STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175287	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eureka Nursing Center	1020 N School Street Eureka, KS 67045

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50659 The facility reported a census of 43 residents with five residents sampled and two residents reviewed for abuse. Based on observation, interview, and record review the facility failed to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident sexual abuse, when independently mobile Resident (R) 2 (who had a history of hypersexual behaviors directed toward staff to include groping, sexual inuendo/comments, and attempting to pull staff into bed with him) grabbed R1's breast on 09/30/24, without her consent. This failure placed R1 in immediate jeopardy due to the lack of facility response and reasonable person concept regarding sexual assault, and the negative impact to R1's psychosocial well-being and feelings regarding her safety. The facility also failed to thoroughly investigate two employee-to-resident abuse allegations which involved R10 when several bruises were documented on 10/03/24 and the facility did not investigate as potential abuse and/or report to the state agency or local police of the multiple bruises of unknown origin. This failure placed the residents at risk for abuse and continued negative impact on their physical, mental, and psychosocial well-being. Findings Included: - Review of the Electronic Health Record (EHR), documented R2 had a diagnosis of vascular dementia (a chronic condition that occurs when the brain's blood supply is interrupted, damaging brain tissue and causing a decline in thinking, memory, and behavior). The 06/18/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R2 had a total mood severity score of one, which indicated minimal depression. R2 required total dependence with activities of daily living (ADL), with bathing. R2 required maximal assistance with dressing, transfers, personal hygiene and toileting. R2 was independent with wheelchair mobility and he had 1-3 days rejection of care. The 07/02/24 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R2 triggered due to his behavior of rejection of care. R2 had a diagnosis of dementia, his cognition would worsen if he became ill and typically would improve once well again. R2 had impulsivity and could have increased agitation and aggression, which could result in unsafe behaviors and the potential for injury, or difficulty with performance of ADLs. The 07/02/24 Behavioral Symptoms CAA documented R2 triggered related to refusal of cares and noted this did not place others at risk. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The 10/15/24 Quarterly MDS documented R2 had a BIMS score of 14, which indicated intact cognition. Review of R2's behaviors revealed one time he wandered and one time he refused care , which were documented in the seven day lookback period. R2 was independent with wheelchair mobility and received an antianxiety (class of medications that calm and relax people) medication daily. The 11/04/24 Care Plan documented the following: 04/15/19 - Staff were instructed to provide redirection and reorientation if R2 had a decline in cognition in the late afternoon and evening as needed. 03/21/21 - R2 could have increased agitation with education or redirection. Staff were instructed to notice the increased agitation and provide R2 with one-on-one and allow him space. 03/25/21 - Staff were instructed to identify cause of behaviors, assess for pain, offer food, drinks or toileting. 06/17/21 - Staff were instructed to provide reminders and redirection when R2 was inappropriate with behaviors of pulling staff into bed with him and he would try to kiss them. 08/08/24 - R2 had episodes of increased agitation/aggression. Staff instructed to administer Memantine (is a medication commonly used to treat moderate to severe dementia and Buspirone (is a medication commonly used to treat anxiety disorders) per orders. The facility provided Care Plan dated 11/04/24 and not uploaded in the EHR included handwritten interventions, which documented staff were instructed to provided one-on-one supervision for 24 hours, dated initiated 09/30/24 and discontinued on 10/01/24. The 11/04/24 Care Plan lacked any interventions related to a sexual abuse incident directed toward a female resident on 09/30/24. R2's Physician Orders documented an order for Memantine 10 milligram (mg) tablet, give one tablet by mouth, two times a day for vascular dementia, date ordered 06/11/24; and Buspirone HCl tablet 5mg, give one tablet by mouth, two times a day for anxiety/agitation, date ordered 07/18/24. The Physician Orders lacked any documentation directing staff to monitor for behaviors of anxiety/agitation. The Progress Note dated 04/11/24 at 01:17 AM revealed R2 grabbed at a staff member's neck and squeezed while staff attempted to obtain vital signs. The Progress Note on 07/03/24 at 09:48 AM, Certified Nurse Aide (CNA) reported R2 had been sexually inappropriate when he slapped/spanked a CNA on the buttock. The CNA informed R2 that was inappropriate behavior, and Nurse discussed with R2 that was inappropriate and R2 laughed and verbalized and understanding. