STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265700	A. BUILDING _____ B. WING _____	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSHIRE AT LAKEWOOD REHAB CENTER	600 N E MEADOWVIEW DRIVE LEES SUMMIT, MO 64064

(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 600 SS=D	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: Based on interview, and record review, the facility failed protect two sampled residents (Resident #3 and #2) from a physical altercation between each other, when Resident #2 tapped Resident #3 on the shoulder with his/her reacher (an instrument used to pull things toward a person that was out of reach) and when Resident #3 hit Resident #2 on the back of his/her head then scratched Resident #2's face, out of 10 sampled residents. The facility census was 107 residents. On 2/24/23 the Administrator was notified of the past noncompliance which occurred on 2/11/23. On 2/11/23 the facility administration was notified of the incident and the investigation was started. Staff were educated on the resident behaviors, interventions were in place at the time of the resident to resident incident. The facility staff immediately separated Resident #2 and Resident	F 600	Past noncompliance: no plan of correction required.	

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

Administrator 3-8-2023

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	Continued From page 1 #3. The deficiency was corrected on 2/13/23. Record review of the facility's policy "Violence between Residents" dated October 24, 2022 showed: -The purpose was to protect the health and safety of residents by ensuring that altercations between residents were promptly reported, investigated, and addressed by the facility. -Facility staff monitored residents for aggressive or inappropriate behavior toward other residents. -Any occurrences of such behavior were promptly reported to the Charge Nurse, the Director of Nursing (DON), and the Administrator. -Response to an altercation. --Separate the residents, and institute measures to calm the situation. --Determine what happened, including what might have led to aggressive conduct on the part of one or more of the residents involved in the altercation. --Notify each resident's representative and Physician of the incident. --Review the events with the Charge Nurse and DON including interventions staff could take to prevent additional incidents. --Consult with the Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem. --Make any necessary changes in the care plan for any or all of the involved residents as necessary. --Document the resident's interventions and there effectiveness in the resident's medical record. --Consult with psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management necessary or as may be recommended by the Physician or	F 600		

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F 600	Continued From page 2 Interdisciplinary Team. --Document the incident, findings, and any corrective measures taken in the resident's medical record. -If after carefully evaluating the situation, it was determined that care could not be readily given within the Facility, transfer the resident. 1. Record review of Resident #2's face sheet showed he/she was admitted to the facility on 12/14/22 with the following diagnoses: -Generalized muscle weakness. -Schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucination or delusions, and mood disorder symptoms, such as depression or mania.) -Depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act). -Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). -He/she was his/her own responsible person. Record review of Resident #2's Pre Admission Screening and Resident Review (PASRR a federally mandated program that required all states to prescreen all people, regardless of payer source or age, seeking admission to a Medicaid certified nursing facility) dated 2/15/23 showed: -He/she did not have a guardian. -He/she did not show any signs of a major mental illness. -He/she did have a current, suspected, or history of a major mental illness that included Anxiety, Schizoaffective disorder, and Depressive disorder.	F 600		

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F 600	Continued From page 3 -He/she did not have any impairment due to serious mental illness. -He/she had not experienced a psychiatric treatment episode that was more intensive than routine follow-up care in the last two years. -He/she did not have a substance related disorder. -He/she did not have a diagnosis or history of an Intellectual disability or related condition. -He/she was not currently a danger to self or others. -Physician's Signature, Discipline, and License number was blank. -Diagnosis list was not attached. -History and Physical was not attached. -He/she had stable mental condition and no mood or behavior symptoms observed and no reported psychiatric conditions. -He/she was oriented to person, place, and time. -He/she had to issues with memory or recall ability. -Level of supervision was two hour checks. -He/she had severe difficulty with vision. Record review of Resident #2's Admission Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility staff for care planning) dated 12/20/22 showed: -His/her Brief Interview for Mental Status (BIMS) score was 15 which indicated he/she was cognitively intact. -He/she had no behaviors. -It was very important to him/her to take care of personal belongings. -It was very important to him/her to have a place to lock up his/her things. Record review of Resident #2's undated care plan showed:	F 600		

