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	175297	A. BUILDING _____ B. WING _____	C 11/27/2023

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00183948. The 2567 was sent electronically on 12/08/23.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 62 residents. The sample included three residents. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free from abuse when Certified Nurse Aide (CNA) M struck R1 on her arm after R1 had physical behaviors towards her. This deficient practice resulted in impaired psychosocial well-being and placed R1 at risk for continued abuse. Findings included: - R1's Electronic Medical Record (EMR)	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/08/2023

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documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and encounter for palliative care (treatment designed to relieve or reduce intensity of uncomfortable symptoms).

The "Annual Minimum Data Set (MDS)" dated 03/30/23, documented a Brief Interview for Mental Status (BIMS) was not conducted due to R1 was rarely/never understood. R1 had physical behaviors directed towards others one to three days in the assessment period. R1 required extensive assistance with two staff for bed mobility, transfers, dressing, and toileting; extensive assistance with one staff for personal hygiene; and total dependence with one staff for locomotion.

The "Quarterly MDS" dated 09/13/23, documented a BIMS was not conducted due to R1 rarely/never understood. R1 had physical and verbal behaviors directed towards others and other behavioral symptoms not directed towards others one to three days in the assessment period. R1 required extensive assistance with two staff for bed mobility, dressing, and toileting; extensive assistance with one staff for personal hygiene; and total dependence with one staff for locomotion.

The "Cognitive Loss/Dementia [progressive mental disorder characterized by failing memory, confusion] Care Area Assessment [CAA]" dated 04/03/23 documented R1 was unable to answer BIMS questions and staff assessment for cognition and showed problems with orientation and recall ability.

The "Activities of Daily Living [ADL]

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Functional/Rehabilitation Potential CAA" dated 04/03/23, documented R1 required extensive assistance with ADL and transfers. R1's speech was clear, and she had difficulty finding words or finishing thoughts.

The "Behavioral Symptoms CAA" dated 03/31/23, documented R1 had physical behaviors in the last week.

R1's "Care Plan" dated 04/12/22 documented R1 had the physical behavior of swinging at staff when resisting cares at times and verbally resisting cares related to her diagnosis of dementia. The "Care Plan" directed staff were to be alert to R1's triggers such as coaxing her to eat and waking her and to avoid them as much as possible by allowing her to feed herself and allowing her to wake naturally. The "Care Plan" documented an intervention dated 09/18/23 that directed if R1 became agitated or unsettled, staff were to try these interventions to de-escalate: allow her time to settle, look at her family album with her, give her plenty of time to respond to staff, make sure her hearing aides were in, and explain procedures in advance.

The facility's "Investigative Report," dated 11/15/23, documented on 11/08/23 CNA N reported to Administrative Nurse D that she assisted CNA M to get R1 dressed for the day. As CNA N and CNA M transferred R1 to her Broda (specialized wheelchair with the ability to tilt and recline) chair, R1 suddenly struck CNA M, a behavior that was not uncommon and was care planned. CNA N described that CNA M quickly released her contact with R1, dropping her into her chair and proceeded to slap R1 twice on each arm while yelling at her to not hit people. R1 had

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no further aggression and did not react to CNA M's aggression. CNA M left the room and CNA N finished seating R1 in her preferred position in the Broda chair. The report documented CNA M was familiar with R1 and had provided ADL care to her many times. The report documented CNA M was immediately escorted out of the building and placed on suspension pending completion of the investigation. Administrative Nurse D assessed R1, who rested quietly in her recliner with her eyes closed. R1 did not react to Administrative Nurse D touching her arms and her arms were pink and warm without bruising.

In a signed "Witness Statement" obtained by the facility on 11/08/23, CNA M stated she and CNA N went into R1's room to get her changed and R1 was in her Broda chair, ripping up her incontinence brief. She stated she told R1 they were going to change her and when CNA M grabbed R1 to stand, R1 swung at her face and tried to kick her. CNA M stated she gently pushed R1's legs and hands away and told her not to hit people then R1 pinched CNA M on her buttocks.

In a signed "Witness Statement" obtained by the facility on 11/08/23, CNA N stated she was helping CNA M get R1 up and dressed for the day and R1 hit CNA M when she picked R1 up. CNA N stated CNA M dropped R1 back in her chair and slapped R1 twice on each arm and yelled at her.

