropic medication monitoring for behaviors but lacked monitoring related to his sexual behaviors or noting of his previous sexual behavioral episodes.</p> <p>On 02/19/25 at 11:20 AM, inspection of the Sunflower Hall revealed 19 female residents within the secured floor.</p> <p>On 02/19/25 at 11:55 AM, R1 walked from his room to the 2nd-floor dining area without staff assistance or supervision.</p> <p>On 02/19/25 at 11:03 AM, Certified Nurse Aide (CNA) M stated R1 was independently mobile and could ambulate without staff assistance. She stated he sometimes used a wheelchair or cane. She stated she was aware of his history of touching females and staff were to monitor his behaviors and document them under the Tasks section of the EMR. She stated care plan should note he was not to be left alone around females or attempt to enter their rooms. She stated she was expected to report all potential behaviors to the nurse. She stated potential abuse should be reported immediately to the nurse, director of nursing, and facility administrator. She stated staff were expected to immediately separate the suspected abuser from the victim and keep everyone safe.</p> <p>On 02/19/25 at 01:04 PM, Licensed Nurse (LN) G stated that R1 was recently moved from the locked unit due to sexual behaviors towards females. He stated behavioral monitoring was documented by the direct care staff under the Tasks section of the EMR. He stated that R1 recently moved to the unit, so he was not sure if the monitoring section was under Tasks for him. He stated staff were expected to keep an eye on him while he was out walking around. He stated all staff had access to the care plan. He stated the care plans should reflect his repeated behaviors toward females, monitoring, coping strategies, and interventions to prevent his behaviors. He reported suspected abuse allegations were to be reported immediately to the director of nursing and facility administrator. He stated staff would immediately separate the perpetrator from other residents and ensure everyone was safe.</p> <p>On 02/19/25 at 02:40 PM, Administrative Nurse D stated R1 was immediately separated from R2 and placed on one-on-one supervision. She stated that R1 was moved to the Sunflower Hall. She stated that R1 had medication changes occurring and was not a risk to the females in the new hallway. She stated staff were expected to monitor R1's behaviors and document them under the Psychotropic Medication Monitoring section of his MAR. She stated events should be documented there. She stated staff were expected to immediately separate the suspected perpetrator from all potential victims.</p> <p>The facility's Abuse, Neglect, and Exploitation policy revised 11/2017 indicated the facility would provide safety and dignity for all residents by implementing proper procedures for enforcing resident rights. The policy noted the facility would protect residents of suspected abuse and all potentially affected residents from incidents of abuse.</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Actual harm Residents Affected - Few	The facility failed to implement effective preventative interventions related to Resident (R)1's sexual behaviors to protect the female residents of the facility. This deficient practice placed R2 (See F600) and 19 female residents at risk.

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>45668</p> <p>The facility identified a census of 117 residents. The sample included eight residents with two reviewed for behavioral services. Based on observation, record review, and interviews, the facility to implement effective behavioral monitoring and interventions related to Resident (R) 1's ongoing sexual behaviors toward female residents. This deficient practice placed R1 at risk for continued behavioral episodes and unmet care needs.</p> <p>Findings Included:</p> <p>- The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and a history of sexual behaviors related to psychiatric illness.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 12/15/24 noted a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The MDS noted he had verbal and physical aggression one to three days weekly. The MDS noted he had rejection of care behaviors one to three days weekly. The MDS noted he was independent with transfers, bed mobility, bathing, toileting, and walking. R1's MDS noted no sexual behaviors.</p> <p>R1's Cognitive Loss Care Area Assessment (CAA) completed 06/11/24 noted he had impaired cognition related to his medical diagnoses. The CAA noted he required reorientation, reminders, and reassurance to make sense of things. The CAA noted a care plan was implemented with interventions and monitoring to reduce the risks.</p> <p>R1's Behavioral Symptoms CAA was not triggered.</p> <p>R1's Care Plan initiated on 10/25/23 noted he was admitted to the long-term care unit due to his medical diagnoses. The plan noted he exhibited sexually inappropriate behaviors related to his psychiatric illness (03/04/24). The plan instructed staff to explain and reinforce to R1 why his behaviors were inappropriate or unacceptable (03/04/24). The plan instructed staff to educate and collaborate with R1 to find successful coping and interaction strategies (03/04/24). The plan instructed staff to administer and monitor his medication's side effects and effectiveness (03/04/24). The plan revealed that R1 was moved to another unit due to exhibiting sexually inappropriate behaviors (02/08/24). The plan lacked information related to his sexual behaviors towards female residents, required supervision around female residents, and required monitoring while out of his room as noted in progress notes. The plan lacked specific triggers and coping strategies needed to prevent his sexual behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's EMR under Progress Notes revealed a Nursing Note completed on 03/04/24. The note revealed direct care staff observed R1 as he sat on a female resident's rollator walker seat. The note revealed that R1 had his head between the female resident's breasts as she pushed him down the hallway for lunch. The note indicated staff separated the residents and asked them to sit away from the female residents during meals. The note revealed that R1 was to be supervised at all times while outside of his room and around other residents.