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Progress Note on 07/16/24 at 02:30 PM revealed R2 wandered up and down the hallways, attempted to open doors, and threw water on the floor. R2 attempted to grab/smack the CNA on the buttock. R2 was informed his behaviors were inappropriate and staff assessed the resident for immediate needs. R2 requested coffee and it was provided. R2 unzipped his pants and told staff to look at it. Nurse called provider for orders. The Progress Note on 07/19/24 at 02:42 PM revealed R2 inappropriately touched staff. The Progress Note on 08/02/24 at an unknown time revealed R2 inappropriately touched staff when care provided that morning. The Progress Note on 09/02/24 at 03:22 PM revealed R2 grabbed his belt, undid his pants in the dining room, and he asked the staff member if she would like a sneak peek. The staff member excused herself and reported R2's behavior to the nurse. The Progress Note on 09/30/24 at 12:45 PM revealed R2 had his arm across R1 and held on to her breast. Staff removed R2 from dining room immediately and assisted him to his room. When R2 was asked by staff why he touched R1 he stated, she liked it, and she didn't say no. R2 was educated by staff that if he was not given verbal consent to touch anyone, then he should not touch them. R2 shook his head and looked down. The facility placed immediate interventions, which included R2 being educated of inappropriateness of touching other residents in that way and placed the resident on 24-hour one-on-one supervision. The progress notes from 09/30/24 thru 11/04/24 lacked any Social Service Designee (SSD) notes regarding the incident on 09/30/24. During an observation on 11/04/24 at 11:00 AM, R1's room was located directly across the hallway from R2's room. R1 sat in her recliner watching television in her room. During an observation on 11/04/24 at 11:48 AM, R2 sat in the dining room at a table as he waited for his lunch. During an interview on 11/04/24 at 11:00 AM, R1 reported that R2 had grabbed her left breast when she was leaving the dining room after lunch. R1 reported she was in shock, scared, uncomfortable, and embarrassed during the incident. She reported she did not know why he grabbed her breast and was glad that someone assisted her that day. R1 reported she tried not to think about how R2 grabbed her, but when she did it bothered her emotionally. R1 had tears in her eyes when she spoke of the incident. R1 reported she was not afraid of R2 at this time and could not recall if a room change was offered to her. R1 reported that R2 had never entered her room and she would not pay attention to R2 anymore. R1 was asked about the male resident mentioned on her care plan, and R1 reported he was just a friend and said she liked him and he was funny, and it was not R2. During an interview on 11/04/24 at 11:48 AM, R2 reported he was by himself in the dining room most of the time and that it did not bother him, he reported he could see everyone in the dining room and could see when they would come in and leave the dining room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 11/04/24 at 11:58 AM, Certified Nurse Aide (CNA) G reported R2 would wander independently in his wheelchair throughout the facility. CNA G reported R2 liked to flirt with female staff and asked staff to sit on his lap. CNA G revealed she was never grabbed or touched inappropriately by R2. CNA G reported she did not know R2 had touched a female resident's breast. CNA G revealed she would report any type of abuse seen, heard of, or suspected of to Administrative Staff A or Administrative Nurse C immediately. During an interview on 11/05/24 at 02:35 PM, CNA H confirmed that R2 did not have interventions about sexual abuse on his care plan. CNA H reported that R2 would grab at the staff and make inappropriate sexual comments towards the female staff, she reported that she would go into his room with another staff member to assist with cares. CNA H reported that she would chart in EHR when a resident had a behavior and let the nurse know. During an interview on 11/04/24 at 12:06 PM. Administrative Nurse D reported the resident's care plan in the EHR was current and updated with the care plans printed in the care plan book located at the nurse's station. Administrative Nurse D confirmed R2's care plan in the book had a 09/30/24 intervention of one-on-one for 24 hours handwritten on it and was discontinued on 10/01/24. She confirmed R2's care plan lacked any documentation about sexual assault to a female resident and/or any additional interventions regarding the incident. During an interview on 11/04/24 at 12:50 PM, Dietary Staff J reported she was the one that witnessed R2, grab at R1's breast. She reported that she would have not seen R2 grab R1's breast if she had not moved towards the entrance of the dining room to clean tables. Dietary Staff J reported R1 self-propelled her wheelchair towards the exit of the dining room like R1 would normally do. She thought that R1 and R2 were just talking to each other until she was able to see what occurred. Dietary Staff J reported that R1 had a horrified look on her face and was frozen as R2 had his hand on her breast. Dietary Staff J reported that she immediately separated the residents and assisted R1 to the nurse. Dietary Staff J reported that R2 liked to propel himself around in the dining room and stopped and talked to the residents, mostly the female residents. Dietary Staff J pointed at R2 who had stopped in front of R8 in the dining room to talk to her. Dietary Staff J reported she had received Abuse, Neglect and Exploitation (ANE) education in the first week of October 2024. During an interview on 11/04/24 at 01:30 PM, R4 hesitated to comment on the question Do you feel safe here? R4 asked what the other residents had stated when the surveyor asked them the same question. R4 was educated that the interviews would not be discussed with other residents. R4 reported she was ok here; she was asked if she could be more specific. She reported that the staff would take good care of her, and no staff or resident had abused her. R4 reported that R2 was very grabby and handsy towards other female residents and female staff and liked to flirt with women. R4 reported she did not want R2 to get into trouble. She reported that R2 had never touched her, but she has seen it happen to other women and it bothered her. R4 reported that she did not report this to staff here as she worried she would get kicked out if she caused any trouble for other residents. During an interview on 11/04/24 at 02:02 PM R2 sat in his wheelchair in his room and watched television. When asked about the incident with R1, R2 stated she was that type of woman and she wanted to be touched, if I didn't touch her someone else would have. R2 reported he liked to flirt with women, and he would never touch a woman unless she asked to be touched. R2 reported he was told that touching R1 was not appropriate and to never do it again. R2 then reported that he was mad about the facilities education with him, because they took her side and not his. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 11/04/24 at 02:29 PM, Licensed Nurse (LN) F reported she was the nurse on the day R2 touched R1's breast. LN F reported that R2 never explained to her why he grabbed at R1, that R2 only stated she never told him no. LN F confirmed that R2 had a history sexual behavior towards the female staff as he would grab at them and make sexual innuendos to the female staff, and staff would tell R2 that was inappropriate behavior. LN F reported to the best of her knowledge R2 was placed on one-on-one supervision for 24 hours and received education noting that touching R1 was inappropriate behavior. During an interview on 11/04/24 at 04:34 PM, Administrative Staff A reported SSD K spoke to R2 about consent and LN F educated R2 about consent before touching other residents, the inappropriate behavior that occurred, and informed R2 not to do it ever again. Administrative Staff A reported the interventions they placed was to prevent R2 from that behavior occurring again. Administrative Staff A reported R2 had never inappropriately touched a resident before and further stated it only happened that one time. During an interview on 11/04/24 at 04:40 PM, SSD K reported R1 was care planned on 10/30/24 regarding a relationship with another male resident as she would be affectionate and want to hold hands and rub his arm. SSD K confirmed it was not R2. SSD K confirmed that R1 had moderately impaired cognition with a BIMS of 10. SSD K reported R2 would not speak to her about the incident. SSD K reported she never went back to talk to him after that day about the inappropriate behavior. SSD K reported she could not recall if R1 was offered a room change as R1 felt safe and confirmed that R1 lived right across the hallway from R2. SSD K reported she visited with R1 several times after the incident and R1 told her she felt safe and had no concerns. SSD K reported she was not aware that R4 was bothered about R2's behaviors of grabbing at others and reported that R4 had never reported her concerns. On 11/05/24 at 11:00 AM Administrative Staff A reported she had the one-on-one supervised signed record for R2 that started on 11/04/24 and Administrative Staff A reported she and Administrative Nurse B had not signed the record on 11/04/24 for the times they had completed one on one supervision for R2. Administrative Staff provided another form that showed initials on them and asked if she could write on the record now for the times, they both had supervised him. The surveyor briefly scanned the form she held and said it was up to her if she wanted to record now on the 11/04/24 one-on-one record, which she did. During an interview on 11/05/24 at 11:05 AM, Nurse Consultant L reported the incident between R1 and R2was not a sexual abuse incident. Nurse Consultant L reported the relationship that R1 and R2 had was just not understood by state agency. Nurse Consultant L reported that R1 did not yell out for help when he touched her breast and that R1 had reported she was not afraid of R2. Nurse Consultant K confirmed that R2's care plan should have been updated after the incident and continued to state it was not sexual abuse. On 11/05/24 at 11:20 AM, Administrative Staff A provided an updated copy of the resident's care plan with a focus area dated 11/04/24, instructing staff to know R2 had a history of inappropriate female contact. On 11/04/24 the facility reinitiated one-on-one supervision for R2. R2 had a room change, which occurred on 11/05/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 11/05/24 at 01:00 PM, Administrative Staff A reported well just looking at it at face value R2 said he would not do it again and he had not since that day, and his room was changed today. R2 continued one-on- one supervision. Administratve Staff A confirmed with a medication change the nurses would assess the medications effectiveness and would continue to monitor his behaviors. During an interview on 11/05/24 at 01:10 PM, Therapy Staff N reported he had the ANE education and stated that he knew that the education was about R1 being touched by R2 and reported that was sexual assault on R1. He was able to state how to report and the different types of abuse correctly. During an interview on 11/05/24 at 02:17 PM, Administrative Staff A reported the staff would monitor behaviors and it would be reported to the charge nurse. The charge nurses use a CUE book (a handwritten communication book for all the nursing staff to review) kept at the nurses' station. The facility policy Abuse Neglect and Exploitation dated May 2023 documented the facility has developed and implemented this policy and procedure to prohibit abuse, neglect, and exploitation. The residents will be free from physical, verbal, emotional, sexual abuse, neglect, and exploitation. Annual training required by all staff on how to report and recognize abuse. Sexual abuse includes, but not limited to, sexual harassment, sexual coercion, or sexual assault, or fondling of any part of the body, or any other form of sexual activity with a resident. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident sexual abuse, when independently mobile R2 (who had a history of hypersexual behaviors directed toward staff to include groping, sexual inuendo/comments, and attempting to pull staff into bed with him) on 09/30/24 he grabbed R1's breast without her consent. This failure placed the residents in immediate jeopardy due to the lack of the facility response and reasonable person concept to sexual assault, and the negative impact to R1's psychosocial well-being and feeling safe. On 11/04/24 at 05:52 PM, Administrative Nurse B and Administrative Nurse C were provided the Immediate Jeopardy (IJ) template and notified that the facility failure to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident sexual abuse and the lack of the facility response and reasonable person concept to sexual assault, and the negative impact to R1's psychosocial well-being and feeling safe, placed R1 in immediate jeopardy. The facility submitted an acceptable plan for removal of the immediate jeopardy on 11/05/24 at 02:45 PM which included the following: 1. R2 was placed on a one on one at approximately 08:30 PM on 11/04/24 and would remain a one on one until alternative living arrangements can be made and/or medication can be implemented to decrease sexual urges. 2. To ensure the psychosocial well-being of R1, a follow-up interview was conducted on 11/04/24. During the interview conducted by Administrative Nurse B and Administrative Nurse C, R1 denied being afraid of R2 or that she was fearful of living across the hall from him. R1 reported she felt safe living at facility and had no complaints. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The surveyor verified the facility implemented the above corrective measures on-site on 11/05/24 at 02:15 PM. The deficient practice remained at a scope and severity level of a D, following the implementation of the removal plan. Administrative Staff A sent an email on 11/05/24 at 03:16 PM with several 15 minute check forms attached for R2 and reported that 15 minute checks were put into place on 10/01/24, after the one on one supervision was discontinued, and the 15 minute checks continued up until 11/04/24 when the facility received the IJ template and placed R2 back on one-on-one supervision; However, at no time during the onsite investigation were the 15-minute checks spoken of in interviews or documented or uploaded in the EHR, and no 15 minute checks were mentioned in the facility's investigations or in the IJ removal plan. - The Electronic Health Records (EHR) documented Resident (R) 10 had the following diagnoses that included cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), depression and need for assistance with personal care. The 02/07/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R10 had a total mood severity score of three, which indicated minimal depression and she had behaviors documented one to three days of hitting, swearing, pushing, yelling, grabbing, pinching, and refused care. R10 was totally dependent on staff for assistance with activities of daily living (ADL) such as toileting hygiene, transfers, personal hygiene, bed mobility, and dressing and required moderate assistance with bathing. R10 was independent with wheelchair mobility and eating. The 02/21/24 Behavioral Symptoms Care Area Assessment (CAA) documented R10 triggered related to rejection of care. R10 would become verbally and physically aggressive with staff. Behaviors would typically occur in the morning but resolved after care was provided. The 02/21/24 Cognitive Loss/Dementia CAA documented R10 triggered related to a BIMS score of three and she would wander daily. R10 had a history of cerebral infarction and had a diagnosis of dementia ((progressive mental disorder characterized by failing memory, confusion). R10 had forgetfulness and had forgotten her husband passed away. The Care Plan documented the following: Staff were instructed to provide Tubi-grips (elasticated tubular bandage designed to provide tissue support in treating strains, sprains, soft tissue injuries, general edema and tissue protection) applied in morning to both upper extremities and removed at bedtime, date initiated 04/01/21. Staff were instructed to provide two staff assist for all transfers; date initiated 02/03/24. Staff were instructed to re-approach R10 in 10 minutes if she was in a safe position if she became physically and verbally aggressive with staff, date initiated 06/04/24. Staff were instructed to use warm wipes when personal care was provided, date initiated 10/03/24. The Care Plan lacked any documentation noting R10 was at risk for bruising. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Facility Reported Incident dated 10/03/24, alleged Certified Nurse Aide (CNA) Q used profanity and was forceful when dressing R10 on 10/01/24. CNA Q was suspended on 10/01/24. Review of the Facility Reported Incident dated 10/07/24, R10's family member reported to Administrative Staff A on 10/03/24 that during a family visit on 09/29/24 R10 was assisted to the bathroom and reported to family member after she was toileted, she had been hit. CNA G was suspended on 10/03/24 and CNA Q remained on suspension from 10/01/24. The 09/30 /24 at 12:11 PM Progress Note revealed R10 had a blood draw on 09/26/24 as lab results were received. The 09/30/24 at 01:16 PM Weekly Skin Assessment completed by Administrative Nurse C revealed R10 had bruising noted on her left elbow a measured bruise, 3.0 centimeters (cm) length by 3.0 cm width, back of left hand a measured