STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 and Complaint Investigation #KS00145198, #KS00144780, #KS00144802, #KS144056, #KS00143962. The amended 2567 was electronically sent to the facility on 09/25/19	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 577		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 577	Continued From page 1	F 577		

The facility identified a census of 79 residents. The sample included 31 residents. Based on observations and interviews the facility failed to place the facility survey results binder in a readily accessible location for the residents, their legal representatives, or their family members. The facility also failed to provide the survey results from the three previous years.

Findings included:

- On 09/12/19 at 09:15 AM the survey results binder was placed on a cabinet behind the receptionist desk, in the front lobby. The binder's spine was facing toward the receptionist desk, without identification documenting the contents. The binder contained survey results from the survey of 07/26/18.

On 09/18/19 at 07:22 AM, the survey results binder was in the same location, with the same lack of identification and documentation.

On 09/16/19 at 02:02 PM the residents attending a resident council meeting stated they were unaware of the location of the facility survey results.

On 09/18/19 at 12:30 PM Administrative Nursing Staff D stated the survey results binder should contain documents from the three previous years of surveys.

The facility lacked a survey result documentation policy.

The facility failed to place the survey results binder in a location that was readily accessible to residents, their legal representatives, or their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 577	Continued From page 2 family members. The facility also failed to provide three years of the survey.	F 577		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 636	Continued From page 3	F 636		

the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents. The sample included 31 residents. Based on observation, interview, and record review the facility failed to assess Resident (R) 21, R73, R80, and R39 "Brief Interview Mental Status" (BIMS). The facility also failed to assess R21 for "Mood". Facility failed to document the Moisture Associated Damage (MASD: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous) for R76 and R62.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

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F 636	Continued From page 4	F 636		

Findings included:

- The electronic medical record (EMR) diagnoses list for R21, documented a diagnosis of cerebral infarction (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).

The Admission "Minimum Data Set" (MDS) dated 06/13/19 for R21 documented a "Brief Interview for Mental Status" (BIMS) as not assessed. The Admission MDS documented a "Mood" score of not assessed.

The "Care Area Assessment" (CAA) for cognition and mood dated 06/18/19 did not trigger due to not being assessed.

Review of the care plan for R21 dated 06/06/19 revealed resident did not have a care plan for cognition or mood.

09/17/19 08:18 AM R21 was in dining room eating breakfast with tablemates. R21 was able to cut her food without any difficulty. R21 propelled herself to dining room in her wheelchair.

Interview on 09/18/19 at 10:35 AM Administrative Nursing Staff E stated BIMS and mood scores should be done if they are able to do it. She did not think there was a time when the BIMS and mood shouldn't be done. If the BIMS and mood scores were not done it probably wouldn't trigger the CAA to trigger the care plan.

Interview on 09/18/19 at 10:49 AM Social Services (SS) X stated she does the BIMS and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 636	Continued From page 5	F 636		

mood assessments for the MDS. If a resident couldn't answer, staff do the assessment. SSX could not say why R21 BIMS and mood scores were not done.

The "Resident Assessment Instrument" (RAI) version 1.16 dated October 2018 stated section C: Cognitive Patterns (BIMS) the items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

The RAI version 1.16 dated October 2018 stated section D: Mood the items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

The facility did not provide a policy for coding the MDS. Facility stated they follow the RAI manual.

The facility failed to assess R21 BIMS and Mood score as required by the RAI.

- The electronic medical record (EMR) "Diagnosis" tab for Resident (R)62 documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin) and hemiplegia (paralysis of one side of the body) / hemiparesis (muscular weakness of one half of the body) of her right side.

The Admission "Minimum Data Set" (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 636	Continued From page 6	F 636		

07/23/19 documented R62 was at risk for skin breakdown. She did not have current alterations in her skin integrity. She received medication treatments to her skin.

The Pressure Ulcer "Care Area Assessment" dated 07/23/19 documented R62 was at risk for skin integrity alterations due her diagnoses. She received Nystatin powder (medication used to treat yeast infections- a fungal infection that affects different body parts) for yeast in her abdominal folds.

The EMR skin assessment tab documented R62 received treatment, ordered by the physician, for redness to her groin on 07/17/19.

The EMR physician order tab documented an order, dated 07/16/19, for Nystatin powder 10,000 units per gram to be applied to the affected areas, topically, three times daily for a fungal infection.

On 09/17/19 at 04:10 PM R62 was resting in her bed. She stated she received medication to treat the redness under her breasts and groin areas.

On 09/18/19 at 10:35 AM the long- term care "Facility Resident Assessment Instrument" (RAI) coordinator E stated R62's MDS assessment should reflect the alterations in skin integrity.

On 09/18/19 at 12:30 PM Administrative Nursing Staff D stated the MDS should reflect the alterations in R62's skin integrity.
The facility lacked a policy for MDS documentation.

The facility failed to accurately document R62's alterations in skin integrity on the MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 636	Continued From page 7	F 636		

- The diagnoses tab on 76's electronic medical record (EMR) documented diagnoses diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and morbid obesity.

