

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2022
NAME OF PROVIDER OR SUPPLIER SHARON LANE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 10315 JOHNSON DRIVE SHAWNEE, KS 66203		
(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 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 05/09/22.	F 000			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included 15 residents with 10 residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to ensure that bathing was provided for one resident who required partial or complete assistance from staff for bathing. This deficient practice placed resident (R)50 at risk for potential skin breakdown and/or skin complications from not maintaining good personal hygiene and bathing practices and impaired psychosocial well-being. Findings included: - The electronic medical record (EMR) for R50 documented diagnosis of transient ischemic attack (TIA-an episode of cerebrovascular insufficiency), contracture (abnormal permanent fixation of a joint) of bilateral knees and left ankle, and peripheral vascular disease (PVD-an abnormal condition affecting the blood vessels). The "Annual Minimum Data Set" (MDS) dated	F 677			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/09/2022

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 677	Continued From page 1 10/08/21 documented R50 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated a moderately impaired cognition. R50 required extensive to total dependence of one to two staff for ADLs. R50 required the use of a wheelchair for mobility. The "Quarterly MDS" dated 04/08/22 documented R50 had a BIMS score of 11 which indicated a moderately impaired cognition. R50 required extensive to total dependence on one to two staff for ADLs. R50 required the use of a wheelchair for mobility. R50 was total dependent on staff of one for bathing. The "ADL Care Area Assessment" (CAA) dated 10/22/21 documented R50 needed assistance with ADLs due to impaired function and mobility. R50 transferred with a Hoyer lift (total body mechanical lift used to transfer residents) and assist of two. He needed limited to extensive assist of one to two with bed mobility, toileting, dressing and hygiene. He used a wheelchair for locomotion. He was incontinent of bowel and bladder and wore a disposable brief and staff assisted with peri-care. The "Life Preferences Care Plan" initiated 11/03/20 documented that R50's bathing would be done based on personal preferences to include type of bathing and frequency. Staff were to continue bathing practices based on R50's individual preferences/choices through the next review period. R50 preferred to have a bath in the evening on Tuesdays and Fridays. The "ADL Care Plan" dated 11/10/20 documented R50 required limited to extensive assistance of one for bathing.	F 677			

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F 677	Continued From page 2 Review of the "Documentation Survey Report" between 02/01/22 and 02/28/22 revealed R50 preferred to take a shower in the evening on Tuesday and Friday. The report revealed that R50 received a shower on three occasions (02/04/22, 02/08/22, 02/22/22). R50 refused a shower on 02/15/22. The report lacked any documentation on scheduled shower days on four occasions (02/01/22, 02/11/22, 02/18/22, and 02/25/22). Review of the "Documentation Survey Report" between 04/01/22 and 04/30/22 documented that R50 preferred a shower in the evening on Tuesday and Friday. The report revealed that R50 received a shower on four occasions (04/01/22, 04/05/22, 04/15/22, and 04/29/22). The report lacked documentation on scheduled shower days on five occasions (04/08/22, 04/12/22, 04/19/22, 04/22/22, 04/26/22). The "Progress Notes" tab of R50's EMR lacked documentation why a bath or shower was not given or was refused on the dates documented above. On 05/04/22 at 01:40 PM Certified Medication Aide (CMA) R stated there was a binder at the nurse's station that had bathing/shower schedules for residents in it. The shower schedule was updated regularly for residents that wanted to change their shower days or frequency. Residents who refused a shower/bath were asked the resident later in the day and if the resident still refused the aide would let the charge nurse know. Staff would then chart the bath/shower or the refusal under "Tasks" in the resident's chart.	F 677			

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F 677	Continued From page 3 On 05/04/22 at 01:55PM Licensed Nurse G stated that a resident's shower schedule was in the shower book as well as in their care plan. The aide would let her know if a resident had refused a bath, the she would go in and talk to the resident and try to get them to take a shower, if the resident still refused she would then document a progress note stating that the resident refused. Showers/baths are documented under the "Tasks" tab and there should be something documented on each day that a resident was scheduled for a shower saying what type of shower/bath was given or if the bath was refused. There would not be any reason "blank" space on bath days other than if it was simply not given or offered. On 05/04/22 at 02:15 PM Administrative Nurse D stated R50 was often non-compliant and resistant of cares. He would often refuse initially and later take a shower. Most days R50 would not even allow staff to lay him down. Administrative Nurse D stated that ideally there should be no reason why a scheduled shower day would not have something documented on that day. Staff could chart that the shower/bath was given, if it was refused, or resident was not available. The facility "Routine Procedures Personal Hygiene-Bathing-Shower" policy dated 04/01/18 documented: It is the policy of this facility to promote skin integrity and dignity for each resident. Each resident will be given a choice for their preference of type of bathing and frequency of bathing. The facility failed to ensure a shower/bath was provided for R50, who required extensive	F 677			

