STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175305	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE PRESBYTERIAN MANOR	1429 KASOLD DR LAWRENCE, KS 66049

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and complaint investigation KS00175739. The 2567 was electronically sent to the facility on 11/07/22.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 12 residents with one reviewed for abuse. Based on observation, interview, and record review the facility failed to implement protective measures for the resident immediately after an allegation of abuse. This deficient practice placed Resident (R) 11 at risk for impaired safety and psychosocial wellbeing.	F 610		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/07/2022

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Findings included:

- R11's Electronic Medical Record (EMR), dated 09/22/22 documented diagnoses of vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes), anxiety disorder (stress that's out of proportion to the impact of the event, inability to set aside a worry, and restlessness), hallucinations (perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there), and depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).

The "Quarterly Minimum Data Set" (MDS), dated 08/26/22, documented R11 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. The MDS documented R11 was verbally abusive one to three times weekly, required limited staff assistance for eating, and extensive staff assistance for bed mobility, transfers, toileting, and hygiene. R11 had range of motion impairment in all extremities, and received antipsychotic (medications used to treat major mental disorders), and antianxiety (medication used to calm fears and stress) medications.

The "Activities of Daily Living (ADL) Care Plan," dated 08/26/22, directed staff to provide total assistance of one to two nursing staff with ADL such as grooming, repositioning, toileting, bathing, eating, transferring and locomotion. The care plan directed staff to explain each procedure to R11 so she can participate in ADL care to the maximum of her ability.

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The "Progress Note," dated 11/02/22 at 06:55 AM, documented about 04:00 AM staff alerted the nurse that R11 had a very large bowel movement. R11 was crying, and stated she had been raped. The nurse checked on her and R11 was sleeping soundly. The note stated at 05:30 AM the nurse offered R11 tramadol (a narcotic drug used for moderate to moderately severe pain); R11 was awake and refused the medication. The nurse asked R11 how she was doing, and R11 said, "you can see for yourself."

The "Progress Note," dated 11/02/22 at 07:03 AM, documented at 04:43 AM the nurse called the on-call nurse to report R11's crying and allegation.

The "Progress Note," dated 11/02/22 at 08:56 AM documented the nurse called R11's representative and reported the resident's statement that she had been raped. The nurse documented R11 had an extra-large bowel movement and staff were performing cares when R11 reported being raped. The nurse documented no male staff worked on the night shift when R11 reported being raped. The note documented the nurse offered the representative the choice of sending R11 to the emergency room (ER) for a rape exam. R11's representative reported that he did not think R11 was raped and reported R11 had made allegations of a man taking and doing things to her in the past. R11's representative did not feel it necessary for R11 to be sent to the ER for a rape exam at that time.

The "Social Worker Progress Note," dated 11/02/22 at 09:11 AM, documented the social worker interviewed R11 regarding her allegation of rape that she made to a nurse that morning.

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The note documented R11 denied telling anyone that she had been raped, stating "I've never told anyone that." R11 denied being touched inappropriately by anyone.

The "Progress Note," dated 11/02/22 at 09:20 AM, documented staff called R11's hospice services and left a message for hospice to call back regarding pain/burning with urination and R11's report of rape.

The "Progress Note," dated 11/02/22 at 10:26 AM, documented hospice returned the call and spoke with the nurse regarding resident's report of rape and R11's behavior the last couple of days.

On 11/02/22 at 08:34 AM, observation revealed R11 in bed, call light in reach, eyes closed, and lying on her left side. The facility's social worker went into the room to visit the resident.

On 11/02/22 at 08:59 AM, observation revealed Certified Nurse Aide (CNA) M and Licensed Nurse G placed non-skid socks on R11, and after three minutes of attempting to get R11 to accept the gait belt, they laid her back down. R11 tried to swing her lags out of bed and self-transfer, she kicked at the blankets, and continued to complain while the aide was getting the lift. The nurse stayed with her. R11 was upset, would not allow them to use the total lift, and told them to leave her alone. R11 stated she knew her rights and wanted to stay where she was, with the lift sling under her. The aide was able to get her to cooperate and they used a gait belt and extensive assistance to transfer R11 to her recliner.

On 11/02/22 at 09:35 AM, Administrative Staff A

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F 610	Continued From page 4	F 610		

stated the resident denied the allegation of rape when the social worker interviewed her and R11 stated no one had ever raped her. Administrative Staff A stated R11 had a very large bowel movement around that time and said that hurt. Administrative Staff A stated no male aids worked that night and none of the male residents came out of their rooms during the night per nursing staff on duty. Administrative Staff A stated R11 had made false accusations before and when she lived at another facility, she had alleged rape.
Administrative Staff A verified the following timeline of notification, intervention, and interviews for 11/02/22:
At 03:40 AM, R11's call light activated, and two aides found R11 asleep and she mumbled when asked if anything was needed. The aides left room without providing cares.
At 04:00 AM, two aides assisted R11 with incontinence cares and during cares R11 complained that she had been raped. The aides notified the nurse who checked on the resident and found her asleep. Administrative Staff A stated the nurse had come to the room while care was being provided but verified the nurse had not documented an assessment.
At 04:43 AM, LN H called the Assistant Director of Nursing (ADON) to report the allegation and that R11 was crying. They discussed if any men were working or if any male residents had been up walking around. Administrative Staff A reported no cameras were reviewed.
At 05:30 AM, LN H attempted to administer medications and R11 refused.
At 06:15 AM, staff reported the allegation to Administrative Staff A.
At 09:00 AM, the social worker interviewed the resident who denied the allegation happened.