The Admission "Minimum Data Set" (MDS) dated 08/30/19 documented R76 had a surgical incision, it lacked documentation of moisture associated skin damage (MASD).

The Pressure Ulcer "Care Area Assessment" dated 09/03/19 documented R76 was at risk for skin breakdown, it lacked documentation for MASD.

The EMR's "Weekly Skin Evaluation" tab dated 08/30/19 documented R76 had redness under both breasts and groin areas and received Nystatin powder (medication used to treat yeast infections- a fungal infection that affects different body parts) to the reddened areas.

The Physician's Order tab of the EMR documented an order, dated 08/24/19 for Nystatin powder 10,000 units per gram applied under abdominal and breast folds, topically, three times daily for redness.

On 09/16/19 at 01:50 PM R76 sat in the main lobby. She stated the alterations in her skin integrity had occurred prior to admitting to the facility.

On 09/18/19 at 10:35 AM the long- term care "Facility Resident Assessment Instrument" (RAI) coordinator E stated R76's MDS assessment should reflect the alterations in skin integrity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 636	Continued From page 8	F 636		

On 09/18/19 at 12:30 PM Administrative Nursing Staff D stated the MDS should reflect the alterations in R76's skin integrity.

The facility lacked a policy for MDS documentation.

The facility failed to accurately document R76's alterations in skin integrity on the MDS.

-The "Electronic Medical Record" (EMR) under the "Diagnosis" tab listed diagnoses for R73 of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion).

The Annual "Minimum Data Set" (MDS) dated 02/19/19 documented a "Brief Interview for Mental Status" (BIMS) should be conducted and the score was blank. The MDS documented R73 required extensive assistance of two staff members for "Activities of Daily Living" (ADL).

The quarterly MDS dated 08/24/19 documented a BIMS score of 05 which indicated severe cognitive impairment. The MDS also documented that R73 required extensive assistance of one staff member for ADL.

The "Care Area Assessment" (CAA) for "Cognitive Loss" dated 02/28/19 documented that R73 has a diagnosis of Alzheimer's disease and dementia which indicated a cognitive deficit.

The care plan for ADL's revised on 07/10/19 directed staff that R73 required extensive assist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 636	Continued From page 9	F 636		

of one staff person for assistance for dressing.

On 09/17/19 R73 at 08:04 AM R73 sat in the dining room in a wheelchair and ate breakfast without difficulty or assistance.

During an interview on 09/18/19 at 10:35 AM "Administrative Nurse" E stated BIMS and mood scores should be done if they are able to do it. She did not think there was a time when the BIMS and mood shouldn't be done. If the BIMS and mood scores were not done it probably wouldn't trigger the CAA to trigger the care plan.

During an interview on 09/18/19 at 10:49 AM, "Social Services" (SS) X stated she did the BIMS and mood assessment for the MDS. If a resident could not answer, the staff did the assessment.

The "Resident Assessment Instrument" (RAI) version 1.16 dated October 2018 stated section C: Cognitive Patterns (BIMS) the items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

The facility did not provide a policy for coding the MDS. Facility stated they follow the RAI manual.

The facility failed to assess R73 BIMS score as instructed and required by the RAI manual.

-The "Electronic Medical Record" (EMR) for R80 under the "Diagnosis" tab documented diagnoses of cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) of the right lower limb and acute osteomyelitis (local or generalized infection of the bone and bone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 636	Continued From page 10	F 636		

marrow) of the right ankle and foot.

The Admission "Minimum Data Set" (MDS) dated 09/02/19 documented a "Brief Interview for Mental Status" (BIMS) should be conducted and the score was blank. The MDS documented that R80 required extensive assistance of two staff members for Activities of Daily Living (ADL).

The "Care Area Assessment" (CAA) dated 09/09/19 for "Cognitive Loss" documented that staff will continue to provide support and encouragement to make good decisions and for safety awareness.

The care plan for cognitive loss revised on 09/08/19 directed staff to monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, understanding others, level of consciousness, mental status.

On 09/16/19 at 04:02 PM R80 sat upright in a wheelchair in his room, with soft boots on bilateral lower extremities (BLE).

During an interview on 09/18/19 at 10:35 AM with Administrative Nurse E stated BIMS and mood scores should be done if they are able to do it. She did not think there was a time when the BIMS and mood shouldn't be done. If the BIMS and mood scores were not done it probably wouldn't trigger the CAA to trigger the care plan.

During an interview on 09/18/19 at 10:49 Am Social Services (SS) X stated she did the BIMS and mood assessment for the MDS. If a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 636	Continued From page 11	F 636		

could not answer the staff did the assessment.

The "Resident Assessment Instrument" (RAI) version 1.16 dated October 2018 stated section C: Cognitive Patterns (BIMS) the items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

The facility did not provide a policy for coding the MDS. Facility stated they follow the RAI manual.

The facility failed to assess R80 BIMS score as required by the RAI.

-The "Electronic Medical Record" (EMR) under the "Diagnosis" tab diagnosis for R39 of dementia (progressive mental disorder characterized by failing memory, confusion).