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F 600	Continued From page 4 -The problem identified: --He/she had the potential to be verbally aggressive related to mental and emotional illness, poor impulse control and hoarding. --He/she did not like having people mess with his/her things. -The desired outcome: --He/she would verbalize understanding of the need to control verbally abusive behavior through the review date. (there was no review date documented). -Interventions included: --Staff would monitor the resident's behaviors per shift. --Staff would document any observed behaviors and attempted interventions. --When the resident became agitated staff would intervene before agitation escalated. --Staff would guide him/her away from the source of distress. Record review of Resident #2's weekly skin observation dated 2/11/23 showed: -He/she had scratches under his/her eyes and by the bridge on his/her nose related to resident to resident altercation. Record review of Resident #2's Trauma Informed Care assessment dated 2/13/23 documented by Social Services Designee showed: -He/she was in an altercation with Resident #3. -He/she was not afraid of the other resident as he/she trusted staff would take care of him/her. Record review of Resident #2's Physical Therapy Treatment Encounter dated 2/15/23 showed: -He/she demonstrated safe and independent use of a reacher in his/her room. -Education provided on the safe use of the	F 600		

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F 600	Continued From page 5 reacher. Record review of Resident #3's PASRR dated 12/16/22 showed: -He/she had signs or symptoms of a major mental illness; aggressive behavior including hitting and kicking. -He/she had a current, suspected or history of a major mental illness; Major Depressive Disorder and Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -He/she had impairment due to serious mental illness; difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or required intervention by mental health or judicial system. -He/she had a diagnosis of Major Neurocognitive Disorder with Lewy Bodies (a disease associated with abnormal deposits of a protein in the brain called Lewy bodies which affects chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood). -He/she was not currently a danger to self or others. -The diagnosis list was not attached. -History and Physical was not attached. -He/she was minimally aggressive. -He/she had an unstable mental condition monitored by a physician or licensed mental health professional at least monthly or behavior symptoms were currently exhibited or psychiatric	F 600		

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F 600	Continued From page 6 conditions were recently exhibited. -He/she was oriented to person, place and situation. -He/she had impaired short term memory. -Level of supervision was two hour checks. Record review of Resident #3's face sheet showed he/she was admitted to the facility on 2/1/23 with the following diagnoses: -Encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition such as a viral infection or toxins in the blood). -Bipolar disorder -Major depression. -Neurocognitive disorder -He/she was his/her own responsible person. Record review of Resident #3's Care plan dated 2/2/22 showed: -The problem identified: --He/she had a behavior problem related to a diagnosis of bipolar disorder and Lewy Body Dementia. -He/she had hoarding tendencies. -He/she yelled at staff if they were touching his/her stuff. -He/she wandered into other resident's rooms and took their things. -He/she had an altercation with Resident #2 dated 2/11/23. -The desired outcome: --He/she would have fewer episodes of behavior. -Interventions included: --He/she was introduced to Resident #2 and moved into the room. --He/she was moved into a room by himself/herself dated 2/11/23. --He/she was placed on 1:1 prior to being sent	F 600		

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F 600	Continued From page 7 out to the hospital for evaluation dated 2/11/23. --Staff were to educate the resident on successful coping and integration strategies. Record review of Resident #3's Admission MDS dated 2/7/23 showed: -His/her BIMS score was 11 which indicated he/she was moderately cognitively impaired. -He/she had hallucinations (an experience involving the apparent perception of something not present). -He/she had behavior symptoms directed toward others. -He/she had verbal behaviors directed toward others. -He/she was at significant risk for physical illness or injury. -He/she significantly interfered with other residents' participation or social activities. -He/she put others at significant risk for physical injury. Record review of the Resident #3's Psychiatric evaluation dated 2/9/23 showed: -Staff recommended the resident be seen due to increased anxiety, agitation, manic, aggressive behavior, and paranoid delusion thinking people were after him/her. -He/she presented with anxiousness, irritability, maniac, hyperverbal, and periods of agitation. -He/she reported he/she was bipolar and was very anxious. -He/she had not slept for the last three days. -He/she had just been discharged from the hospital where he/she had been in a coma (a state of prolonged unconsciousness) for three days. -His/her spouse verified that he/she had just been discharged from the hospital and had been in a	F 600		

