STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	C 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 67205

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00175903 and KS00176598. A complaint survey was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 12/13 thru 12/14/22. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 12/14/22 at 03:00 PM, the Administrator was provided a copy of the IJ template and informed of the IJ. Based on interview and record review, the facility failed to ensure R1 was free from the inappropriate sexual behaviors/advances of R2, who had a history of inappropriate sexual behavior. On 12/06/22, due to lack of staff supervision, R2 spent an unknown amount of time in R1's room and put his hand up her shirt and down her pants, touching R1's chest and genitals. This deficient practice placed R1 in immediate jeopardy and at risk for psychosocial and physical harm. The facility provided an acceptable plan for removal of the immediate jeopardy on 12/14/22 at 06:40 PM. The survey team validated the removal of the immediate jeopardy as of 12/14/22 at 08:30 PM. The deficienet practice remained at a "G" scope and severity folloiwng the removal of the immediate jeopardy. A 2567 was electronically sent to the facility on 12/29/22.	F 000		
F 600	Free from Abuse and Neglect	F 600		

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

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.

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F 600 SS=J	Continued From page 1 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 reported a census of 59 residents with two residents reviewed for abuse. Based on record review and interview, the facility failed to ensure Resident (R) 1 was free from the inappropriate sexual behaviors/advances of R2, who had a history of inappropriate sexual behaviors; both verbal towards the staff in the facility and physical towards R1 on 11/05/22. R2 was treated with medication to help reduce sexual behaviors and the care plan directed staff to monitor R2 and encourage him not to sit within arm's length of female residents. However, on 12/06/22, due to lack of staff supervision, R2 spent an unknown amount of time in R1's room and put his hand up her shirt and down her pants, touching R1's chest and genitals. This deficient practice placed R1 in immediate jeopardy and at risk for psychosocial and physical harm. Findings included:	F 600		

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- The "Physician Orders" (PO), dated 11/29/22, for R2, included a diagnosis of dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).

The "Annual Minimum Data Set" (MDS), dated 07/01/22, documented R2 with a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had verbal behavioral symptoms directed at others for one to three days during the seven-day lookback period. R2 required extensive assistance of two staff members for bed mobility, transfer, and toilet use. The resident used a wheelchair for mobility and received antidepressant medication during the lookback period.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 07/06/22, documented the resident with a diagnosis of dementia and experienced negative behaviors during the assessment period that was directed at others.

The "Quarterly MDS," dated 09/24/22, documented R2 with a BIMS score of 15, indicating intact cognition, and exhibited no behaviors. R2 required extensive assistance of two staff members for bed mobility, transfer, and toilet use. The resident used a wheelchair for mobility and received antianxiety and antidepressant medication during the seven-day lookback period.

The "Care Plan," updated 12/06/22, advised the staff R2 had a history of a stroke and memory

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problems and they were to provide cues to promote the resident's independence and ensure his safety. The resident required two staff members to assist with bed mobility, toileting, and transfer and R2 used a wheelchair for mobility. The resident had behaviors due to restlessness and made sexual comments towards the staff. Staff were to redirect and let R2 know it was not ok to speak to staff in that manner 09/28/22. Staff educated R2 not to touch female residents in inappropriate areas 12/06/22. Staff were to monitor resident and encourage him not to sit within arm's length of a female resident 09/28/22. The resident received medication for inappropriate behaviors and moved to another unit to separate R2 from the female resident that he sought out 12/06/22.

A "Behavior Note," dated 11/05/22 at 01:18 PM, written by Licensed Nurse (LN) G documented R2 touched a female table neighbor during the mid-day meal. Staff immediately separated R2 and the female table neighbor to separate tables for the remainder of the meal. Staff notified LN G as acting Manager on Duty and Director of Nursing (DON) in a timely manner. When questioned about this incident, R2 denied the incident happened and denied touching any female neighbors in a private or inappropriate manner. R2 then verbalized understanding that inappropriate touching of any other resident was not an acceptable action or behavior.

A "Facility Investigation," dated 11/11/22, documented on or about 11/07/22 at lunch time, staff reported R2 appeared to reach over and attempt to fondle the breast of female resident, R1. R1 reported R2 tried to fondle her breast and it made her uncomfortable.

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A "Physician Communication," dated 11/28/22 at 06:07 PM, by LN H revealed a communication to the physician regarding R2 asking multiple staff to perform sexual acts with him in his room and to lay on his bed. R2 made those requests frequently throughout the day with any of the staff members. R2's family member requested information about any medication that would reduce the behaviors.