bruise, 0.6 cm length by 0.5 cm width, back of left hand a measured bruise, 3.0 cm length by 2.5 cm width, on left wrist a measured bruise, 0.5 cm length by 0.8 cm width and on her left upper back of arm a measured bruise, 1.0 cm length by 0.8 cm. R10 noted to have scattered areas of bruising to her left upper arm. The left elbow area and the larger of the bruises on her left hand both appeared to be in the healing process with faded or yellow colored edges. The smaller bruised areas appear to be newer. The 10/02/24 at 04:22 PM Progress Note revealed R10 was visited by Social Service Designee (SSD) K and she was asked if she felt safe at the facility, R10 stated well I guess and reported her needs were met. R10 was in a good mood during the visit. The 10/03/24 at 03:56 PM Progress Note revealed a weekly skin assessment was completed by Administrative Nurse B and Licensed Nurse (LN) I on this date. The 10/09/24 at 12:30 PM Progress Note revealed LN I assisted with a discharge skin assessment when R10 was toileted. LN I noted R10 continued to have areas of discoloration to both upper arms which was consistent with the last skin assessment completed by LN I and Administrative Nurse B. No new skin issues noted. The Progress Notes reviewed from 09/30/24 through 10/09/24 lacked any documentation of any nurse assessment completed on R10 after the10/01/24 incident. Review of the written Complaint Investigation Witness Statement dated 10/02/24, by LN O revealed R10 was assessed by LN O on 10/01/24, noted R10 had a flat affect when spoken to, did not want to talk about the incident and did not want to get up and dressed. LN O noted scattered bruising on both upper arms, which were purple in color, some areas were noted to be yellow in color on the edges of the bruises. The 09/26/24 at 03:45 PM Weekly Skin Assessment completed by LN I revealed no skin concerns noted and R10 had trace edema (swelling resulting from an excessive accumulation of fluid in the body tissues) of both lower extremities' ankle region. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The 10/03/24 at 11:54 AM Weekly Skin Assessment signed by Administrative Nurse B on 10/03/24 revealed R10 had 15 bruised areas documented on the assessment. Left wrist had a measured bruise, 1.2 cm by 1.5 cm, left wrist had a measured bruise, 1.3 cm by 1.0 cm, left forearm had a measured bruise 1.5 cm by 3 cm, left hand had a measured bruise 101cm (later corrected to measure 1.1cm) by 0.7 cm, left wrist had a measured bruise, 1.0 cm by 0.5 cm and another measured bruise on left wrist measured 1.0 cm by 0.8 cm. Right upper arm had a measured bruise 1.0 cm by 1.0 cm, left forearm had a measure bruise 2.0 cm by 3.1 cm, left hand had a measured bruise, 4.5 cm by 3.3 cm, right wrist had a measured bruise 6.0 cm by 4.8 cm, left upper arm had a measured bruise, 0.6 cm by 0.8 cm, right hip had a measured bruise, 0.7 cm y 1.1 cm, right upper arm had a measured bruise, 1.2 cm y 0.8 cm, right calf had a measured bruise, 1.4 cm by 1.0 cm and left upper arm had a measured bruise, 1.5 cm by 1.3 cm. R10 had three scratched areas noted on the right shin that measured, 1.5 cm by 0.2, 4.2 cm by 0.5 cm and 5.1 cm by 1.3 cm. LN I documented right upper arm had light fading bruise, left upper arm very faint bruise and purple bruise, right hip purple with faded edges and right calf very light faded bruise. The 10/04/24 at 12:23 PM, Non Pressure Sore Assessment competed and signed by Administrative Nurse C revealed R10 had a bruise on left that measured 4.5 cm by 3.3 cm, date of onset10/01/24 and was a new wound. A bruise on left hand that measured 1.1 cm by 0.7 cm, date of 10/01/24 which had improved. A bruise that measured 2.0 cm by 3.1 cm, date of onset 10/01/24 which had improved. A bruise that measured on left forearm, 1.5 cm by 3.0 cm, date of onset 10/01/24 which had improved. Plan of care updated for all areas. The 10/04/24 at 12:29 PM Non Pressure Sore Assessment completed and signed by Administrative Nurse C revealed R10 had a measured bruise on left wrist, 1.3 cm by 1.0 cm, date of onset was 10/01/24 and was a new wound. A measured bruise on left wrist, 1.0 cm by 0.5 cm, date of onset 10/01/24 and had improved, right upper arm had a measured bruise, 1.2 cm by 0.8 cm, date of onset 10/01/24 which had improved. A bruise on left upper arm measured, 0.6 cm by 0.8 cm, date of onset 10/01/24 which had improved. Plan of care updated for all areas. The 10/04/24 at 12:32 PM Non Pressure Sore Assessment completed and signed by Administrative Nurse C revealed R10 had a measured bruise on left upper arm measured 1.5 cm by 1.3 cm date of onset, 10/01/24 was a new wound. R10 had a bruise on right hip that measured 0.7 cm by 1.1 cm date of onset 10/01/24 w had improved. R10 had a measured bruise on right calf, 1.4 cm by 1.0 cm date of onset 10/01/24 and had improved. R10 had a measured abrasion (scraping or rubbing away of skin) on right shin, 5.1 cm by 1.3 cm date of onset 10/01/24 had improved. All the areas noted had plan of care updated. The 10/04/24 at 12:38 PM Non Pressure Sore Assessment completed and signed by Administrative Nurse C revealed R10 had a measured abrasion on right shin, 1.5 cm by 0.2 cm, date of onset 10/01/24 had improved and plan of care updated. Additionally, a measured abrasion on right shin, 4.2 cm by 0.5 cm date of onset 10/01/24 had improved and plan of care updated. (continued on next page)

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Eureka Nursing Center	1020 N School Street Eureka, KS 67045

