STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265595	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shangri-LA Rehab & Living Center	930 NE Duncan Road Blue Springs, MO 64014

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45403 Based on interview and record review, the facility failed to promote and facilitate one sampled resident's (Resident #3) self determination out of four sampled residents. The facility census was 76 residents. Review of the facility's undated Nursing Home Resident's Rights showed: -The law requires nursing home to promote and protect the rights of resident and stresses individual dignity and self-determination. -Right to dignified existence. --Be treated with consideration, respect, and dignity, recognizing each resident's individuality. --Quality of life is maintained or improved. --Exercise rights without interference, coercion, discrimination, or reprisal. -Right to self-determination. --Reasonable accommodation of needs and preferences. --Participate in developing and implementing a person-centered plan of care that incorporates person and cultural preferences. --Choice about designating a representative to exercise his/her rights. --Request, refuse, and/or discontinue treatment. -Right to be fully informed of . --The type of care to be provided, and risks and benefits of proposed treatments. --Changes of the plan of care, or in medical or health status. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Rights during discharge/transfer. --Receive 30-day written notice of discharge or transfer that includes, the reason, the effective date, the location going to, appeal rights and process for filing an appeal, and the name and contact information for the long-term care ombudsman. --Preparation and orientation to ensure safe and orderly transfer or discharge. Review of the facility's undated Admission Policy showed: -It is the policy of the corporation to admit and/or retain only those residents whose health care needs can be met through services of the facility and staff, in cooperation with outside resources under contract with the facility. --Involuntary transfers or discharges. --Except for the case of late payment or nonpayment, the facility shall notify the resident and the resident family member, surrogate or representative of the transfer and the reasons for the transfer as stated in the clinical record. 1. Review of Resident #3's Face Sheet showed he/she was admitted to the facility on [DATE] with diagnoses including dementia (a serious loss of cognitive ability in a previously unimpaired person, beyond what might be expected from normal aging) and major depressive disorder (a mental disorder characterized by a feeling of profound and persistent sadness or despair and is frequently accompanied by a loss of interest in things that were once pleasurable). Review of the Resident's Power of Attorney (POA) document showed the resident's POA had been invoked with two physician signatures. Review of the Resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 2/26/24 showed the resident was moderately cognitively impaired. Review of the resident's Nurse's Notes on 4/7/24 showed: -It was reported the resident had his/her hand in another resident's pants. -The resident placed in line of sight. -The resident unable to recall the alleged incident. -The Administrator was notified. -The resident placed on one on one. -The resident family/POA notified. -The POA came to facility and spoke to Administrator. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/7/24 at 11:00 A.M., the Administrator said the resident had only grabbed the elastic of the another residents' pants, pulled the elastic back and let go. The resident never placed his/her hand in the pants of the other resident. The resident had no known history of touching other residents inappropriately. Review of the Resident's Social Service Progress Note dated 4/9/24 at 10:00 A.M. showed: -The Social Service Designee (SSD) was asked by the facility Administrator to send referral to a locked same sex facility. -Three referrals were made for the resident. Review of the resident's Nurse's Note dated 4/7/24 through 4/15/24 showed he/she continued on one on one observation with no behaviors. Review of the facility Investigation Report dated 4/16/24 showed: -On 4/7/24 at approximately 11:45 A.M. the Administrator was notified the resident had his/her hand inside the waist band of another residents' clothing by the Director of Nursing (DON). -Interventions include a one on one facility staff presence (one staff person assigned to one resident) with the resident. -The resident was sent to the hospital for evaluation per physician request. -The POA was upset and was informed the resident would remain on one on one supervision during waking hours while the Administrator worked on his/her investigation. -In conclusion, no sexual abuse had occurred. -Per the facilities Admission, Transfer and Discharge Policy and Procedure, a transfer or discharge was necessary to meet the resident's welfare, and the resident's welfare could not met in the facility. -The resident would remain on a one on one supervision during waking hours until a same sex unit in another facility was located. During an interview on 4/16/24 at 10:19 A.M. the resident POA said: -He/she spoke to SSD on 4/8/24 and was told the steps were to notify the family, then Administrator of the allegations, then the Administrator appoints the DON or someone to investigate the allegations. -When notified of the incident, he/she came to the facility right away, spoke with the Administrator and a nurse had given him/her the Administrator's phone number. -The Administrator said there was video of the incident but refused to allow him/her to view the video. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No facility staff had spoken to him/her about transferring the resident to another location and the facility staff were now not communicating at all with him/her. -When he/she contacted the Administrator for further communication, the Administrator said it was his/her personal phone number and not to call it again. -He/she had contacted the Ombudsman. -The Administrator informed him/her the resident would be sent to a locked same sex facility. -He/she contacted the hospital social worker who contacted the Administrator and reminded him/her they could not transfer the resident without communication with the POA. -The hospital social worker was helping the POA seek alternate placement for the resident. During an interview on 4/16/24 at 11:46 A.M. the resident said all questions should go to his/her POA. During an interview on 4/16/24 at 12:28 P.M. the SSD said: -He/she was responsible for admissions, discharges and transfers for the residents in the facility. -He/she was actively working on transferring the resident. -On 4/9/24 during the morning meeting the Administrator had said the POA would not be notified of the intent to transfer. -The POA had not been notified of the referrals made or the intent to transfer the resident or the acceptance of the referral to another facility. -The Administrator shut down all communication about the resident. During an interview on 4/16/24 at 2:00 P.M. the DON said: -He/she had reviewed the video and did not see the resident have his/her hands in another resident pants. The resident had no prior inappropriate behaviors. -The resident was sent out for medical and psychological evaluation. -He/she was not aware of a discharge notice or any discussion with the POA. -The one on one supervision for the resident was not necessary and could be discontinued once a final decision had been made. During an interview on 4/17/27 at 7:30 A.M. Certified Medication Technician (CMT) A said: -He/she witnessed the incident of alleged sexual abuse with the resident. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did see contact between the residents, but could only assume the intentions were sexual in nature so he/she reported it. During an interview on 4/17/24 at 7:44 A.M. the POA said: -The facility called local law enforcement on 4/8/24 related to the allegations the day after the alleged incident. The resident did not understand why the police were called. -LPN A told the POA the resident cried when the police came and did not know why law enforcement was called. -The staff told him/her on 4/8/24 they were not talking to him/her and then called to notify him/her they were sending the resident to the hospital. -The resident was unable to process what had happened and he/she was concerned about the resident's overall safety. -If the resident was in his/her right mind, he/she would feel like his/her whole world was going down. -None of the allegations was the character of the resident and the resident would be blown away by the allegations. -The resident was made to feel less than a person and as a criminal. -The whole situation would negatively impact the resident dignity if he/she was in his/her right mind. -He/she had made multiple attempts to communicate with the facility. -He/she was concerned about the outcome of the investigation and not aware of his/her rights to locate alternate placement for the resident. -On 4/8/24 he/she brought an advocate to the facility to speak with the Administrator, and when any questions were asked the Administrator would shut them down. The Administrator did not want to answer questions about their protocol. -When he/she tried to get clarification as to what actually happened, the Administrator stated he/she was not going to tell the POA anything. -The DON agreed the facility did not have to answer any of the POA's questions. -On 4/9/24 the POA and his/her spouse went again to try to speak to the Administrator. -They attempted to communicate their desire to relocate the resident due to the adversarial environment, but needed to know what had happened to find appropriate placement. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she with the Regional Director was the investigator of the allegations and would determine when the one to one was no longer needed, the situation was resolved and everyone was safe. -One on one is someone sitting relatively close, keeping close contact with the person to make sure everyone is well protected. -He/she was responsible to provide 30 day notice in writing when a discharge was initiated to the resident and/or resident representative when needs could no longer be met. -He/she instructed the SSD to make referrals to alternative placement. -He/she had not spoken to the family/POA since the alleged incident on 4/7/24 and informed them at that time the resident may go to an same sex locked facility. -The resident enjoyed conversation with staff and the one to one had no negative outcome. -He/she was unsure if the resident understood he/she was a safety risk and required someone with him/her at all times. During an interview on 4/23/24 at 12:15 P.M. the Ombudsman said: -The Administrator contacted him/her because he/she wanted to issue a discharge notice to the resident. -The administrator was not communicating with POA. -The facility was not respecting the rights of the resident through the discharge process or communicating with the resident legal authorized representative, the POA. MO00234382