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	175298	A. BUILDING _____ B. WING _____	C 06/02/2022

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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 investigation KS00172097 and KS00171652. The 2567 was sent electronically on 06/13/22.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/13/2022

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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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 83 residents. The sample included three residents reviewed for catheter (flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care. Based on record review, interview, and observation, the facility failed to ensure to Resident (R)1 was treated with respect and dignity when R1's catheter urine bag was uncovered and visible while R1 sat in common areas. This placed R1 at risk for impaired psychosocial well-being.

Finding included:

- R1's electronic medical record (EMR) under the "Diagnoses" tab documented dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors, acute kidney failure, weakness, and difficulty in walking.

The "Annual Minimum Data Set" (MDS) assessment dated 11/26/21 documented a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognition. R1 required limited assistance of two staff members for activities of daily living (ADL) which included

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bed mobility, transfers, and toilet use. R1 required extensive assistance of one person for personal hygiene and locomotion on and off the unit. The MDS recorded R1 was always incontinent and did not have an indwelling catheter.

The "Care Area Assessment (CAA) for Cognitive Loss" dated 11/26/21 documented R1 had confusion and difficulty focusing on simple words or small conversations.

The "CAA for Urinary Incontinence" dated 11/26/21 documented R1 was incontinent of bowel and bladder.

The "Quarterly MDS" assessment dated 05/06/22 documented a BIMS score of 99 which indicated severely impaired cognition. R1 required extensive assistance of two staff members for ADL's which included bed mobility, transfers, and personal hygiene. R1 required limited assistance of two staff members for toilet use, and limited assistance of one staff member for dressing. R1 had an indwelling catheter.

R1's "Catheter Care Plan" initiated 05/04/22 directed staff to change the catheter bag and tubing as ordered, monitor for signs and symptoms of discomfort on urination and frequency. It directed staff to monitor and document pain and or discomfort due to the catheter. The care plan directed staff to monitor/record/report to the medical director signs and symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, or altered mental status. The care plan also directed staff to secure the catheter to

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facilitate flow of urine, prevent kinking of tubing, and accidental removal.

Review of a photograph of R1 taken inside the facility and time/date stamped 05/13/22 at 05:55 PM revealed R1 sat in a chair with her catheter bag suspended underneath her wheelchair. The urine collection bag lacked a privacy bag and red urine was visible in the catheter bag. There was dark red sediment visible in the catheter tubing.

Review of a photograph taken inside the facility time/date stamped 05/15/22 at 04:13 PM revealed R1 sat in a chair in the common area, with red tinged urine in an uncovered catheter bag. The catheter bag was hooked to the footrest of the chair and laid on the floor. The catheter tubing laid directly on the floor leading to the bottom of R1's pant leg.

On 06/01/22 at 11:20 AM R1 laid in her bed with the blankets pulled up to her chest. R1 had her eyes closed and appeared comfortable. The bed was in the lowest position with floor mats to either side of her bed. R1 did not have urinary catheter visible.

On 06/01/22 at 01:35 PM Certified Nurse Aide (CNA) M stated the catheter tubing should not drag on the floor for sanitary reasons. CNA M revealed the urine catheter bags should be in a dignity bag and if there was ever a concern, she would change it out and get a new catheter and dignity bag.

On 06/01/22 at 01:55 PM Administrative Nurse D stated R1 had the catheter adhesive lock on her leg to keep it in place. Administrative Nurse D further stated R1's tubing was never on the floor

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F 550	Continued From page 4 and she could not recall a red tinge to R1's urine. Administrative Staff A revealed that R1 was reviewed by her regularly and she made sure the catheter tubing was not on R1's wheelchair. Administrative Nurse D reviewed the photographs (referenced above) confirmed the photos were of R1 in the facility common area. Administrative Nurse D confirmed the photographs showed R1's catheter tubing on the floor, and there was no dignity bag covering the catheter bag, Administrative Nurse D confirmed red colored liquid present in R1's urine collection bag in the photograph. On 06/01/22 at 02:35 PM, an anonymous reporter inside the facility stated R1 had to have the catheter tubing taped to R1's leg due to the facility did not have any catheter anchoring devices available.. The anonymous reporter revealed R1 rarely had a dignity bag to cover up the catheter bag. The facility's "Infection Control Policy/Procedure: Catheter Care, Indwelling" policy revised 07/2013 directed the catheter bag to be covered with a privacy bag. The facility failed to ensure to R1 was treated with dignity and respect when R1's catheter urine collection bag was uncovered and visible to other residents and visitors. This placed R1 at risk for impaired psychosocial well-being.	F 550		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		

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admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 83 residents. The sample included three residents for catheter (flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care. Based on record review, interview, and observation, the facility failed to

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ensure to Resident (R)1 received appropriate catheter care, monitoring, assessment, and physician notification of catheter related complications and concerns. This placed R1 at increased risk for complications related to indwelling catheter.