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 11/04/24 at 03:35 PM, Certified Nurse Aide (CNA) P reported she was the CNA that reported CNA Q for abuse toward R10 the morning of 10/01/24. CNA P reported CNA Q used profanity toward R10 when she attempted to dress R10. CNA P reported that R10 tried to bite at CNA Q and that is why CNA Q had pushed R10 down in bed and pulled on R10's arms while she continued to use profanity. CNA P reported she left R10's room to look for Administrative Nurse C, when Certified Medication Aide (CMA) R stopped CNA P and asked her what was wrong. CNA P did not explain what had happened she stated, I'm done. CNA P reported that LN O located her a couple minutes later at the nurse's station and CNA P explained what had happened in R10's room to LN O. CNA P reported that LN O escorted CNA Q out of the facility approximately around 11:35 AM. CNA P reported that she did complete ANE education the first week of October 2024. During an interview on 11/04/24 at 04:00 PM, CNA G reported that she was suspended for the allegation of abuse that R10 made a comment to her family of being hit in the leg when she was toileted by CNA G and CNA Q on 09/29/24 during a visit. R10's family did not report this until 10/03/24. CNA G reported that CNA Q no longer worked at the facility. CNA reported she was allowed to come back to work on 10/04/24 but had to complete the ANE training before she could work. During an interview on 11/05/24 at 02:15 PM, Administrative Nurse B made no comment when questioned origin of several bruises and if there had been an investigation of the several bruises noted investigated noted on the weekly skin assessment in EHR that was completed by her and LN I on 10/03/24. During an interview on 11/05/24 at 02:15 PM, Administrative Nurse C reported she thought the bruises were reported on the facility investigation report and she read out loud from the facility report #0983 a head to toe assessment performed with noted bruising on back of hands from lab draws on a prior day, with no signs of mishandling or physical maltreatment. Administrative Nurse C confirmed there was no progress note or skin assessment documented in R10's EHR after the 10/01/24 incident until 10/03/24 when a skin assessment was completed by Administrative Nurse B. The questioned was asked again how R10 received several bruises that were noted on the 09/30/24 and 10/03/24 weekly skin assessments. Administrative Nurse C reported she was unsure how R10 received all of the bruises that were documented, except for one bruise that was located on R10's right wrist from a blood draw on 09/26/24. During an interview on 11/05/24 at 02:15 PM, Administrative Staff A reported that R10 was independent with her wheelchair mobility, and she would bump into objects and walls at times. The weekly skin assessments from 08/01/24 through 09/26/24 in EHR were reviewed and confirmed documentation of no skin issues noted on any of the assessments. Administrative Staff A reported that the bruises were of unknown origin and the facility lacked an investigation for the bruises. During an interview on 11/05/24 at 02:35 PM, CNA H reported if a new bruise or skin issue was noted she would report that to the charge nurse. CNA G also revealed she would document in the EHR in the bathing task section any skin issues noted. During an interview on 11/05/24 at 02:38 PM, CNA G reported if a new bruise, skin tear or wound was observed that she had not observed before she would notify the charge nurse. During an interview on 11/05/24 at 02:40 PM, LN E reported if a staff member repor [TRUNCATED]

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. 50659 The facility reported a census of 43 residents with five residents sampled and one resident reviewed for sexual abuse. Based on observation, interview, and record review the facility failed to ensure staff protected residents from sexual abuse, when independently mobile Resident (R) 2 (who had a history of hypersexual behaviors directed toward staff to include groping, sexual inuendo/comments, and attempting to pull staff into bed with him) grabbed R1's breast on 09/30/24, without her consent. This failure placed R1 and other female residents in immediate jeopardy due to the facility did not place interventions to protect R1 and other female residents who resided in the facility, from R2's unwanted sexual abuse/assault. This failure placed the residents at risk for abuse and continued negative impact on their physical, mental, and psychosocial well-being. Findings Included: - Review of the Electronic Health Record (EHR), documented R2 had a diagnosis of vascular dementia (a chronic condition that occurs when the brain's blood supply is interrupted, damaging brain tissue and causing a decline in thinking, memory, and behavior). The 06/18/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R2 had a total mood severity score of one, indicated minimal depression. R2 required total dependence with activities of daily living (ADL), with bathing. R2 required maximal assistance with dressing, transfers, personal hygiene and toileting. R2 was independent with wheelchair mobility, and he had 1-3 days of behavior when he rejected care. The 07/02/24 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R2 triggered for this CAA due to his behavior of rejection of care. R2 had a diagnosis of dementia, his cognition would worsen if he became ill and typically would improve once well again. R2 had impulsivity and could have increased agitation and aggression, which could result in unsafe behaviors and the potential for injury, or difficulty with performance of ADLs. The 07/02/24 Behavioral Symptoms CAA documented R2 triggered for this CAA related to refusal of cares and noted this did not place others at risk. The 10/15/24 Quarterly MDS documented R2 had a BIMS score of 14, which indicated intact cognition. Review of R2's behaviors revealed one time he wandered and one time he refused care, which were documented in the seven-day lookback period. R2 was independent with wheelchair mobility and received an antianxiety (class of medications that calm and relax people) medication daily. The 11/04/24 Care Plan documented the following: 04/15/19 - Staff were instructed to provide redirection and reorientation if R2 had a decline in cognition in the late afternoon and evening as needed. 