The admission "Minimum Data Set" (MDS) dated 01/11/19 documented a "Brief Interview for Mental Status" (BIMS) should be conducted and the score was blank.

The MDS documented R39 required extensive assistance of one staff member for "Activities of Daily Living" (ADL).

The quarterly MDS dated 07/26/19 documented a BIMS score of 05 which indicated severe cognitive impairment. The MDS also documented that R39 required extensive assistance of one staff member for ADL.

The "Care Area Assessment" (CAA) for "Cognitive Loss" dated 01/17/19 did not trigger due to not being assessed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 636	Continued From page 12 The care plan for "Cognitive Function" revision date 07/23/19 for R39 directed staff to identify themselves at each interaction. When speaking to her make eye contact, reduce any distractions. To use simple directive sentences and return if agitated. On 09/16/19 R39 at 08:28 AM sat in dining room in wheelchair ate breakfast without difficulty or assistance. During an interview on 09/18/19 at 10:35 AM with "Administrative Nurse" E stated BIMS and mood scores should be done if they are able to do it. She did not think there is a time when the BIMS and mood shouldn't be done. If the BIMS and mood scores are not done it probably wouldn't trigger the CAA to trigger the care plan. During an interview on 09/18/19 at 10:49 AM "Social Services" (SS) X stated she did the BIMS and mood assessment for the MDS. If a resident could not answer the staff did the assessment. The "Resident Assessment Instrument" (RAI) version 1.16 dated October 2018 stated section C: Cognitive Patterns (BIMS) the items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions. The facility did not provide a policy for coding the MDS. Facility stated they follow the RAI manual. The facility failed to assess R39 BIMS score.	F 636		
F 684	Quality of Care	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 684 SS=D	Continued From page 13 CFR(s): 483.25	F 684		

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents. The sample included 31 residents. Based on interviews and record review the facility failed to obtain a physician ordered stool sample for Resident (R)14.

Findings included:

- The "Diagnoses" tab of the electronic medical record (EMR) for R14 documented a diagnosis of chronic atrial fibrillation (rapid, irregular heart beat).

The Annual "Minimum Data Set" (MDS) dated 07/02/19 documented a "Brief Interview for Mental Status" (BIMS) score of 15 which indicated intact cognition. She required extensive staff assistance with her bed mobility and supervision with assist of one staff for transfer, toileting and dressing.

The "ADL Functional/Rehabilitation Potential" Care Area Assessment dated 07/05/19 documented R14 needed supervision to one-person assistance with dressing, bed mobility, transfers, toileting, personal hygiene and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 14	F 684		

bathing.

The "Orders" tab revealed a physician order directing staff to obtain a stool sample to test for ova (parasite egg) and parasite dated 08/19/19.

Review of the "Medication Administration Record" (MAR) for the month of August revealed the stool sample was initialed as collected on 08/31/19. Further review revealed the sample was never collected and a new order to collect the stool sample was obtained on 09/17/19.

The , "Physician Progress Note", under the "Assessment" tab, documented on 08/19/19 R14 was seen at the request of nursing who reported they had seen white "string like" worms in stool. The note recorded R14 reported she stopped seeing bugs in her stool 5 days ago and had not seen anymore. It further documented R14 reported she had itching of her rectum when she saw the worms.

On 09/17/19 at 08:10 AM R14 was observed sitting in the dining room working on a crossword puzzle and eating breakfast.

On 09/17/19 at 10:00 AM Licensed Nursing (LN) G stated there were no results in the portal for the stool sample. Stated it was not done, or I would have results and that he would get a new order.

On 09/17/19 at 01:04 PM Administrative Nurse D stated the stool sample was not collected for R14 on 08/19/19. She said a new order was obtained today (09/17/19) and the sample was collected today.

The "Lab Test Results" policy revised 08/2019 did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

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F 684	Continued From page 15 not address collection of lab specimens or samples. The facility failed to obtain a stool sample from R14 to check for ova and parasite.	F 684		
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 79 residents. The sample included 31 residents. Based on observations, record review, and interviews, the facility failed to answer Resident (R)21's call light for 56 minutes in which time R21 sustained a fall. Findings included: - The electronic medical record (EMR) for R21 documented a diagnosis of cerebral infarction (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). The Admission "Minimum Data Set" dated 06/13/19 documented a "Brief Interview for Mental Status" score of not assessed and R21 required extensive assist for "Activities of Daily Living" (ADL) of one to two staff members for bed mobility, transfers, locomotion on and off the unit,	F 689		

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F 689	Continued From page 16	F 689		

dressing and toilet use.

The "Care Area Assessment" (CAA) for ADLs dated 06/18/19 for falls documented R21 was at risk for falls related to impaired mobility and function. R21 needed assistance with ADLs and was incontinent.

The "Assessment" tab in the EMR revealed a "Fall Risk Score" of 14 (high risk) on 08/18/19.

Review of the call light response time log on 09/16/19 for R21 revealed R21's call light went off for 56 minutes on 08/20/19 from 05:12 PM until approximately 06:08 PM.