In a signed "Witness Statement" on 11/27/23, CNA N stated she and CNA M were in R1's room to get her up for the day and R1 had ripped up her incontinence brief which upset CNA M. She stated CNA M told her she was going to lift R1 while CNA N pulled her pants up. When CNA M

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picked R1 up, R1 pinched and hit CNA M and CNA M dropped R1 back into her Broda chair and hit R1 for sure on the left arm. CNA N stated she heard two slaps. CNA N stated R1 grabbed her left arm, rubbed it, and stated "ow ."

On 11/27/23 at 11:02 AM, R1 laid in her bed with her eyes closed and appeared to be resting comfortably.

On 11/27/23 at 11:16 AM, CNA N stated on 11/08/23, she and CNA M went into R1's room to get her ready and when CNA M picked her up from her Broda chair so CNA N could pull up her pants, R1 pinched and hit CNA M. She stated CNA M dropped R1 back into her chair then slapped R1. CNA N stated she was not sure if it was two separate arms or just her left arm, but it was loud slapping and R1 rubbed her left arm and said "ow" quietly. CNA N stated there was no way CNA M's actions could have been mistaken as anything other than a slap.

On 11/27/23 at 11:37 AM, CNA M was unavailable for interview.

On 11/27/23 at 11:45 AM, CNA N stated her statement differed from her original statement because on the morning of 11/08/23, she was under a lot of pressure and in her head, it was both arms that were slapped because it was two slaps. She stated she actually saw CNA M make contact with R1's left arm.

On 11/27/23 at 11:46 AM, Licensed Nurse (LN) G stated she worked on 11/08/23 but was told about the incident the next day. She stated she did not witness any injuries on R1.

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F 600	Continued From page 5	F 600		

On 11/27/23 at 12:44 PM, CNA N stated the charting system listed behavior triggers and interventions. She stated right now, R1's trigger was anything to do with her foot because of wounds. CNA N stated if R1 hit staff, staff were to calm her down and talk to her. She stated the care plan does not direct staff to slap or push R1's arms or hands.

On 11/27/23 at 01:13 PM, LN G stated she was not sure if the CNAs had access to the care plans, but the care plans had behavior triggers and interventions on them. She stated R1's behaviors included swinging at staff, yelling out, and sometimes crying. LN G stated if R1 had behaviors, staff were to gently calm her and talk to her. She stated if R1 was hitting staff, staff could have stopped what they were doing and gave her time to calm down along with general reassurance and staying out of her space.

On 11/27/23 at 01:18 PM, Administrative Nurse D stated on 11/08/23, CNA N came into her office shortly after 08:00 AM and stated she saw CNA M hit R1. She had CNA N stay in her office while she got CNA M to write a witness statement then escorted CNA M out of the building. Administrative Nurse D stated CNA M wrote in her witness statement that they were changing R1 and R1 swung at CNA M's face, so she gently pushed her hands and legs away. Administrative Nurse D stated the facility substantiated the abuse and education was conducted on abuse, neglect, and exploitation (ANE) but not on behavior management. She stated CNAs had access to the care plans which contained what behaviors residents typically exhibited and how staff were to intervene. Administrative Nurse D stated R1's care plan directed during behaviors,

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F 600	Continued From page 6 staff were to let her be and reapproach which did not happen on 11/08/23. She stated she expected if R1 had behaviors, staff allowed time for her to settle down, look at her family album, give her plenty of time, make sure she had her hearing aids in, and explained procedures in advance. Administrative Nurse D stated CNA N reported to her that she and CNA M had went in to change R1 and when CNA M lifted R1 up, R1 started hitting CNA M. CNA N stated to Administrative Nurse D that CNA M then dropped R1 back into her chair, slapped her twice on each arm, and yelled at her. Administrative Nurse D stated CNA N did not report that R1 said "ow" after the slap. The facility's "ANE: Abuse Prevention, Intervention, Reporting, and Investigation- Staff Treatment of Residents" policy, last revised 09/07/22, directed residents had the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, exploitation, and involuntary seclusion. The policy directed prevention measures were in place which provided residents, families, and staff information related to reporting and handling concerns and grievances and included identifying, correcting, and/or intervening in situations in which abuse was more likely to occur. The facility failed to prevent physical abuse when CNA M hit R1 on 11/08/23. The scope and severity were determined to be actual harm based on the "reasonable person" concept due to the circumstances of R1's impaired cognitive status and inability to self-identify and express her feelings.	F 600		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		

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§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 62 residents. The sample included three residents with one reviewed for dementia (progressive mental disorder characterized by failing memory, confusion) care. Based on observations, record review, and interviews, the facility failed to provide dementia care and services for Resident (R) 1 when the facility failed to ensure CNA M followed care-planned interventions in response to R1's dementia related behaviors. This deficient practice created an environment that affected R1's ability to maintain her highest practicable level for physical, mental, and psychosocial well-being and placed the resident at risk for ongoing abuse (See F600).