03/21/21 - R2 could have increased agitation with education or redirection. Staff were instructed to notice the increased agitation and provide R2 with one-on-one and allow him space. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 11/04/24 at 12:06 PM. Administrative Nurse D (MDS Nurse), reported the resident's care plan in the EHR was current and updated with the care plans printed in the care plan book located at the nurse's station. Administrative Nurse D confirmed R2's care plan in the book had a 09/30/24 intervention of one-on-one for 24 hours handwritten on it and was discontinued on 10/01/24. She confirmed R2's care plan lacked any documentation about sexual assault to a female resident and/or any additional interventions regarding the incident. During an interview on 11/04/24 at 12:50 PM, Dietary Staff J reported she was the one that witnessed R2, grab at R1's breast. She reported that she would have not seen R2 grab R1's breast if she had not moved towards the entrance of the dining room to clean tables. Dietary Staff J reported R1 self-propelled her wheelchair towards the exit of the dining room like R1 would normally do. She thought that R1 and R2 were just talking to each other until she was able to see what occurred. Dietary Staff J reported that R1 had a horrified look on her face and was frozen as R2 had his hand on her breast. Dietary Staff J reported that she immediately separated the residents and assisted R1 to the nurse. Dietary Staff J reported that R2 liked to propel himself around in the dining room sometimes and stop and talk to the residents, mostly the female residents. Dietary Staff J pointed at R2 who had stopped in front of R8 in the dining room to talk to her. Dietary Staff J reported she had received Abuse, Neglect and Exploitation (ANE) education in the first week of October 2024. During an interview on 11/04/24 at 01:30 PM, R4 hesitated to comment on the question Do you feel safe here? R4 asked what the other residents had stated when the surveyor asked them the same question. R4 was educated that the interviews would not be discussed with other residents. R4 reported she was ok here; she was asked if she could be more specific. She reported that the staff would take good care of her, and no staff or resident had abused her. R4 reported that R2 was very grabby and handsy towards other female residents and female staff and liked to flirt with women. R4 reported she did not want R2 to get into trouble. She reported that R2 had never touched her, but she has seen it happen to other women and it bothered her. R4 reported that she did not report this to staff here as she worried she would get kicked out if she caused any troubles for other residents. During an interview on 11/04/24 at 02:02 PM R2 was seated in his wheelchair in his room and watching television. When asked about the incident with R1, R2 stated she was that type of woman and she wanted to be touched, if I didn't touch her someone else would have. R2 reported he liked to flirt with women, and he would never touch a woman unless she asked to be touched. R2 reported he was told that touching R1 was not appropriate and to never do it again. R2 then reported that he was mad about the facilities education with him, because they took her side and not his. During an interview on 11/04/24 at 02:29 PM, Licensed Nurse (LN) F reported she was the nurse on the day R2 touched R1's breast. LN F reported that R2 never explained to her why he grabbed at R1, that R2 only stated she never told him no. LN F confirmed that R2 had a history sexual behavior towards the female staff as he would grab at them and make sexual innuendos to the female staff, and staff would tell R2 that was inappropriate behavior. LN F reported to the best of her knowledge R2 was placed on one-on-one supervision for 24 hours and received education noting that touching R1 was inappropriate behavior. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 11/04/24 at 04:34 PM, Administrative Staff A reported SSD K spoke to R2 about consent and LN F educated R2 about consent before touching other residents, the inappropriate behavior that occurred, and informed R2 not to do it ever again. Administrative Staff A reported the interventions they placed was to prevent R2 from that behavior occurring again. Administrative Staff A reported R2 had never inappropriately touched a resident before and further stated it only happened that one time. During an interview on 11/04/24 at 04:40 PM, SSD K reported R1 was care planned on 10/30/24 regarding a relationship with another male resident as R1 would be affectionate and want to hold hands and rub his arm. SSD K confirmed it was not R2, she reported that R1 liked to be affectionate with some men, she reported that is not why she thought R2 grabbed R1's breast though. SSD K confirmed that R1 had moderately impaired cognition with a BIMS of 10. SSD K reported R2 would not speak to her about the incident. SSD K reported she never went back to talk to him after that day about the inappropriate behavior. SSD K reported she could not recall if R1 was offered a room change as R1 felt safe and confirmed that R1 lived right across the hallway from R2. SSD K reported she visited with R1 several times after the incident and R1 told her she felt safe and had no concerns. SSD K reported she was not aware