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 07/10/24. The note revealed direct care reported they observed R1 seated in the dining room next to R2 (severely cognitively impaired resident). The note revealed that R1 and R2 were inappropriately touching each other. The note indicated R2 was immediately moved away from R1 and both residents were kept separated for the rest of the shift.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 07/14/24. The note revealed that R1 walked up to a female resident and began patting her on the shoulder. The note revealed the resident became distressed and attempted to push his hand away from her. The note revealed staff had to ask R1 to leave the female resident alone.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 12/07/24. The note revealed that R1 punched a female resident hand as she attempted to throw food at him. The note revealed she was moved to another table.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 02/02/25. The note revealed staff observed R1 approach a female resident while she lay in the common area recliner. The note revealed that R1 began touching the female resident's outer arm. The note revealed the female resident attempted to push his arm away and R1 resisted. The note revealed that R1 pushed the female resident's arm downward and continued touching her arm. The note revealed staff immediately separated both residents. The note indicated staff sat with the female resident during meal service due to concerns for her safety.</p> <p>A Facility Incident Report #3462 completed on 02/08/25 revealed that R1 was observed by staff touching R2's breast and buttocks during meal service. The report indicated that R1 was moved away from R2 and placed on one-on-one supervision.</p> <p>R1's EMR under Progress Notes revealed a Nursing Note completed on 02/08/25. The note revealed R1 was moved off the secured unit and moved to the Sunflower Hall. No information related to R1's sexual behavior episode on 02/08/25 was completed in his progress notes.</p> <p>R1's EMR under Tasks revealed no entries related to behavioral monitoring.</p> <p>R1's EMR under Treatment Administration Report (TAR) revealed no monitoring related to his sexual behaviors or noting of his previous sexual behavioral episodes.</p> <p>R1's EMR under Medication Administration Report (MAR) revealed psychotropic medication monitoring for behaviors but lacked monitoring related to his sexual behaviors or noting of his previous sexual behavioral episodes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Shawnee Gardens Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6416 Long Street Shawnee, KS 66216	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/19/25 at 11:55 AM, R1 walked from his room to the 2nd-floor dining area without staff assistance or supervision.</p> <p>On 02/19/25 at 11:03 AM, Certified Nurse's Aide (CNA) M stated R1 was independently mobile and could ambulate without staff assistance. She stated he sometimes used a wheelchair or cane. She stated she was aware of his history of touching females and staff were to monitor his behaviors and document them under the Tasks section of the EMR. She stated care plan should note he was not to be left alone around female or attempt to enter their rooms. She stated she was expected to report all potential behaviors to the nurse.</p> <p>On 02/19/25 at 01:04 PM, Licensed Nurse (LN) G stated the care plan should identify specific behaviors and interventions each resident. He stated R1 had behavioral monitoring and preventative interventions in place to prevent his behaviors.</p> <p>On 02/19/25 at 02:40 PM, Administrative Nurse D stated R1 was immediately separated from R2 and placed on one-on-one supervision. She stated that R1 was moved to the Sunflower Hall. She stated that R1 had medication changes occurring and was not a risk to the females in the new hallway. She stated staff were expected to monitor R1's behaviors and document them under the Psychotropic Medication Monitoring section of his MAR. She stated events should be documented there. She stated staff were expected to immediately separate the suspected perpetrator from all potential victims.</p> <p>The facility's ADL Care of Dementia Unit Residents policy revised 10/2019 indicated staff will ensure the appropriate supervision, and ongoing behavioral monitoring for cognitively impaired residents to maintain the highest level of functioning. The plan indicated care plan intervention will be monitored on an ongoing basis for effectiveness and updated as needed.</p> <p>The facility failed to implement effective behavioral monitoring and interventions related to R1's ongoing sexual behaviors toward female residents. This deficient practice placed R1 at risk for continued behavioral episodes and unmet care needs.</p>		