Finding included:

- R1's Electronic Medical Record (EMR) under the "Diagnoses" tab documented dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors, acute kidney failure, weakness, and difficulty in walking.

The "Annual Minimum Data Set" (MDS) assessment dated 11/26/21 documented a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognition. R1 required limited assistance of two staff members for activities of daily living (ADL) which included bed mobility, transfers, and toilet use. R1 required extensive assistance of one person for personal hygiene and locomotion on and off the unit. The MDS recorded R1 was always incontinent and did not have an indwelling catheter.

The "Care Area Assessment (CAA) for Cognitive Loss" dated 11/26/21 documented R1 had confusion and difficulty focusing on simple words or small conversations.

The "CAA for Urinary Incontinence" dated 11/26/21 documented R1 was incontinent of bowel and bladder.

The "Quarterly MDS" assessment dated 05/06/22 documented a BIMS score of 99 which indicated

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severely impaired cognition. R1 required extensive assistance of two staff members for ADL's which included bed mobility, transfers, and personal hygiene. R1 required limited assistance of two staff members for toilet use, and limited assistance of one staff member for dressing. R1 had an indwelling catheter.

The "Catheter Care Plan" initiated 05/04/22 directed staff to change the catheter bag and tubing as ordered, monitor for signs and symptoms of discomfort on urination and frequency, monitor and document for pain and or discomfort due to the catheter, monitor/record/report to the medical director for signs and symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, or altered mental status. The care plan also directed staff to secure the catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal.

The "Physician Order" dated 05/03/22 ordered the catheter bag to be changed as needed for leakage, accumulation of sediment, or discoloration of bag.

The "Physician Order" dated 05/03/22 ordered indwelling catheter to be changed every 30 days.

The "Physician Order" dated 05/03/22 ordered to check catheter anchor every shift and replace as needed.

The "Physician Order" dated 05/03/22 ordered indwelling catheter care every shift.

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The "Physician Order" dated 05/27/22 ordered to discontinue the Foley catheter in the evening.

The "Medication Administration Record" (MAR) for May 2022 revealed indwelling catheter care every shift 05/03/22 through 05/28/22 completed 49 out of 50 opportunities.

Review of a photograph of R1 taken inside the facility and time/date stamped 05/13/22 at 05:55 PM revealed R1 sat in a chair with her catheter bag suspended underneath her wheelchair. The urine collection bag lacked a privacy bag and red urine was visible in the catheter bag. There was dark red sediment visible in the catheter tubing.

Review of a photograph taken inside the facility time/date stamped 05/15/22 at 04:13 PM revealed R1 sat in a chair in the common area, with red tinged urine in an uncovered catheter bag. The catheter bag was hooked to the footrest of the chair and laid on the floor. The catheter tubing laid directly on the floor leading to the bottom of R1's pant leg.

Review of R1's clincial record from 05/13/22 through 05/23/22 lacked evidence the bloody urine was identified by nursing staff and lacked evidence of physician notification regarding the blood tinged urine.

On 06/01/22 at 09:45 AM Licensed Nurse (LN) G stated she provided cares for R1's catheter but she could not recall R1's urine ever being red tinged or with sediment. LN G further stated that the catheter anchor was applied to R1's leg, but R1 pulled it off.

On 06/01/22 at 11:20 AM R1 laid in her bed with

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the blankets pulled up to her chest. R1 had her eyes closed and appeared comfortable. The bed was in the lowest position with floor mats to either side.

On 06/01/22 at 01:35 PM Certified Nurse Aide (CNA) M stated that the catheter tubing should not drag on the floor for sanitary reasons. CNA M further stated that if a resident were to have sediment or discoloration in the urine, she would report it to her nurse, especially if it was red tinged.

