

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

PRINTED: 12/10/2021
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 C 12/08/2021	
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			F 000			
F 677 SS=D	The following citations represent the findings of complaint investigation #KS00167195 and KS00164246. The 2567 was sent electronically on 12/10/21. 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 54 residents. The sample included five residents reviewed for bathing. Based on record review and interviews, the facility failed to provide consistent bathing for Resident (R) 5. This deficient practice placed R5 at increased risk for skin breakdown and decreased self-esteem and dignity. Findings included: - R5 admitted to facility on 08/20/21 and discharged on 11/25/21. The "Diagnoses" tab of R5's Electronic Medical Record (EMR) documented diagnoses of generalized weakness and need for assistance with personal cares. The "Admission Minimum Data Set (MDS)" dated 08/24/21, documented R5 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R5 required extensive physical assistance with one staff for bathing;			F 677			

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

TITLE

(X6) DATE

12/10/2021

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.

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

PRINTED: 12/10/2021
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 C 12/08/2021
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 677	Continued From page 1 limited physical assistance with one staff for bed mobility, transfers, dressing, and toileting. The MDS recorded R5 was at risk for pressure ulcers (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin). The "Quarterly MDS" dated 11/19/21, documented R5's BIMS score was not assessed due to rarely/never understood. R5 required extensive physical assistance with one staff for bed mobility, dressing, toileting, and personal hygiene; extensive physical assistance with two staff for transfers; and total physical dependence with one staff for bathing. R5 was at risk for pressure injuries and had skin tears. The "Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 08/24/21, documented R5 needed supervision to limited assistance of one with mobility, transfers, dressing, personal hygiene, toileting, and bathing. The "ADL/Mobility Care Plan" dated 08/31/21, documented R5 required assistance with personal cares and mobility and directed R5 required limited to extensive assistance with one staff for bathing. On 11/16/21 at 11:17 AM an anonymous reporter verbalized to the state agency R5 had previously resided in a different room on the other side of the facility. When R5 moved to the other side, she was not added to the shower list. The reporter voiced concern R5 had not received a shower for well over a month. The "Documentation Survey Report" documented	F 677			

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

PRINTED: 12/10/2021
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 C 12/08/2021
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 677	Continued From page 2 R5 was scheduled for bathing after breakfast on Tuesdays and Fridays. Review of the report for 09/01/21 to 11/25/21 (85 days) revealed R5 received two baths: 10/22/21 and 11/16/21. "Not Applicable (NA)" was documented on 09/03/21, 09/10/21, 09/14/21, 10/08/21, 10/12/21, 10/19/21, and 11/09/21. The following dates lacked bathing documentation: 09/07/21, 09/17/21, 09/21/21, 09/24/21, 09/28/21, 10/05/21, 10/15/21, 10/26/21, 11/02/21, 11/05/21, 11/12/21, 11/19/21, and 11/23/21. The report lacked indication R5 refused bathing. On 12/08/21 at 01:49 PM, Certified Nurse Aide (CNA) M stated the aides were responsible for bathing and bathing was documented in Point of Care (POC- EMR system for CNA documentation) and on assignment sheets. CNA M stated blanks or missing documentation meant the bathing did not get done or it did not get documented. CNA M stated "NA" might have been used if a resident was out of facility. Staff knew who required assistance by looking at the Kardex (communication tool used by nursing staff by providing current patient information across shifts). On 12/08/21 at 01:57 PM, Administrative Nurse D stated the aides were responsible for bathing and bathing was documented in POC and on assignment sheets. She stated blanks or missing documentation meant bathing did not get documented, if an aide was unable to complete bathing then they notified the nurse so the nurse could have re-approached the resident. Administrative Nurse D stated bathing was scheduled and completed based on resident preference. If a resident transferred to a different unit, staff were able to see when bathing was	F 677			

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

PRINTED: 12/10/2021
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 C 12/08/2021
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 677	Continued From page 3 scheduled in the EMR. The facility's "Resident Routine Daily Preferences" policy, last revised 11/15/20, directed the facility honored resident preferences for daily routines including bathing. The "policy" directed all preferences were added/revised on the resident's baseline/comprehensive individualized care plan and direct care staff were instructed to follow the preferences of each resident at all times. The facility failed to provide consistent bathing for R5. This deficient practice placed R5 at increased risk for skin breakdown and decreased self-esteem and dignity.	F 677			