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F 677	Continued From page 4 assistance with bathing, which had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial well-being.	F 677			
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 56 residents. The sample included 15 residents, with two residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure staff implemented interventions per the plan of care for Resident (R) 52. This deficient practice placed R52 at risk for major injuries related to falls. Findings included: - R52's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and hypertension (elevated blood pressure). The "Admission Minimum Data Set" (MDS) dated 11/30/21 documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated	F 689			

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F 689	Continued From page 5 moderately impaired cognition. The MDS documented that R52 required extensive assistance of one staff member for transfers and toileting, limited assistance of one staff member for bed mobility, ambulation in room and dressing. The MDS documented R52 required supervision of one staff member for ambulation in hallway, locomotion on the unit, and personal hygiene and was independent with eating after setting up assistance. The MDS documented R52 had one fall with injury during look back period. The "Quarterly MDS" dated 04/08/22 documented a BIMS score of nine which indicated moderately impaired cognition. The MDS documented that R52 required extensive assistance of one staff member for locomotion on and off the unit, limited assistance of one staff member transfers, bed mobility, ambulation in room, dressing, toileting, and personal hygiene and was independent with eating after setting up assistance. The MDS documented R52 had one non-injury fall during the look back period. R52's " Fall Care Area Assessment" (CAA) dated 12/06/21 documented she was at risk for further falls related the need of assistance with activities of daily living (ADL's) and use of antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment testing) and other mental emotional conditions). R52's "Care Plan" dated 11/23/21 documented R52 required a call light within reach and directed staff to ensure her room and environment was clutter-free. Review of the EMR under "Progress Notes" tab	F 689			

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F 689	Continued From page 6 revealed R52 had an unwitnessed fall in the bathroom on 11/25/21 which she received a skin tear to right forearm and an x-ray of left hip was ordered related to pain, which was negative for a fracture. On 01/15/22 an unwitnessed non-injury fall was documented which occurred in R52's room. On 03/28/22 an unwitnessed non-injury fall occurred in the bathroom. On 05/02/22 at 01:38 PM R52 laid on her bed with her eyes closed. The bedside table was outside of her reach and the call light hung across bedside table, also out of reach. Papers and clothing were observed on the floor next her bed. On 05/03/22 at 08:26 AM R52 laid on bed asleep. The bedside table was out of reach and the call light was on the floor next to the bed, also out of reach. On 05/03/22 at 02:42 PM R52 sat in her wheelchair. She propelled herself out of the room, and down the hallway. R52 asked facility staff where her bathroom was located. Facility staff directed R52 to a bathroom location. R52 propelled herself into the bathroom and transferred herself onto the toilet. On 05/04/22 at 07:10 AM R52 laid on bed. The bedside table was out of reach., Paperclothing were on served on the floor next to the bed and the call light was also noted on the floor next to bed, out of reach. On 05/04/22 at 01:46 PM in an interview, Certified Medication Aide (CMA) R stated the fall interventions were on each of the resident's Kardex (a medical information system used by nursing staff to communicate important	F 689			

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F 689	Continued From page 7 information on their patients. It was a quick summary of individual patient needs that was updated at every shift change) and everyone had access to the Kardex. On 05/04/22 at 02:00 PM in an interview, Licensed Nurse (LN) G stated the staff should review the care plan daily. LN G stated the nurses can make changes to the resident's care plan when needed such as falls. LN G stated nurses start the fall investigation after a fall occurred and then sent to be review by administration. LN G stated R52 required minimal contact assist with transfers and reminders to use her call light. On 05/04/22 at 02:14 PM in an interview, Administrative Nurse D stated charge nurses add an intervention to the resident's care plan directly after each fall. Administrative Nurse D stated the nurse starts the fall investigation after each fall and all staff can review the resident's care plan. Administrative Nurse D stated any changes or new intervention come across the resident's Kardex as an alert. Review of the facility "Accident/Fall Prevention" policy last revised on March 2020 documented the charge nurse would review the resident's care plan and make any additions to the care plan that are needed. The care plan team will investigate and determine the root cause of the fall and implement appropriate fall interventions to prevent further falls. The facility failed to implement the fall interventions for R52, which placed her at risk for further falls.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690			