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F 600	Continued From page 8 coma for three days. -The resident was having paranoid delusions. -His/her medications were reviewed. Record review of Resident #3's Nurses' Progress note date 2/10/23 showed: -The nurse spoke with Resident #3 about getting a roommate. -Resident #2 and Resident #3 were introduced to one another, spoke, and agreed to room move. Record review of the facility's Abuse Investigation Timeline showed: -The investigation was started on 2/11/23 at 5:00 A.M. -Resident #2 and Resident #3 were involved in a resident to resident altercation. -The DON was notified on 2/11/23 at 4:10 A.M. -The Administrator was notified on 2/11/23 at 4:20 A.M. -The State was notified on 2/11/23 at 7:44 A.M. -The Physician for both Resident #2 and Resident #3 was notified on 2/11/23 at 8:48 A.M. -Resident #3's spouse was notified on 2/11/23 at 8:48 A.M. -The abuse checklist was completed. -Resident #2's statement, taken by the nurse said: --He/she was on his/her side of the room drinking milk, when Resident #3 came into the room. --Resident #3 asked if he/she could look in his/her refrigerator, he/she told the resident no. --Resident #3 thought all of Resident #2's things belonged to him/her. --When he/she went to put the milk back in the refrigerator when Resident #3 attacked him/her. --Resident #3 grabbed at his/her eyes and started to hit him/her. --Staff came in to break it up.	F 600		

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F 600	Continued From page 9 -Resident #3's statement, taken by the nurse said: --He/she was in the room mopping the floor up because he/she had spilled water on accident. --Resident #2 started to yell and tell him/her to hurry up and told him/her to pick up his/her clothes off of the floor. --He/she told Resident #2 that he/she was moving as fast as he/she could. --Resident #2 started to hit him/her with his/her reacher across his/her back and head because he/she was not moving fast enough. --He/she told Resident #2 to stop hitting him/her but Resident #2 kept hitting him/her. -He/she had to fight back to get away from Resident #2. --Resident #2 would not stop so he/she kept pushing Resident #2 towards the door to get out. --A staff member came in to break it up. --Staff brought Resident #3 to the nurses' station. -Education was provided to the staff by 2/13/23. Record review of facility Abuse training dated 2/13/23 showed all staff had been trained by 2/13/23. During an interview on 2/23/23 at 10:45 A.M. Resident #2 said: -He/she was in his/her room watching TV when his/her roommate (Resident #3) came into their room. -Resident #3 had just moved in that day. -Resident #3 asked him/her for a bottle of water out of his/her refrigerator. -He/she gave Resident #3 a bottle of water from his/her refrigerator. -Resident #3 took the bottle of water and poured the water on the floor. -He/she tapped Resident #3 on the shoulder with	F 600		

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F 600	Continued From page 10 his/her reacher and told Resident #3 to clean up the spill. -Resident #3 then hit him/her on the back of his/her head four or five times with his/her hand. -Resident #3 stuck his/her thumbs in his/her eyes and scratched his/her face just below his/her eyes. -A staff member heard the altercation and came into the room and took Resident #3 out of the room. -They were separated and he/she had not seen Resident #3 since then. -He/she felt the staff could keep him/her safe in the facility. Record review of the resident roster dated 2/23/23 showed Resident #3 was not listed as a current resident in the facility. During an interview on 2/23/23 at 2:20 P.M. the Administrator and DON said: -Resident #3 was with a different resident who had a lot of belongings in the room so staff wanted to move him/her in with someone who had less stuff in their room. -On 2/10/23 Resident #2 and Resident #3 met each other and they seemed to get along. -Resident #3 was moved into Resident #2's room. -On 2/11/23 about 4:00 A.M. there was a physical altercation between Resident #2 and Resident #3. -Staff heard the altercation and went into the room to break it up. -Staff took Resident #3 out of the room to the Nurses' desk where he/she sat with the Nurse. -Resident #3's family and physician were notified of the altercation. -Resident #2 was placed on 1 on 1 observation. -The physician wanted Resident #3 sent out to the hospital.	F 600		