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F 610	Continued From page 5 On 11/02/22 at 01:15 PM Administrative Staff A verified the nurse did not document an assessment of the resident at the time of the allegation. She stated, based on the fact that no men were working or wandering, the facility felt the triggers that caused her to allege rape were events of the past 24 hours of overstimulation and her past behaviors were taken into account. The resident had stated a man came into her room and raped her. The night nurse checked on the resident at 05:30 AM, The day shift supervisor LN G, and Administrative Nurse E both had been to see the resident, but had not assessed her due to the social worker had just interviewed R11 and they felt she might become upset with too much stimulation. Administrative Staff A stated without a potential perpetrator, staff established R11 was in a safe place and verified no immediate safety interventions were implemented from the time of the allegation to R11 denying the allegation. The facility's "Abuse Prevention, Intervention, Reporting and Investigation" policy, dated 09/07/22, documented upon receiving reports of suspected sexual abuse the executive director and the health services director are immediately notified to arrange for the examination of the resident. Residents will be monitored for possible signs of abuse. Residents are to be protected during investigations. The facility failed to implement protective measures for R11 immediately after an allegation of rape, placing the resident at risk for impaired safety and psychosocial wellbeing.	F 610		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		

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§483.35 Nursing Services
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure staff possessed the skills and knowledge necessary to perform and record an immediate physical assessment of Resident (R) 11 after an allegation of rape. This deficient

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practice placed R11 at risk for unidentified injury and delayed treatment decisions.

Findings included:

- R11's "Electronic Medical Record" (EMR), dated 09/22/22 documented diagnoses of vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes), anxiety disorder (stress that's out of proportion to the impact of the event, inability to set aside a worry, and restlessness), hallucinations (perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there), and depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).

The "Quarterly Minimum Data Set" (MDS), dated 08/26/22, documented R11 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. The MDS documented R11 was verbally abusive one to three times weekly, required limited staff assistance for eating, and extensive staff assistance for bed mobility, transfers, toileting, and hygiene. R11 had range of motion impairment in all extremities, and received antipsychotic, and antianxiety medications.

The "Activities of Daily Living(ADL) Care Plan", dated 08/26/22, directed staff to provide total assistance of one to two nursing staff with ADLs such as grooming, repositioning, toileting, bathing, eating, transferring and locomotion. The care plan directed staff to explain each procedure to R11 so she can participate in ADL care to the maximum of her ability.

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The "Progress Note," dated 11/02/22 at 06:55 AM, documented about 04:00 AM staff alerted the nurse that R11 had a very large bowel movement. R11 was crying and stated she had been raped. The nurse checked on her and R11 was sleeping soundly. The note stated at 05:30 AM the nurse offered R11 tramadol (a narcotic drug used for moderate to moderately severe pain),R11 was awake and refused the medication. The nurse asked R11 how she was doing, and R11 said, "you can see for yourself."

R11's medical record lacked a physical or mental assessment of the resident after the allegation of rape.

On 11/02/22 at 08:34 AM, observation revealed R11 in bed, call light in reach, eyes closed, and lying on her left side. The facility's social worker went into the room to visit the resident.

On 11/02/22 at 09:35 AM, Administrative Staff A verified the following timeline of notification, intervention, interviews for 11/02/22:
At 03:40 AM, R11's call light activated, and two aides found R11 asleep and she mumbled when asked if anything was needed. The aides left room without providing cares.
At 04:00 AM, two aides assisted R11 with incontinence cares and during cares R11 complained that she had been raped. The aides notified the nurse who checked on the resident and found her asleep. Administrative Staff A stated the nurse had come to the room while care was being provided but verified the nurse had not documented an assessment.

On 11/02/22 at 01:15 PM Administrative Staff A verified the nurse did not document an

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assessment of the resident at the time of the allegation. Administrative Staff A verified the day shift supervisor LN G, and Administrative Nurse E both had been to see the resident but had not assessed her due to the social worker had just interviewed R11 and they felt she might become upset with too much stimulation. Administrative Staff A verified no immediate safety interventions were implemented and no physical assessment had been completed from the time of the allegation to when R11 denied the allegation.

The facility's "Abuse Prevention, Intervention, Reporting and Investigation" policy, dated 09/07/22, documented upon receiving reports of suspected sexual abuse the executive director and the health services director are immediately notified to arrange for the examination of the resident. Residents will be monitored for possible signs of abuse. Residents are to be protected during investigations.

The facility failed to ensure licensed nurse staff possessed the skills and knowledge necessary to perform a full assessment to assess for injuries and attempt to preserve the scene in the presence of a rape allegation. placing R11 at risk for unidentified injuries.