R21 had a non-injury fall on 08/20/19 at 05:57 PM while the call light was going off for 56 minutes.

The "Progress Notes" tab in the EMR dated 08/20/19 at 05:57 PM documented the nurse found R21 in sitting up position with her back towards the bed. R21 denied hitting her head. No visible injuries present. Will continue to monitor. Director of Nursing (DON) and family notified.

09/17/19 at 08:18 AM R21 was observed in dining room eating breakfast with tablemates. R21 was able to cut her food without any difficulty. R21 propelled herself to dining room in her wheelchair.

On 09/16/19 at 08:12 AM Licensed Nurse (LN) J stated staff don't carry call light pagers. They look at call light monitor at the nurse's station frequently to check on call lights.

On 09/16/19 10:07 AM Certified Nurse Aid (CNA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

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F 689	Continued From page 17	F 689		

M stated she knew people were calling for help by looking at the main computer panel at nurse's station. She looks at the main computer panel when she walks by the nurse's station. Walkie talkies are used to communicate to each other.

On 09/16/19 10:19 AM Administrative Staff B stated she does monitor the call lights on her computer. Observation of Administrative Staff B's computer revealed the call light application was not open on her computer. She needed someone to come up and log in for her because she uses another staff member's log in information and that she needs to get her own login username and password. When asked how she communicated a call light was on to the staff, Administrative Staff B stated after three minutes she will send it out over the walkie talkie to let the staff know which call light is going off. Administrative Staff B works 08:00 AM to 05:00 PM.

On 09/16/19 10:15 AM Administrative Staff D stated there were pagers at one point. We are trying to recalibrate them and redistribute them to staff. The receptionist monitors the call light monitor and radio's to staff when a call light goes off. She stated at night there was always someone at the nurse's station and monitoring was not an issue.

On 09/16/19 10:05 AM Administrative Staff A stated staff do have pagers they use to know whose call light needs answered. They checked call lights last week to make sure the call light system and pagers were working. he stated staff should always have pagers with them.

Interview on 9:05 AM at 09/18/19 Licensed Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 18 I (LN) stated R21 needs one person assist for transfers and toileting. LNI went on to state R21 does not refuse cares. Interview on 0918/19 at 08:55 AM Certified Nurse Aide (CNA) O stated the R21 needs assist of one person for transfers and toileting. CNA O stated R21 sometimes refuses care. Interview on 09/18/19 at 12:32 PM Administrative Nurse D stated R21 needs assist of one staff for transfers and toileting. Review of the call light response time log on 09/16/19 for Resident (R)21. R21's call light went off for 56 minutes on 08/20/19 from 05:12 PM until approximately 06:08 PM. R21 had a non-injury fall on 08/20/19 at 05:57 PM while the call light was going off for 56 minutes. The facility's "Call Light" policy revised 08/2019 documented it is the policy of this facility to provide the resident a means of communication with nursing staff. Answer the call light as soon as possible (goal is within five minutes). The facility failed to respond to R21's call light for 56 minutes during which time R21, who required assistance for ADLs and had a fall.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 19	F 698		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 79 residents. The sample included 31 residents, with one resident reviewed for dialysis (a process for removing waste products and excess fluid from the body when the kidneys are unable to adequately filter the blood). Based on record review, observation, and staff interviews, the facility failed to perform and document assessments of the dialysis access site for Resident (R) 56.

- The Electronic Medical Record (EMR) for R56 documented diagnoses of end stage renal disease (a terminal disease because of irreversible damage to the kidneys), stage 5 chronic kidney disease (kidneys are damaged and cannot filter blood as they should), and dependence on renal dialysis.

The Admission "Minimum Data Set" (MDS) dated 12/17/18 documented a "Brief Interview for Mental Status" (BIMS) score of 13, which indicated intact cognition. R56 had renal failure and dialysis.

The quarterly MDS dated 8/9/19 documented a BIMS of 15 which indicated intact cognition . R56 had renal failure and dialysis.

The "Functional Status" section of the "Care Area Assessment" (CAA) dated 12/17/18 documented that R56 required a one person assist for Activities of Daily Living (ADLs).

The "Urinary Incontinence and Indwelling Catheter" section of the CAA documented that R56 had end stage renal disease and was on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 698	Continued From page 20	F 698		

hemodialysis.

The care plan dated 12/24/18 revealed that R56 required dialysis on Tuesdays, Thursdays and Saturdays. Staff should check the arteriovenous fistula (AV-a surgically created connection between an artery and a vein used for hemodialysis) site every shift, and as needed for bruit (an audible vascular sound associated with turbulent blood flow usually heard with the stethoscope) and thrill (palpable vibration). Staff should check the dressing and AV site for redness, swelling, bleeding, warmth, and drainage and contact the physician to report abnormalities.

The EMR revealed a physician order initially dated 12/10/18 and most recently on 8/14/19 that staff is to assess the AV shunt/fistula for bruit and thrill every shift and as needed, and document the results. Staff is to assess the shunt every shift for signs and symptoms of infection.

