STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175401	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bonner Springs Nursing & Rehab Center	520 E Morse Street Bonner Springs, KS 66012

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** 39752 The facility identified a census of 29 residents. The sample included three residents reviewed for abuse. The facility failed to provide adequate supervision to ensure residents remained free from resident-to-resident abuse when Resident (R)1 threw a ceramic mug at R2 during an unsupervised altercation in the dining room. This resulted in a broken nose for R2 and placed the resident at risk for pain, impaired psychosocial well-being, and ongoing abuse. Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab, recorded diagnoses of alcoholic cirrhosis of the liver, dysphagia (swallowing difficulty), dementia (a progressive mental disorder characterized by failing memory and confusion), mental disorder, mood affective disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) disorder bipolar (a major mental illness that causes people to have episodes of severe high and low moods) type, adjustment disorder with mixed disturbance of emotions and conduct, restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), abnormalities of gait and mobility, a history of falling and hepatic encephalopathy (a broad term for any brain disease that alters brain function or structure). The Admission Minimum Data Set (MDS) dated [DATE] documented per staff interview, R1 had short and long-term memory problems. The MDS documented R1 was short-tempered and easily annoyed for two to six days during the observation period, with no behaviors documented. R1 required partial to moderate assistance from the staff with transfers and set-up assistance with eating. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated 04/04/24 documented R1 had impaired cognition related to his diagnoses of dementia, impaired cognition, and encephalopathy. The Activities of Daily Living [ADL] CAA dated 04/04/24 documented R1 had impaired self-care and mobility. The Behavioral Symptoms CAA dated 04/04/24 documented R1 wandering due to dementia. (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 - Actual harm Residents Affected - Few	R1's Care Plan initiated on 04/21/22 documented staff would cue, reorient, and supervise R1 as needed. The plan recorded an intervention dated 08/18/23 that directed staff to analyze the times of date, places, circumstances, triggers, and what de-escalated his behavior and document it. R1 had a personal history of trauma and team members would be mindful of trauma-informed care when assisting R1. R1's Care Plan revised on 08/19/23 documented R1 placed on one-on-one checks as directed by the administration until not seen as a threat to others. R1's Care Plan initiated on 10/07/23 documented on 09/21/23 R1 became upset when an unidentified resident entered R1's room and sat in R1's recliner. R1 reported the unidentified resident made a menacing move towards R1 so R1 started hitting the unidentified resident. The plan recorded an intervention revised on 02/22/24 that documented R1 had an altercation with another resident. R1's Care Plan initiated on 07/08/24 directed staff to give R1 as many choices as possible about care and activities. Nursing staff would provide care in pairs until R1 was clear of physical aggression. The Incident Follow-Up Note dated 02/22/24 at 06:39 PM documented R1 had an altercation with an unidentified resident. R1 was physically aggressive towards another unidentified resident. R1 was placed on one-on-one monitoring after getting separated immediately from the unidentified resident. The Incident Follow-Up Note dated 09/04/24 at 05:20 PM documented staff heard a commotion in the dining room that sounded like someone hitting the tables. Licensed Nurse (LN) G looked around the corner into the dining room and saw objects being thrown across the dining room by both R1 and R2. R2 threw a vase at R1 and R1 threw his ceramic mug at R2. Both R1 and R2 were heard yelling back and forth at each other. LN G tried to separate R1 and R2. When R1 was asked about the event, R1 stated since R2 threw something first, he had to throw something back. R1 and R2 were separated and placed under one-on-one supervision. R2 was sent out to the emergency room , and R1 continued one-on-one supervision due to aggressive, angry behaviors that continued after the incident had concluded to protect the other residents in the dining room. A review of R2's emergency department paperwork dated 09/05/24 at 06:54 AM revealed that R2 had a comminuted fracture (break or splinter of the bone into more than two fragments) of the nasal bones and nasal bridge. Certified Medication Aide (CMA) R's Notarized Witness Statement dated 09/04/24 documented CMA R stood facing the dining room in the front living area, passing medication. CMA R documented the residents at the back of the dining room were pounding on the table. CMA R documented she continued her medication pass, but upon looking up she observed R1 and R2 throwing objects at each other. CMA R hollered for help and LN G helped CMA R calm the situation down. LN G's undated Notarized Witness Statement documented LN G had taken R2's finger stick blood sugar and returned to the nurse's station when LN G heard a commotion in the dining room. LN G looked around the corner and observed R2 standing at his table yelling at R1 and R1 was yelling back at R2. LN G watched R2 throw a vase at R1's face and immediately R1 threw his ceramic mug at R2. LN G observed blood dripping down R2's face. LN G documented she was attempting to separate R1 and R2. LN G placed R1 one-on-one with staff in the dining room to keep the other residents safe. