STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. BUILDING _____ B. WING _____	C 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND POST ACUTE REHABILITATION	**7850 FREEMAN AVENUE KANSAS CITY, KS 66112**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00172306, KS00172307, KS00172308, and KS00172222. The 2567 was sent electronically on 06/14/22.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 83 residents. The sample included one resident reviewed for elopement (when cognitively impaired resident exits the facility without staff knowledge). Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent elopement for Resident (R)1, who was independently mobile and cognitively impaired. This deficient practice placed R1 at risk for injury. Findings included: - R1's Electronic Medical record (EMR) documented under the "Diagnoses" tab unsteadiness on feet, muscle weakness, abnormalities in gait and mobility, and hypertension (elevated blood pressure). The "Admission Minimum Data Set" (MDS) assessment dated 03/31/22 documented a Brief	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/14/2022

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 689	Continued From page 1	F 689		

Interview for Mental Status (BIMS) score of nine which indicated a moderately impaired cognition. R1 was independent with no physical help or set up for transfers, walking in room and corridor, locomotion on and off the unit. R1 was independent with set up help only for eating, toilet use, and personal hygiene. R1 had no wandering behavior.

The "Activities of Daily Living Care Area (CAA)" assessment dated 03/31/22 documented R1 was at risk for alteration in self-care and was at risk for complications related to a recent coronary artery bypass graft (CABG-a surgical procedure wherein a healthy artery or vein is grafted to bypass the blocked artery/vein).

The "Elopement/Wandering Evaluation" dated 03/31/22 and 04/04/22 documented R1 was not at risk/low risk for elopement.

The "Care Plan" recorded an intervention dated 04/22/22 which directed R1 ambulated independently with no asistive devices. The "Care Plan" dated 04/29/22 recorded R1 was at risk for behaviors such as yelling at staff and agitation and directed staff to approach him in a calm manner.

The "Progress Note" dated 05/19/22 at 07:56 PM documented at approximately 06:15 PM R1 was identified as missing from the facility. The staff searched the facility and did not locate R1. At that time staff began a search outside of the building. R1 was located at a bus stop. R1 willingly returned to the facility. R1 was assessed and had no injuries. R1 had an elevated blood pressure and staff administered medication to help lower the blood pressure.

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F 689	Continued From page 2 The "Facility Investigation" documented R1 was not at risk for elopement and had no previous elopement attempts. The report recorded the front doors were locked but alarmed only for residents with Wander guards (bracelet which triggers door alarm). The report recorded the causative factor was the resident followed a visitor out of the door. On 06/08/22 at 01:54 PM Administrative Nurse E stated the resident was not an elopement risk per the elopement assessment. On 06/08/22 at 03:20 PM Administrative Nurse D stated R1 must have gone out the front doors when family was leaving the facility. Administrative Nurse D said staff was always seated at the front desk by the doors but revealed that if that staff needed to go to the bathroom or step out, someone from the front offices would help. Administrative Nurse D further revealed that she did not know for sure what the evening shift receptionist did to cover the door if needed. The facility's "Policy/Procedure - Nursing: Elopement/Unsafe Wandering" Policy revised 01/2022 directed that residents with high risk factors identified on an elopement/wandering evaluation are considered at risk and will have an individualized care plan developed that included measurable objectives and timeframes. The facility failed to ensure R1 received adequate supervision to ensure R1's safety when R1 exited the facility through the front door. This placed R1 at risk for accidents and related injuries.	F 689		
F 726 SS=D	Competent Nursing Staff	F 726		

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F 726	Continued From page 3 CFR(s): 483.35(a)(3)(4)(c) §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 identified a census of 83 residents. The sample included three residents. Based on recrod review and interview, the facilty failed to ensure staff possessed the appropriate skills, abilities and credentials when intervenous	F 726		

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F 726	Continued From page 4	F 726		

(IV-admisnitraered directly into the vein) antibiotics were administered by non IVcertified staff. This deficient practice placed Resident (R) 3 at risk for inappropriate care and unecessary complications.

Findings included:

- Review of R3's Electronic Medical Record, R3 under the "orders" tab revealed a "Physician Order" dated 05/20/22 for acyclovir sodium solution (antiviral medication) 250 milliliter (mL) per hour intravenously every eight hours until 05/24/22.

Review of R3's "Medication Administration Record" (MAR) for May 2022 revealed Licensed Nurse (LN) I docuemnted adminsitration of the acyclovir sodium solution IV on 05/20/22 at 02:39 AM, 05/21/22 at 05:19 AM, and 05/22/22 at 05:15 AM.

Review of LN I's licensing and credentials via the Kansas State Board of Nursing license verification website (KSBN.com) revealed LN I received her Licensed Practical Nurse (LPN) license on 05/25/1988. The verification indciated LN I had an active license but indciated LN Iwas not IV certified.

On 06/08/22 at 02:24 PM LN G stated LN I had administered IV medications and LN G believed LN I was IV certified.

On 06/08/22 at 03:20 PM Administrative Nurse D stated she would have to review things closer to make sure that someone who is IV certified was working on that shift that could cover administering IV fluids and medications ordered.

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F 726	Continued From page 5 The facility's "Policy/Procedure - Nursing Clinical: Medication Administration" revised 12/21 directed that only staff members authorized by license would administer medications and treatments. It further directed that Registered Nurse's (RN), LPN, and Certified Medication Aides would keep current licensure on file. The facilty failed to ensure staff possessed the appropriate skills, abilities and credentials whenIV antibiotics were administered by non IVcertified staff. This deficient practice placed R3 at risk for inappropriate care and unecessary complications	F 726		