Review of the EMR revealed that staff failed to monitor and document R56's dialysis AV site for thrill and bruit and signs of infection on 7/14/19, 7/24/19, 7/26/19, 7/30/19, 7/31/19, 8/7/19, 8/8/19, 8/9/19, 8/12/19, 8/21/19, 8/23/19, 8/26/19, 8/30/19, 9/2/19, 9/4/19, 9/9/19, 9/11/19, 9/13/19, and 9/15/19.

On 09/16/19 08:29 AM R56 was observed sitting in his wheelchair in the dining room. No assistance was needed with the meal. R56 ate 100 % of his meal. R56 wheeled himself to another table and talked to residents sitting there.

On 09/17/19 at 08:09 AM Licensed Nurse (LN) K took vital signs on R56 in preparation for dialysis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 698	Continued From page 21	F 698		

She assessed dialysis AV access site for infection, felt for thrill, and listened for bruit. The dialysis communication form was completed and placed in R56's bag to take to dialysis.

On 09/17/19 at 3:50 PM R56 returned from dialysis. LN L took vital signs on R56. LN L inspected the access site for bleeding, swelling, and signs of infection. She used a stethoscope to listen for bruit. She felt the site for thrill.

On 09/17/19 at 09:00 AM LN K stated that documentation related to dialysis is done in the EMR. To care for the dialysis access site, she stated that she makes sure the site is not bleeding, swollen, or showing signs of infection. The dressing should be changed if needed. LN K stated that the access site should be checked for infection, thrill and bruit should be assessed on every shift and before and after dialysis.

On 09/17/19 at 03:28 PM LN L stated that dialysis information is documented in the dialysis communication book and in the EMR. She stated that to assess the dialysis access site she feels for thrill, listens with a stethoscope for the bruit, and inspects the site for infection and bleeding. She stated the dressing on the access site should be changed if it is needed. LN L stated that the access site should be monitored each shift and before and after dialysis.

On 09/18/19 at 12:31 PM Administrative Nurse D stated that for a resident receiving dialysis the nurses should assess the dialysis access site for thrill, bruit and infection every shift and before and after dialysis. She said when there are no initials documented in the EMR for a medication and/or treatment, it indicates the medication and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 698	Continued From page 22 treatment was not done. The facility policy "Renal Dialysis, Care of Resident, Hemodialysis Access Site, Diet/Fluid Restrictions, Care Plans" dated 8/2019 documented that the AV fistula and AV graft sites are checked for condition, bruit and thrill every shift. The facility failed to ensure that the assessment of the AV shunt site for dialysis was performed and documented for R56 which placed R56 at risk for complications related to the AV fistula site such as infection, obstruction, or bleeding.	F 698		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		

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	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 756	Continued From page 23	F 756		

and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents. The sample included 31 residents, with five residents reviewed for unnecessary medications. Based on observation, interviews and record review the facility failed to ensure the consultant pharmacist identified and reported irregularities for the missed documentation of physician orders for the inter-venous (IV) medications and monitoring for Resident (R) 80.

Findings included:

-The "Electronic Medical Record" (EMR) for R80 under the "Diagnosis" tab documented diagnoses of cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) of the right lower limb and acute osteomyelitis (local or generalized infection of the bone and bone marrow) of the right ankle and foot.

The Admission "Minimum Data Set" (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 756	Continued From page 24	F 756		

09/02/19 documented a "Brief Interview for Mental Status" (BIMS) should be conducted and the score was blank. The MDS documented that R80 required extensive assistance of two staff members for Activities of Daily Living (ADL). The MDS documented R80 received antibiotic (medication used to treat infections) therapy for three days during look back period.

The "Care Area Assessment" (CAA) dated 09/09/19 for "Pressure Ulcer" documented that R80 was at risk for pressure ulcers due to impaired mobility, and incontinence.

The care plan for skin integrity revised on 09/08/19 directed staff to monitor/document location, size and sign or symptoms of infection to physician. "

The "Orders" tab revealed a physician's order dated 09/02/19 which directed staff to flush midline IV catheter with 10 milliliters (ML) of normal saline (NS) before and after IV medication administration and every shift.

The "Medication Administration Record" (MAR) lacked documentation of the flush being administered for eight days on night shift dated 09/02, 09/04, 09/05, 09/09, 09/11, 09/12, 09/13, and 09/15.

The "Orders" tab revealed a physician order dated 09/02/19 check IV site for any signs or symptoms of complications or adverse reaction from IV therapies every shift.

The "Medication Administration Record" (MAR) lacked documentation for monitoring the IV site eight days on night shift dated 09/0, 09/04, 09/05,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 756	Continued From page 25	F 756		

09/09, 09/11, 09/12, 09/13, and 09/15.

On 09/16/19 at 04:02 PM R80 sat upright in a wheelchair in her room, with soft boots on bilateral lower extremities (BLE).

During an interview with Licensed Nurse (LN) H on 09/18/19 at 09:55 AM, LN H stated if the MAR had no staff initials, that indicated the medication or treatment was not given or completed as ordered.