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Facility Investigation dated 09/11/24 documented at approximately 05:36 PM on 09/04/24 R1 and R2 had an unwitnessed altercation in the dining room. The altercation escalated to R1 and R2 throwing a vase and a ceramic mug at each other. The object thrown by R1 struck R2 in the face causing injury to his nose. During an observation on 09/18/24 at 11:53 AM R1 sat in his wheelchair in the dining room. R1 appeared calm and well-groomed. R1 wore a hat and self-propelled around the dining room tables. During an observation on 09/18/24 at 12:01 PM, R2 sat at a table near the living room area, while R1 sat three tables away from R2 near the back of the dining room. R2 appeared well-groomed and somber while awaiting lunch. The tables of R1 and R2 were approximately 15 feet apart. During an observation on 09/18/24 at 03:10 PM, R2 lay in his bed with his blankets pulled up over his shoulders. R2 responded to his name and stated that he had no concerns with anyone in the facility. R2 asked if there was anything else because he wanted to take a nap. During an observation on 09/18/24 at 03:12 PM, R1 lay in his bed on his back watching television and appeared relaxed. R1 did not respond to his name. During an interview on 09/18/24 at 12:41 PM, LN G stated R1 and R2 sat at the same table on 09/04/24. R2 threw a vase that was on the table as decoration at R1. R1 reported to LN G that the vase bounced off R1's hat. LN G stated R1 instantly threw the ceramic mug at R1 and broke R2's nose. LN G reported it was at the beginning of the meal and she had not heard the banging on the tables but had witnessed R1 and R2 throwing things. LN G tried to recall the delay in the meal being served and stated she felt it was a kitchen problem and one of the CNAs on shift had to help in the kitchen. LN G stated nursing staff should not be going outside during meals. LN G revealed when the residents and staff are awaiting the meals to be served the CNAs will take out their trash because the shift change occurs when the residents are in the dining room at dinner time and a late dinner puts the CNAs late on finishing their shift tasks. During an interview on 09/18/24 at 01:50 PM, CNA M stated she and CNA N took all the trash out. CNA M said when she got back into the building R2 was bloody and getting cleaned up by LN G. CNA M said LN G and CMA R told her it was not the first time R1 and R2 had gotten into it. CNA M stated she was new to the building and had not witnessed any altercations with R1 or R2, but staff had mentioned it had happened before. CNA N stated CMA R was watching the dining room. During an interview on 09/18/24 at 02:06 PM, CMA R stated she stood in the living room facing the dining room passing medication. CMA R revealed that her husband had just called, and she was on the phone when it started to get rowdy in the back of the dining room. CMA R proceeded to get off the phone and the next thing CMA R knew; things were being thrown. CMA R stated at first when the residents were pounding on the table it was playful and the residents were laughing. CMA R revealed she did not know what happened between R1 and R2, but it intensified. CMA R revealed R1 had a history of behaviors and has had multiple altercations with other residents; R2 is a little rowdy and very mouthy. CMA R further revealed that R1 is very quiet but also very crazy and would react quickly. CMA R stated staff were to have at least one staff person in the dining room watching the residents. CMA R stated that when Dietary BB worked, dinner was served a little late. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/18/24 at 03:10 PM, CNA N was in the kitchen getting the resident drinks ready for dinner. CNA N stated when she came out of the kitchen, she was informed that R1 was on one-on-one and R2 was being sent out because R2 was bleeding. CNA N revealed that at times she goes into the kitchen to get the drinks for the residents because the residents are not fed until 05:30 PM to 06:000 PM. CNA N stated that in the past two years, R1 had behaviors and has been sent out to geriatric psych facilities related to his behaviors. CNA N stated she had seen behaviors previously with R1. CNA N revealed that she would have not let the banging continue with the residents and would have gone to ask the residents what was going on before it got to things being thrown. During an interview on 09/18/24 at 02:26 PM Administrative Nurse D stated that R1 historically has had behaviors. Administrative Nurse D stated that both CNAs should not have been taking out the trash and that the CMA should not have taken the call while monitoring the dining room. Administrative Nurse D further stated that staff should have been alert to the banging on the table when it involved R1. Administrative Nurse D stated that Dietary BB did come in late to his shift. Administrative Nurse D stated staff should be present in the dining room to be able to be observant and make sure behaviors did not occur. Administrative Nurse D stated that she had not had the staff do abuse and neglect training after the R1 and R2 had the altercation, but training has been going on monthly since she started. Administrative Nurse D stated she did training on resident abuse, respect for residents, and inappropriate conversations monthly since April of this year. During an interview on 09/18/24 at 03:30 PM Administrative Staff A stated it was the expectation for two nursing staff to be in the dining room with the residents when the residents were in the dining room to eat. Administrative Staff A stated if a staff member needed to take a phone call, she expected the staff member to alert her fell ow staff and step off the floor to somewhere private. Administrative Staff A said she expected staff to attempt to redirect the residents before the behaviors escalated. Administrative Staff A stated she had recently received training on handling behaviors with residents in the building and it was sent out for the staff to complete. Administrative Staff A stated she had completed the training herself, so she knew what was included in the training the staff were taking. The facility's policy Resident-to-Resident Altercations revised August 2021 documented that facility staff would monitor residents for aggressive and or inappropriate behavior towards other residents, family members, visitors, or staff. The facility's policy Abuse Prevention Program revised on August 2024 documented the community had a zero-tolerance on abuse, neglect, exploitation, or misappropriation. The policy interpretation and implementation documented the facility would protect the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteer staff from other agencies, family members, legal representatives, friends, visitors, or any other individuals. The policy required staff training and or orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behaviors. The facility failed to ensure the residents received the needed supervision to ensure resident safety and to prevent episodes of resident-to-resident abuse when R1 threw a ceramic mug at R2 and fractured R2's nose.