Findings included:

- R1's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and encounter for palliative care (treatment designed to relieve or reduce intensity of uncomfortable symptoms).

The "Annual Minimum Data Set (MDS)" dated 03/30/23, documented a Brief Interview for Mental Status (BIMS) was not conducted due to R1 was rarely/never understood. R1 had physical behaviors directed towards others one to three days in the assessment period. R1 required

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extensive assistance with two staff for bed mobility, transfers, dressing, and toileting; extensive assistance with one staff for personal hygiene; and total dependence with one staff for locomotion.

The "Quarterly MDS" dated 09/13/23, documented a BIMS was not conducted due to R1 rarely/never understood. R1 had physical and verbal behaviors directed towards others and other behavioral symptoms not directed towards others one to three days in the assessment period. R1 required extensive assistance with two staff for bed mobility, dressing, and toileting; extensive assistance with one staff for personal hygiene; and total dependence with one staff for locomotion.

The "Cognitive Loss/Dementia [progressive mental disorder characterized by failing memory, confusion] Care Area Assessment [CAA]" dated 04/03/23 documented R1 was unable to answer BIMS questions and staff assessment for cognition showed problems with orientation and recall ability.

The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential CAA" dated 04/03/23, documented R1 required extensive assistance with ADL and transfers. R1's speech was clear, and she had difficulty finding words or finishing thoughts.

The "Behavioral Symptoms CAA" dated 03/31/23, documented R1 had physical behaviors in the last week.

R1's "Care Plan" dated 04/12/22 documented R1 had the physical behavior of swinging at staff

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when resisting cares at times and verbally resisting cares related to her diagnosis of dementia. The care plan directed staff were to be alert to R1's triggers such as coaxing her to eat and waking her and to avoid them as much as possible by allowing her to feed herself and allowing her to wake naturally. The care plan documented an intervention dated 09/18/23 that directed if R1 became agitated or unsettled, staff were to try these interventions to de-escalate allow her time to settle, look at her family album with her, give her plenty of time to respond to staff, make sure her hearing aides were in, and explain procedures in advance.

The facility's "Investigative Report," dated 11/15/23, documented on 11/08/23 CNA N reported to Administrative Nurse D that she assisted CNA M to get R1 dressed for the day. As CNA N and CNA M transferred R1 to her Broda (specialized wheelchair with the ability to tilt and recline) chair, R1 suddenly struck CNA M, a behavior that was not uncommon and was care planned. CNA N described that CNA M quickly released her contact with R1, dropping her into her chair and proceeded to slap R1 twice on each arm while yelling at her to not hit people. R1 had no further aggression and did not react to CNA M's aggression. CNA M left the room and CNA N finished seating R1 in her preferred position in the Broda chair. The report documented record review, staff interview, environmental review, and assistive device review revealed that two CNAs assisted R1 to dress for the day and were in the process of transferring R1 to her Broda chair when R1 struck out at CNA M. CNA M responded by releasing her grasp of R1 and slapping her twice, once on each forearm while yelling at R1 "do not hit people." CNA M was familiar with R1

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F 744	Continued From page 10	F 744		

and had provided ADL care to her many times. The report documented CNA M was immediately escorted out of the building and placed on suspension pending completion of the investigation. Administrative Nurse D assessed R1, who rested quietly in her recliner with her eyes closed. R1 did not react to Administrative Nurse D touching her arms and her arms were pink and warm without bruising.

In a signed "Witness Statement" on 11/08/23, CNA M stated she and CNA N went into R1's room to get her changed and R1 was in her Broda chair, ripping up her incontinence brief. She stated she told R1 they were going to change her and when CNA M grabbed R1 to stand, R1 swung at her face and tried to kick her. CNA M stated she gently pushed R1's legs and hands away and told her not to hit people then R1 pinched CNA M on her buttocks.

In a signed "Witness Statement" on 11/08/23, CNA N stated she was helping CNA M get R1 up and dressed for the day and R1 hit CNA M when she picked R1 up. CNA N stated CNA M dropped R1 back in her chair and slapped R1 twice on each arm and yelled at her.