During an interview with Administrative Nurse D 09/18/19 at 12:44 PM, she stated that the expectation was for staff to chart directly after administrating or completing a treatment and if the MAR had no staff initials, that indicated that the medication or treatment was not given or completed as ordered.

During an interview with Consultant Pharmacist GG 09/18/19 at 02:05 PM stated she reviews every residents chart monthly and reviews the MAR's quarterly to check for parameters. She sends the report to the director of nursing monthly by email.

The facility "Services of a Licensed Pharmacist" policy revision date 08/19 documented that the pharmaceutics will address irregularities and develop mechanisms for communicating, address and resolving issues related to pharmaceutical services.

The facility failed to ensure that the pharmacist constant identified the irregularities for missed documentation for R80's physician order for checking the IV site to assess that it was free from signs or symptoms of complications from Iv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 756	Continued From page 26 therapies and the midline IV flush was completed as order, to prevent possible infection or IV obstruction.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 residents. The sample included 31 residents, with five residents reviewed for unnecessary medications. Based on observation, interviews and record review the facility failed to ensure physician orders for Resident (R) 80 related to inter-venous (IV) medications and monitoring were followed to prevent infection and IV obstruction.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 757	Continued From page 27	F 757		

Findings included:

-The "Electronic Medical Record" (EMR) for R80 under the "Diagnosis" tab documented diagnoses of cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) of the right lower limb and acute osteomyelitis (local or generalized infection of the bone and bone marrow) of the right ankle and foot.

The Admission "Minimum Data Set" (MDS) dated 09/02/19 documented a "Brief Interview for Mental Status" (BIMS) should be conducted and the score was blank. The MDS documented that R80 required extensive assistance of two staff members for Activities of Daily Living (ADL). The MDS documented R80 received antibiotic (medication used to treat infections) therapy for three days during look back period.

The "Care Area Assessment" (CAA) dated 09/09/19 for "Pressure Ulcer" documented that R80 was at risk for pressure ulcers due to impaired mobility, and incontinence.

The care plan for skin integrity revised on 09/08/19 directed staff to monitor/document location, size and sign or symptoms of infection to physician. "

The "Orders" tab revealed a physician's order dated 09/02/19 which directed staff to flush midline IV catheter with 10 milliliters (ML) of normal saline (NS) before and after IV medication administration and every shift.

The "Medication Administration Record" (MAR) lacked documentation of the flush being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 757	Continued From page 28	F 757		

administered for eight days on night shift dated 09/02, 09/04, 09/05, 09/09, 09/11, 09/12, 09/13, and 09/15.

The "Orders" tab revealed a physician order dated 09/02/19 check IV site for any signs or symptoms of complications or adverse reaction from IV therapies every shift.

The "Medication Administration Record" (MAR) lacked documentation for monitoring the IV site eight days on night shift dated 09/0, 09/04, 09/05, 09/09, 09/11, 09/12, 09/13, and 09/15.

On 09/16/19 at 04:02 PM R80 sat upright in a wheelchair in his room, with soft boots on bilateral lower extremities (BLE).

During an interview with Licensed Nurse (LN) H on 09/18/19 at 09:55 AM, LN H stated if the MAR had no staff initials, that indicated the medication or treatment was not given or completed as ordered.

During an interview with Administrative Nurse D 09/18/19 at 12:44 PM, she stated that the expectation was for staff to chart directly after administrating or completing a treatment and if the MAR had no staff initials, that indicated that the medication or treatment was not given or completed as ordered.

The facility "Medication Administration Inter-venous (IV) Medication" policy revised on 08/19 documented to record the procedure and the resident's tolerance to the procedure on the resident's medication record including the appearance of the IV site.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 757	Continued From page 29 The facility failed to ensure that R80's physician order for checking the IV site was free signs or symptoms of complications from Iv therapies and the midline IV flush was completed as order, to prevent possible infection or IV obstruction.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility reported a census of 79 residents. The sample included 31 residents and six medication carts. Based on observation, record	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 761	Continued From page 30	F 761		

review, and interview, the facility failed to properly label and store one Lantus and two Humalog individual insulin (medication used to treat a chronic condition that affected the way the body processed blood sugar) pens, and three medication inhalers in two of six medication carts.

Findings included:

- On 9/12/19 at 8:19 AM the medication cart on Maple Hills Two contained the following inhalers (medications used to treat breathing difficulties):

One Bevespi inhaler, opened and undated;
One Advair inhaler opened and undated.

On 9/12/19 at 9:14 AM the medication cart on Maple Hills One contained the following insulin and inhalers:

One Lantus and two Humalog insulin injection pens, opened and undated;
One Bevespi inhaler, opened and undated.

According to the U.S. Food and Drug Administration, Lantus insulin expires 28 days after opening.

A review of the manufacturer's instructions for the Advair inhaler noted it should be discarded one month after opening.

A review of the manufacturer's instructions for the Bevespi inhaler noted it should be discarded three months after removal from the foil pouch (three weeks for the inhalation canister).