On 06/01/22 at 01:55 PM Administrative Nurse D stated R1 had the catheter adhesive lock on her leg to keep it in place. Administrative Nurse D further stated R1's tubing was never on the floor and she could not recall a red tinge to R1's urine. Administrative Staff A revealed that R1 was reviewed by her regularly and she made sure the catheter tubing was not on R1's wheelchair. Administrative Nurse D reviewed the photographs (referenced above) confirmed the photos were of R1 in the facility common area. Administrative Nurse D confirmed the photographs showed R1's catheter tubing on the floor, and there was no dignity bag covering the catheter bag, Administrative Nurse D confirmed red colored liquid present in R1's urine collection bag in the photograph.

On 06/01/22 at 02:35 PM, an anonymous reporter inside the facility stated R1 had to have the catheter tubing taped to R1's leg due to the facility did not have any catheter anchoring devices available. The anonymous reporter revealed R1 rarely had a dignity bag to cover up the catheter bag. The anonymous reporter further stated the charge nurse that worked when R1

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F 690	Continued From page 10 had the bloody urine acknowledged the bloody urine and stated the physician was notified. The facility's "Infection Control Policy/Procedure: Catheter Care, Indwelling" policy revised 07/2013 directed the catheter tubing may be secured with a securement device as needed to prevent migration of the catheter, friction, or tension. The facility's "Policy/Procedure-Nursing Clinical: Catheter Drainage Bag" policy revised 05/2007 directed the catheter and drainage bag should be changed if an obstruction of the system is suspected, if sediment is accumulation in the lumen of the tubing, or if the system has been contaminated. It further directed staff to document all appropriate information in the medical record. The facility failed to ensure R1 received appropriate catheter cares when staff failed to ensure the catheter tubing was off the floor, and staff failed to monitor and repot blood tinged urine to the physician. This placed R1 at increased risk for infection and other catheter related complications.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		

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F 758	Continued From page 11 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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The facility identified a census of 83 residents. The sample included one resident for medication review. Based on observation, record review and interview, the facility failed to ensure Resident (R)1 had an appropriate indication for a prescribed antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medication. This placed R1 at risk of not reaching or maintaining her highest practicable level of mental, physical, and psychosocial wellbeing due to unnecessary medication.

Findings included:

- R1's Electronic Medical Record (EMR) under the "Diagnoses" tab documented dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors, acute kidney failure, weakness, and difficulty in walking.

The "Annual Minimum Data Set" (MDS) assessment dated 11/26/21 documented a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognition. R1 required limited assistance of two staff members for activities of daily living (ADL) which included bed mobility, transfers, and toilet use. R1 required extensive assistance of one person for personal hygiene. locomotion on and off the unit. R1 received antipsychotic medications three days during the look back period.

The "Care Area Assessment (CAA) for Psychotropic" dated 11/26/21 documented R1 took psychotropic (type of medication affecting mood or thought) medication related to dementia and depression.

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F 758	Continued From page 13	F 758		

The "Quarterly MDS" assessment dated 05/06/22 documented a BIMS score of 99 which indicated severely impaired cognition. R1 required extensive assistance of two staff members for ADLs which included bed mobility, transfers, and personal hygiene. R1 required limited assistance of two staff members for toilet use, and limited assistance of one staff member for dressing. R1 received antipsychotic medications during the look back period.

The "Care Plan" for impaired thought process related to dementia initiated on 11/20/20 documented social services provided psychosocial support as needed.

The "Care Plan" for verbally abusive behaviors related to dementia initiated 11/12/21 directed staff to document observed behaviors and attempted interventions, and psychiatric/psychogeriatric consult as indicated.

The "Physician Order" dated 05/03/22 ordered aripiprazole (antipsychotic medication) 10 milligram (mg) give 10 mg by mouth one time a day for dementia with behavioral disturbances as evidenced by (AEB) negative statements.

On 06/01/22 at 01:44 PM Administrative Nurse E stated that dementia was not an appropriate diagnosis for an antipsychotic medication.

On 06/01/22 at 01:55 PM Administrative Nurse D stated that dementia is not an appropriate diagnosis for an antipsychotic.

The facility's "Policy/Procedure: Psychotropic Drug Use" policy revised 10/2021 directed that

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 06/02/2022

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

(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 758	Continued From page 14 psychotropic drugs are not given unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. The facility failed to ensure R1 had the appropriate diagnosis for the prescribed antipsychotic medication when aripiprazole was ordered to treat dementia. This place R1 at risk of not reaching or maintaining her highest practicable level of mental, physical, and psychosocial wellbeing due to unnecessary medications.	F 758		