A "Nursing Note," dated 11/29/22 at 07:49 AM, revealed Administrative Nurse E spoke to R2 privately concerning very inappropriate sexual comments made to the staff earlier in the shift. R2 was alert and oriented with a BIMS score of 15. Administrative Nurse E educated R2 on the proper way to communicate with the staff and he was made aware that the comments he made to the staff were making them uncomfortable.

A "Nursing Note," dated 12/06/22 at 04:53 PM, by Administrative Nurse D documented at approximately 01:00 PM, staff witnessed R2 leaving a female resident's room. The female resident (R1), reported R2 fondled her breast and genitals under her clothing. She said that was the first time he had come to her room and done this. Staff reported the incident to the DON, state agency, local police department, and the emergency contacts for both residents. R2 denied fondling the female resident and stated he only went in there to talk to her. Police officers informed him it was not appropriate to touch other female residents that lived in the unit, and he needed to stay away from the female resident that reported this situation. R2 verbalized understanding.

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A "Witness Statement," dated 12/06/22, by Administrative Nurse F, revealed she was assisting clinical staff members to find R2 as he was scheduled for therapy. Administrative Nurse F observed R2 leaving R1's room in his motorized wheelchair. Administrative Nurse F immediately went into R1's room and found her sitting in her recliner with her feet elevated. Administrative Nurse F inquired about her visitor and R1 stated R2 liked to come into her room sometimes. The nurse asked R1 what happened during their visit and R1 grabbed her breasts and stated that R2 touched them and tried to help her get her pants down. Administrative Nurse F asked R1 if she was okay and R1 stated she was and that she didn't need anything before Administrative Nurse F left the room to immediately notify the DON about the situation.

A "Witness Statement," dated 12/06/22, by Administrative Nurse D, revealed Administrative Nurse F informed her that she witnessed R2 leaving R1's room. Administrative Nurse F immediately went into R1's room and asked why R2 was visiting her and R1 informed Administrative Nurse F that R2 fondled her. Administrative Nurse D went directly to R1's room and inquired about the situation. R1 reported R2 was "getting a feel" while she motioned towards her breast area. R1 reported R2 fondled her breast and genital area. Administrative Nurse D asked if it happened above or underneath her clothing. R1 reported R2 touched her under her clothes. R2 told her he needed to get under them. R1 did not give the resident permission to touch her or want him to touch her. She stated, "I just wanted him to get it over with so he would calm down." R1 also stated that R2 had never done that to her before.

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Interview on 12/04/22 at 10:48 AM, with Administrative Nurse D verified the above statements. She was not sure why R2 singled out and targeted R1. R2 had always been inappropriate with the staff and did not bother the residents. R2 was on daily behavior monitoring and charting due to behaviors towards staff. She educated R2 about inappropriate sexual behaviors towards others and he understood as he had a BIMS of 15. Nothing else happened between the residents until the incident on 12/06/22. The resident could move about in the unit in his wheelchair and staff did not see him go into R1's room. When she talked to R1 about it, R1 stated that she lifted up her shirt so he could touch her and also moved her pants and brief so he could put his hand in them. Nothing else happened and R2 left her room after he touched her genitals. R2 was moved downstairs into a different room and nothing else has happened since.

The facility policy, "Abuse Prevention," approved 06/22, documented " ...Our residents have the right to be free from abuse, neglect ...This includes ...sexual or physical abuse ...Sexual Abuse is non-consensual sexual contact of any type with the resident ... b. Does not want the contact to occur ... 2. Any forced, coerced, or extorted sexual activity with a resident ...Training ...5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond ...These symptoms, include but are not limited to ...b. Wandering ..."

The facility failed to ensure R1 was free from the inappropriate sexual behaviors/advances of R2, who had a history of inappropriate sexual

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behavior. On 12/06/22, due to lack of staff supervision, R2 spent an unknown amount of time in R1's room and put his hand up her shirt and down her pants, touching R1's chest and genitals. This deficient practice placed R1 in immediate jeopardy and at risk for psychosocial and physical harm.

The facility provided their plan of removal on 12/14/2022 at 06:40 PM, which included the following implementation.
1. On 12/06/22 at 01:50 PM, the police and the medical director were notified.
2. On 12/06/22, R2 was moved to a different unit/floor of the facility and away from R1.
3. On 12/07/22, residents in the facility were reviewed by Administrative Staff A and residents reported they had not had any unwanted male visitors in their rooms or unwanted physical touching from others. Residents reported they felt safe in the facility.
4. Education of staff regarding ANE policies and reporting of incidents of Abuse, Neglect, and Exploitation to Administrative staff immediately was completed on 12/14/22 at 08:00 PM. Any remaining staff were contacted by the facility and advised they would be unable to work until education was completed.
5. Resident was put on one-on-one status on 12/14/22 at 08:30 PM..

The facility completed the removal plan on 12/14/22 at 08:30 PM.