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F 600	Continued From page 11 -Resident #3 was sent to the hospital. -Resident #3 came back from the hospital later that same day. -Resident #3 was placed on 1 on 1 observation. -Resident #3 was moved to a different room in the facility. -Resident #2 and Resident #3 had different stories as to what happened. -Resident #3 said he/she had stumbled into the room and then stumbled into the other resident. -Resident #3 had scratched Resident #2 in his/her eyes. -Resident #2 said he/she was drinking milk when Resident #3 scratched him/her in the eyes. -After 48 hours Resident #2 had no further behaviors and the 1 on 1 was discontinued. -Resident #3 had his/her Geodon (medication used to treat bipolar disease) increased. -Resident #3 was still on 1 on 1 observation. -Resident #3 was upset and was sent out to the hospital a second time on 2/20/23 for medication management. -The facility was not aware of any previous issues with Resident #3. -On 2/15/23 Resident #3's spouse said the resident had anger issues, which the facility had not known about. -Resident #3 was currently at the hospital awaiting placement at a Geriatric Psychiatric facility. -The Social Worker had been looking for placement for Resident #3. -Resident #2 was seen by the facility physician. -Head to toe assessment was completed on both residents. -Residents were separated. -State was notified. -Investigation was completed. -All staff was in-serviced on the facility's abuse	F 600		

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F 600	Continued From page 12 policy. During an interview on 2/23/23 at 3:00 P.M. Registered Nurse (RN) A said: -He/she was working the night of the altercation from 11:00 P.M. to 7:00 A.M. -He/she did not see the altercation. -Resident #2 and Resident #3 were separated immediately. -Resident #3 was in his/her wheelchair and moved to the Nurses' station where he/she was put on a 1 on 1. -Resident #3 had attacked Resident #2. -Resident #2 had scratches underneath his/her eyes and was bleeding. -He/she directed staff to keep the two residents separated. -Resident #2 was also put on 1 on 1 in his/her room. -He/she did a head to toe assessment and took vital signs on Resident #2. -He/she cleansed Resident #2's scratches on his/her face. -He/she asked Resident #2 if he/she wanted to go to the hospital and he/she declined. -He/she asked Resident #2 if he wanted her to call the police and he/she declined. -He/she did a head to toe assessment and vital signs on Resident #3. -He/she asked him/her if he/she wanted to call the police and he/she declined. -He/she asked Resident #3 if he wanted to go to the hospital and he/she did. -Resident #3 told the nurse, he/she was hit by Resident #2 with his/her grabber, when he/she was mopping up water on the floor. -Resident #2 said he/she was in their room drinking milk, when Resident #3 pushed and hit him/her.	F 600		

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	265700	A. BUILDING _____ B. WING _____	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSHIRE AT LAKEWOOD REHAB CENTER	600 N E MEADOWVIEW DRIVE LEES SUMMIT, MO 64064

(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 600	Continued From page 13 -Resident #2 had been in the room by himself/herself. -Resident #3 had moved in with Resident #2 less than 12 hours before the altercation took place. -Resident #2 could be anxious but was easy to redirect. -Resident #2 did not have any behaviors that he/she was aware of. -Resident #3 was in a different room with a roommate and to his/her knowledge had not had any behaviors. -He/she did not know why Resident #3 was moved in with Resident #2. -He/she had notified the physician, family, Administrator, and DON of the incident. -He/she stayed with Resident #3 until he/she went out to the hospital. -One of the Certified Nursing Assistants stayed with Resident #2 who was tearful. -Staff calmed Resident #2 down. -Resident #3 returned to the facility from the hospital later that day. -He/she had training on abuse during orientation and since the incident. -Staff were to separate the residents and make sure they were safe. -Staff were to call the Administrator. -Resident #2 was his/her own person and said he/she would call his/her family to notify them of the incident. -Resident #2's physician should have been notified. -Administration would call the State. -Since the incident on 2/11/23 he/she had worked with Resident #3 and he/she has had behaviors. -Resident #3 was on 1 on 1 observation. -Resident #3 had "trash talked" to staff. -Resident #3 had been sexually inappropriate to staff.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265700	A. BUILDING _____ B. WING _____	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSHIRE AT LAKEWOOD REHAB CENTER	600 N E MEADOWVIEW DRIVE LEES SUMMIT, MO 64064

(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 600	Continued From page 14 -Resident #3 had delusional thinking that someone was in his/her chair. -Resident #3 had been sent out to the hospital a second time and was still in the hospital. -Resident #2's eyes were red after the altercation and had scratches underneath both eyes after the altercation. MO00213894	F 600		