that R4 was bothered about R2's behaviors of grabbing at others and reported that R4 had never reported her concerns. On 11/05/24 at 11:00 AM Administrative Staff A reported she had the one-on-one supervised signed record for R2 that started on 11/04/24 and Administrative Staff A reported she and Administrative Nurse B had not signed the record on 11/04/24 for the times they had completed one on one supervision for R2. Administrative Staff provided another form that showed initials on them and asked if she could write on the record now for the times, they both had supervised him. The surveyor briefly scanned the form she held and said it was up to her if she wanted to record now on the 11/04/24 one-on-one record, which she did. During an interview on 11/05/24 at 11:05 AM, Nurse Consultant L reported the incident between R1 and R2 was not a sexual abuse incident. Nurse Consultant L reported the relationship that R1 and R2 had was just not understood by state agency. Nurse Consultant L reported that R1 did not yell out for help when he touched her breast and that R1 had reported she was not afraid of R2. Nurse Consultant K confirmed that R2's care plan should have been updated after the incident and continued to state it was not sexual abuse. On 11/05/24 at 11:20 AM, Administrative Staff A provided an updated copy of the resident's care plan with a focus area dated 11/04/24, instructing staff to know R2 had a history of inappropriate female contact. On 11/04/24 the facility reinitiated one-on-one supervision for R2. R2 had a room change, which occurred on 11/05/24. During an interview on 11/05/24 at 01:00 PM, Administrative Staff A reported well just looking at it at face value R2 said he would not do it again and he had not since that day, and his room was changed today. R2 continued one-o one supervision. With a medication change the nurses would assess the medications effectiveness and would continue to monitor his behaviors. During an interview on 11/05/24 at 01:10 PM, Therapy Staff N reported he had the ANE education and stated that he knew that the education was about R1 being touched by R2 and reported that was sexual assault on R1. He was able to state how to report and the different types of abuse correctly. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 11/05/24 at 02:17 PM, Administrative Staff A reported the staff would monitor behaviors and would be reported to the charge nurse. The charge nurses use a CUE book (a handwritten communication book for all the nursing staff to review) kept at the nurses' station. The facility policy Abuse Neglect and Exploitation dated May 2023 documented the facility has developed and implemented this policy and procedure to prohibit abuse, neglect, and exploitation. The residents will be free from physical, verbal, emotional, sexual abuse, neglect, and exploitation. Annual training required by all staff on how to report and recognize abuse. Sexual abuse includes, but not limited to, sexual harassment, sexual coercion, or sexual assault, or fondling of any part of the body, or any other form of sexual activity with a resident. The facility failed to ensure staff protected residents from sexual abuse, when independently mobile R2 (who had a history of hypersexual behaviors directed toward staff to include groping, sexual inuendo/comments, and attempting to pull staff into bed with him) on 09/30/24 he grabbed R1's breast without her consent. This failure placed R1 and other female residents in immediate jeopardy due to the facility did not place interventions to protect R1 and other female residents who resided in the facility, from R2's unwanted sexual abuse/assault. This failure placed the residents at risk for abuse and continued negative impact on their physical, mental, and psychosocial well-being. On 11/04/24 at 05:52 PM, Administrative Nurse B and Administrative Nurse C were provided the Immediate Jeopardy (IJ) template and notified that the facility failure to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident sexual abuse and the lack of the facility response and reasonable person concept to sexual assault, and the negative impact to R1's psychosocial well-being and feeling safe, placed R1 in immediate jeopardy. The facility submitted an acceptable plan for removal of the immediate jeopardy on 11/05/24 at 02:45 PM which included the following: 1. R2 was placed on a one on one at approximately 08:30 PM on 11/04/24 and would remain a one on one until alternative living arrangements can be made and/or medication can be implemented to decrease sexual urges. 2. To ensure the psychosocial well-being of R1, a follow-up interview was conducted on 11/04/24. During the interview conducted by Administrative Nurse B and Administrative Nurse C, R1 denied being afraid of R2 or that she was fearful of living across the hall from him. R1 reported she felt safe living at facility and had no complaints. The surveyor verified the facility implemented the above corrective measures on-site on 11/05/24 at 02:15 PM. The deficient practice remained at a scope and severity level of a D, following the implementation of the removal plan. Administrative Staff A sent an email on 11/05/24 at 03:16 PM with several 15 minute check forms attached for R2 and reported that 15 minute checks were put into place on 10/01/24, after the one on one supervision was discontinued, and the 15 minute checks continued up until 11/04/24 when the facility received the IJ template and placed R2 back on one-on-one supervision; However, at no time during the onsite investigation were the 15-minute checks spoken of in interviews or documented or uploaded in the EHR, and no 15 minute checks were mentioned in the facility's investigations or in the IJ removal plan.