On 9/12/19 at 08:19 AM Certified Medication Aide R stated that inhalers should be labeled with an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 761	Continued From page 31 open date. On 09/12/19 at 08:51 AM Licensed Nurse (LN) J verified that the insulin and inhaler in the medication cart on Maple Hills One should be labeled with an open date and verified that they were not. On 09/18/19 at 12:32 Administrative Nursing Staff D stated that insulin should be dated when opened but she did not know if inhalers should be dated when opened. She stated she would have to double check the policy. The facility's policy "Medication Storage Limits" revised 8/2019, states that all medications are to be stored based on resident safety and pharmaceutical product integrity. The facility failed to properly label and store one Lantus and two Humalog individual insulin pens, and four medication inhalers in two of six medication carts, which could potentially cause adverse consequences or ineffective treatment to the residents.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 812	Continued From page 32	F 812		

facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents. The sample included 31 residents. Based on observation, record review, and interview, the facility failed to label, date and monitor stored foods, including but not limited to leftovers, so that foods are used by their use-by date, are frozen, or discarded.

Findings included:

- Observation during the initial tour of the kitchen on 09/12/19 at 08:21 AM revealed the following items in the refrigerators, freezers, and dry storage area:

In the refrigerators in the kitchen were a container of ground meat without a label or date, three cooked hamburger patties wrapped in plastic wrap without a date or label, two breaded chicken tenders in an opened package without a label or date, a container with cutup fresh fruit that was not labeled or dated, mozzarella cheese wrapped in plastic wrap not labeled or dated, pasteurized cheese slices opened and wrapped in plastic wrap without a date, cut up cantaloupe in storage container covered with plastic wrap without a label or date, and watermelon cut up in storage container covered with plastic wrap not dated or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 812	Continued From page 33	F 812		

labeled.

In the freezers in the kitchen there were bags of potato chunks, hash browns, tater tots, potato wedges all opened not wrapped or labeled or dated, 10 cooked sausage patties wrapped in plastic wrap with no label or date.

The walk-in cooler had a container of leftover salad with no date or label on it.

The cold storage freezer had an opened bag of hash browns that was not wrapped or labeled with an open date, a package with one chicken breast opened and not dated, an open package with two pita breads with no label or date on them, and another opened package with 14 chicken breasts not labeled or dated. All items were removed and discarded at that time.

A return visit to the kitchen and walk-in refrigerator and freezer on 09/17/19 at 11:26 AM, revealed the following: two pieces of pizza in a Ziploc bag not labeled or dated, a bag of frozen corn opened and not wrapped or dated, a bag of frozen asparagus opened and not wrapped or dated, cooked bacon wrapped in plastic not labeled or dated.

Interview with Dietary staff BB on 09/12/19 at 08:45 AM, stated she has been trying to work with staff to make sure they are dating and labeling items when they open them.

Interview with Dietary staff CC on 09/17/19 at 11:26 AM, stated she has been working hard to change things in the kitchen since she was hired in November 2018. She has been working with staff to make sure they check all items stored to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 812	Continued From page 34 make sure they are wrapped, labeled, and dated when they are opened. All staff go through an orientation and a dietary class/training when hired about proper food handling and storage and then have an annual in-service as well. The facility policy "Food Storage", revised 08/2019, failed to have documentation about proper storage, labeling, and/or dating of opened food containers, packages, and leftover food items. The facility failed to ensure foods that were left over from meals and placed in the refrigerator/freezer were labeled and dated to ensure food was used or thrown away in a timely manner. The facility failed to ensure that food items stored in the walk-in refrigerator/freezer were wrapped, labeled, and dated to ensure food was used or discarded in a timely manner. This potentially put all the resident who consumed food prepared and stored in the kitchen at risk of a food borne illness.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 880	Continued From page 35 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 880	Continued From page 36 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 resident. The sample included 31 residents. Based on observations, record review, and interviews the facility failed to utilize accepted standard universal precautions (infection prevention practices which include but are not limited to hand hygiene and use of gloves and storage of medical equipment). Findings included: - An observation on 09/12/19 at 08:17 AM revealed Licensed Nurse (LN) II enter room 134 without washing her hands. She donned gloves outside of the resident's room, obtained a tissue, entered the room, rearranged the resident's blankets with both hands, and held the resident's eyes open while administering eye drops. An observation on 09/12/19 at 12:05 PM revealed a urinary catheter drainage bag (bag to collect urine from a catheter-a hollow flexible tube that collects urine from the bladder and leads to the drainage bag) hanging from the bed in room 213.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 880	Continued From page 37	F 880		

The catheter tubing was uncapped and lying on the floor.

An observation on 09/16/19 at 09:10 AM revealed a supplemental oxygen mask (device which fits over a person's nose and mouth to administer oxygen) unbagged and lying on the floor.

An observation on 09/17/19 at 07:33 AM LN G entered room 122 and did not wash her hands prior to setting up the equipment for the resident's gastrostomy tube feeding (the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall). She then picked up a walkie talkie from her pocket, turned it off, and replaced it in her pocket without changing gloves or washing hands prior to administering the tube feeding.