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F 690	Continued From page 8 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 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 56 residents.	F 690			

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F 690	Continued From page 9 The sample included 15 residents with four reviewed for incontinence care. Based on observation, record review, and interviews, the facility failed to implement incontinence care interventions for Residents (R) 37 and R204. This deficient practice placed the residents at risk for complications related to and increased incontinence. Findings Included: -The electronic medical record (EMR) indicated the following diagnosis for R37: type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), diabetic neuropathy (nerve damage due to persistent high blood sugar resulting in loss of sensation or presence of nerve related pain), dementia without behaviors (progressive mental disorder characterized by failing memory, and confusion), muscle weakness, and sciatica (a severe pain that radiates from the back into the hip and outer side of the leg). R37's "Quarterly Minimum Data Set (MDS)" dated 03/11/22 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS indicated that she had frequent bowel and bladder incontinence with a toileting program in place. Her MDS stated that she required extensive assistance with bed mobility, transfers, personal hygiene, locomotion, and toileting. R37's "Activities of Daily Living (ADL's) Care Area Assessment (CAA)" dated 09/10/21 stated that she required limited to extensive assistance with all ADL's related to her medical diagnosis. The	F 690			

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F 690	Continued From page 10 CAA stated that she was occasionally incontinent of bladder but continent of bowel. R37's "Urinary Incontinence CAA" dated 09/10/21 stated the she was a risk for skin breakdown and urinary tract infections related to her occasional incontinence. The CAA indicated that she had a Braden (scale for predicting pressure ulcer risk) score of 18 and required to have a pressure relieving mattress and wheelchair cushion. A review of R37's "Care Plan" dated 09/20/21 indicated that she required limited to extensive assistance from one staff member for bathing, bed mobility, dressing, personal grooming, and toileting. The care plan indicated that she usually had to use the bathroom once per night but lacked documentation of an individualized toileting program and lacked person centered interventions related to the management of bowel and bladder incontinence including timeframes for night time toileting. A review of R37's "Bowel and Bladder" assessment completed 09/05/21 indicated that she was incontinent three times or less each week and continent of bowel upon her admission. The assessment indicated that she had mixed urge and stress incontinence. The assessment recorded a voiding diary and a toileting plan were completed. The assessment indicated that R204 should be wearing incontinence briefs. R37's "ADL Function and Restorative Assessment" completed 03/10/22 indicated that she required limited assistance toileting. The assessment indicated that she was bowel continent and bladder continent with dribbles. A review of R37's "Bladder Incontinence	F 690			

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F 690	Continued From page 11 Lookback" report from 01/01/22 through 05/03/22 (123 days reviewed) revealed that she had 79 bladder incontinence occurrences reported. On 05/02/22 at 08:00 AM R37 was observed in her room watching television. R37's wheelchair had protective cushioning per her care plan for skin prevention. R37 reported that she did require some assistance from staff but does not know of a toileting program. An interview on 05/04/22 at 01:48 PM with Certified Medication Aid (CMA) R, she stated that the direct care staff use a Kardex (condensed form containing information pulled directly from resident's care plan) to identify a resident's toileting status and if any special precautions were needed. She reported that R37 was incontinent but unable to verify if the resident was on a toileting program. She reported that the direct care staff can let the charge nurse know if information is missing from the Kardex or needed to update information. An interview on 05/04/22 at 02:00 PM with Licensed Nurse (LN) G, she stated that toileting plans should be in the care plan utilized by direct care staff. She reported that R37 was started on a toileting program after the voiding dairy was completed. She reported that R37 was incontinent and does require cares and assistance with toileting. She stated the nursing staff can view both the care plans and the Kardex information. She noted that the nursing staff can reported missing information to the MDS coordinator or the Director of Nursing to update a resident's care plan. An interview on 05/04/22 at 02:13 PM with	F 690			