In a signed "Witness Statement" on 11/27/23, CNA N stated she and CNA M were in R1's room to get her up for the day and R1 had ripped up her incontinence brief which upset CNA M. She stated CNA M told her she was going to lift R1 while CNA N pulled her pants up. When CNA M picked R1 up, R1 pinched and hit CNA M and CNA M dropped R1 back into her Broda chair and hit R1 for sure on the left arm. CNA N stated she heard two slaps. CNA N stated R1 grabbed her left arm, rubbed it, and stated "ow."

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F 744	Continued From page 11	F 744		

On 11/27/23 at 11:02 AM, R1 laid in her bed with her eyes closed and appeared to be resting comfortably.

On 11/27/23 at 11:16 AM, CNA N stated on 11/08/23, she and CNA M went into R1's room to get her ready and when CNA M picked her up from her Broda chair so CNA N could pull up her pants, R1 pinched and hit CNA M. She stated CNA M dropped R1 back into her chair then slapped R1. CNA N stated she was not sure if it was two separate arms or just her left arm, but it was loud slapping and R1 rubbed her left arm and said "ow" quietly. CNA N stated there was no way CNA M's actions could have been mistaken as anything other than a slap.

On 11/27/23 at 11:37 AM, CNA M was unavailable for interview.

On 11/27/23 at 11:45 AM, CNA N stated her statement differed from her original statement because on the morning of 11/08/23, she was under a lot of pressure and in her head, it was both arms that were slapped because it was two slaps. She stated she actually saw CNA M make contact with R1's left arm.

On 11/27/23 at 11:46 AM, Licensed Nurse (LN) G stated she worked on 11/08/23 but was told about the incident the next day. She stated she did not witness any injuries on R1.

On 11/27/23 at 12:44 PM, CNA N stated the charting system listed behavior triggers and interventions. She stated right now, R1's trigger was anything to do with her foot because of wounds. CNA N stated if R1 hit staff, staff were to

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F 744	Continued From page 12	F 744		

calm her down and talk to her. She stated the care plan does not direct staff to slap or push R1's arms or hands.

On 11/27/23 at 01:13 PM, LN G stated she was not sure if the CNAs had access to the care plans, but the care plans had behavior triggers and interventions on them. She stated R1's behaviors included swinging at staff, yelling out, and sometimes crying. LN G stated if R1 had behaviors, staff were to gently calm her and talk to her. She stated if R1 was hitting staff, staff could have stopped what they were doing and gave her time to calm down along with general reassurance and staying out of her space.

On 11/27/23 at 01:18 PM, Administrative Nurse D stated on 11/08/23, CNA N came into her office shortly after 08:00 AM and stated she saw CNA M hit R1. She had CNA N stay in her office while she got CNA M to write a witness statement then escorted CNA M out of the building. Administrative Nurse D stated CNA M wrote in her witness statement that they were changing R1 and R1 swung at CNA M's face, so she gently pushed her hands and legs away. Administrative Nurse D stated the facility substantiated the abuse and education was conducted on abuse, neglect, and exploitation (ANE) but not on behavior management. She stated CNAs had access to the care plans which contained what behaviors residents typically exhibited and how staff were to intervene. Administrative Nurse D stated R1's care plan directed during behaviors, staff were to let her be and reapproach which did not happen on 11/08/23. She stated she expected if R1 had behaviors, staff allowed time for her to settle down, look at her family album, give her plenty of time, make sure she had her hearing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175297	A. BUILDING _____ B. WING _____	C 11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPEKA PRESBYTERIAN MANOR	4712 SW 6TH AVE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 13	F 744		

aids in, and explained procedures in advance. Administrative Nurse D stated CNA N \reported to her that she and CNA M had went in to change R1 and when CNA M lifted R1 up, R1 started hitting CNA M. CNA N stated to Administrative Nurse D that CNA M then dropped R1 back into her chair, slapped her twice on each arm, and yelled at her.

The facility's "Behavioral Health Services" policy, last revised 10/27/22, directed providing behavioral health care and services was an integral part of the person-centered environment and the facility provided treatment and services to meet dementia and cognitive impairment needs of residents. The policy directed a resident who displayed or was diagnosed with dementia received appropriate treatment and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being per dementia policies and procedures.

The facility failed to provide dementia care and services for R1 when the facility failed to ensure CNA M followed care-planned interventions in response to her behaviors. This deficient practice created an environment that affected R1's ability to maintain her highest practicable level for physical, mental, and psychosocial well-being and placed the resident at risk for ongoing abuse (See F600)..