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(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 690	Continued From page 12 Administrative Nurse D, she stated that toileting programs should be in the care plans. She stated each resident will have a bowel and bladder assessment to assess if an individual program was needed. The resident would have a three-day voiding assessment completed and then a plan for toileting completed. A review of the facility's "Urinary and Bowel Incontinence" policy revised 2019 stated that the facility will complete a three-day voiding and bowel pattern upon admission to assess residents continency and frequency of incontinent episodes. The policy stated that facility will develop an appropriate toileting plan for each resident and repeat the assessment if the resident had a change in patterns. The policy stated that resident's that are incontinent of bowel and bladder will receive appropriate treatment and services to prevent urinary tract infections and restore as much normal function as possible. The facility failed to implement a toileting program for R37. This deficient practice placed the residents at risk for complications related to incontinence. -The electronic medical record (EMR) indicated the following diagnosis for R204: muscle weakness, obstructive uropathy (blockage in your urinary tract), hypertension (high blood pressure), hemiplegia (paralysis of one right side of the body), hemiparesis (muscular weakness of one half of the body), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), nephritis (Inflammation of the kidneys that causes swelling of the face, hands, feet and legs, blood pressure, blood in urine, and reduced	F 690			

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F 690	Continued From page 13 kidney function), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and need for assistance with personal cares. R204's "Entry Minimum Data Set (MDS)" dated 04/19/22 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated she had an indwelling urinary catheter (tube inserted into the bladder to drain urine into a collection bag). The MDS noted that her bowel incontinence was not rated and had no bowel program initiated. The MDS indicated that R204 required extensive assistance with mobility, transfers, locomotion, toileting, and bathing. A review of R204's MDS revealed no Care Area Assessment (CAA) available to view in the resident's EMR due to resident's admission to facility on 04/14/22. A review of R204's "Care Plan" revised 05/03/22 stated that she required catheter care every shift, monitor for symptoms of infections, provide privacy, and check the catheter bags position for comfort. The care plan lacked resident-centered interventions related to the management and/or prevention of her bowel incontinence. A review of R204's "Bowel and Bladder" assessment completed 04/25/22 indicated that she was bowel incontinent three times or less weekly and had an indwelling urinary catheter. The assessment decision stated to review for continued use of the indwelling catheter but did not mention developing a toileting plan for bowel maintenance. The assessment indicated that			F 690			

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F 690	Continued From page 14 R204 should be wearing incontinence briefs. A review of R204's "Incontinence Lookback" report from her admission on 04/14/22 through 05/03/22 (21 days reviewed) revealed that she had 22 bowel incontinence occurrences reported. On 05/04/22 at AM R204 sat in her room watching television. She denied any concerns or complaints. An interview on 05/04/22 at 01:48 PM with Certified medication Aid (CMA) R, she stated that the direct care staff use a Kardex (condensed form containing information pulled directly from resident's care plan) to identify a resident's toileting status and if any special precautions were needed. She reported that she knows of R204 but has not directly worked with her. She reported that the direct care staff can let the charge nurse know if information is missing from the Kardex or needed to update information. An interview on 05/04/22 at 02:00 PM with Licensed Nurse (LN) G, she stated that toileting plans should be in the care plan. She reported that R204 had a bowel and bladder assessment completed but not sure if a toileting planned had been added to the care plan. She stated the nursing staff can view both the care plans and the Kardex information. She noted that the nursing staff can reported missing information to the MDS coordinator or the Director of Nursing to update a resident's care plan. An interview on 05/04/22 at 02:13 PM with Administrative Nurse D, she stated that toileting programs should be in the care plans. She stated each resident will have a bowel and bladder	F 690			

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F 690	Continued From page 15 assessment to assess if a individual program is needed. The resident will have a three-day voiding assessment completed and then a plan to for toileting completed. A review of the facility's "Urinary and Bowel Incontinence" policy revised 01/2019 stated that the facility will complete a three-day voiding and bowel pattern upon admission to assess residents continency and frequency of incontinent episodes. The policy stated that facility will develop an appropriate toileting plan for each resident and repeat the assessment if the resident had a change in patterns. The policy stated that resident's that are incontinent of bowel and bladder will receive appropriate treatment and services to prevent urinary tract infections and restore as much normal function as possible. The facility failed to implement bowel incontinence interventions for R204 resulting in frequent bowel incontinence. This deficient practice placed the residents at risk for complications related to incontinence.	F 690			