On 09/18/19 at 10:58 AM Direct Care Staff N stated urinary catheter drainage bags and tubing are stored in a marked bag in the resident's bathroom, when not in use.

On 09/18/19 at 12:30 PM Administrative Nursing Staff D stated she expected the urinary catheter drainage bag tubing to be stored in the residents' bathroom and not uncapped on the floor. She expected the oxygen mask to be placed in a pull time bag and not resting, uncovered, on the floor. She expected staff to sanitize their hands prior to entering a resident's room and washing their hands after performing cares.

The facility's Hand Washing policy dated August 2019 documented hand washing is generally considered the most important single procedure for preventing infections. Waterless hand washing products may be used in limited circumstances

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

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F 880	Continued From page 38 but are not a substitute for good hand washing. Waterless hand washing products are not used for skin care treatments or administration of eye drops. The facility's Infection Control Prevention and Control Program policy dated September 2017 documented the prevention of spread of infections is accomplished by use of the standard precautions, appropriate treatment. Aseptic (the use of practices and procedures to prevent contamination from pathogens) practices are followed, by personnel, in performing procedures and disinfection of equipment. Hand hygiene procedures are followed by staff involved in direct resident contact. The facility failed to utilize accepted universal precautions while performing resident care and storing resident's medical supplies, which could potentially lead to the spread of infections.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 residents. The sample included 31 residents. Based on record review and interviews the facility failed to	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 881	Continued From page 39	F 881		

promote and implement a system to monitor antibiotic use and effectiveness for the residents of the facility.

Findings included:

- The facility's 2019 Infection Control Tracking and Trending notebook lacked documentation for infections occurring in the facility for April, May, and June 2019. The notebook also lacked documentation of the types of organisms causing infections identified in March 2019.

On 09/18/19 at 10:08 AM Infection Control Preventionist F stated she gathers information regarding infections, the microorganisms causing the infections, and the antibiotics used to treat the infections daily and compiles monthly reports of the data collected. She verified the facility did not have information on the microorganisms causing the infection in March 2019, or the tracking for infections in April, May, and June 2019.

The facility's Infection Control Prevention and Control Program policy dated September 2017 documented the program is comprehensive in that it addresses the detection, prevention, and control of infections among residents and personnel. The facility provides on-going monitoring of infection occurrences, records their number and frequency, detect outbreaks, and epidemics, and detects unusual pathogens with infection control implications.

The facility failed to promote and implement a system to monitor the use of antibiotic use and effectiveness, which had the potential of increasing the risk for the spread of antibiotic resistive infections.

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	175550	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILLS HEALTHCARE, INC, DBA SHAWNEE POST ACUT	7600 ANTIOCH ROAD OVERLAND PARK, KS 66204

(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 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		

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F 883	Continued From page 41	F 883		

medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents. The sample included 31 residents. Based on record reviews and interviews the facility failed to vaccinate eligible residents, who had not refused, with the influenza vaccine for two of the five Residents (R)47, R14 reviewed. The facility also failed to document an influenza vaccine consent or declination form for Fall of 2018 for R73.

Findings included:

- Review of R47's electronic medical record (EMR) immunization tab included a signed permission document for the influenza vaccine. The EMR lacked documentation of R47 receiving the vaccine in the fall of 2018.

R14's EMR immunization tab included a signed permission document for the influenza vaccine. The EMR lacked documentation of R14 receiving the vaccine in the fall of 2018.

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F 883	Continued From page 42 R73's EMR immunization tab lacked an influenza vaccine consent or declination form for the fall of 2018. On 09/18/19 at 10:08 AM Infection Control Preventionist F stated she and the weekend nursing supervisor provide consents, for the influenza vaccines, to the residents and monitor the vaccines given. She verified the lack of documentation for R47, R14, and R73. The facility's "Immunizations, Influenza and Pneumococcal" policy dated November 2016 documented each resident is offered an influenza immunization October 1 until directed by the health department to stop vaccinations. The facility staff document that the resident either received or did not receive the influenza immunization. The facility failed to provide the influenza vaccine to R47 and R14, after they had given consent to receive and failed to document an influenza vaccine consent or declination form was offered to R73, which placed the residents at risk for acquiring, transmitting, and experiencing complications from influenza disease.	F 883		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities.	F 919		

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F 919	Continued From page 43	F 919		

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents. The sample included 31 residents. Based on observations and interviews, the facility failed to maintain a working call light system, due to a lack of facility staff pagers, required to notify the facility staff of the residents' need for assistance.

Findings included:

- On 09/16/19 at approximately 08:00 AM, during an observation of the call light monitoring system, a resident's call light initiated without notification on a pager.

On 09/16/19 at 08:12 AM Licensed Nurse (LN) J stated staff don't carry call light pagers. They look at call light monitor at the nurse's station frequently to check on call lights.

On 09/16/19 10:07 AM Certified Nurse Aid (CNA) M stated she knew people were calling for help by looking at the main computer panel at nurse's station. She looks at the main computer panel when she walks by the nurse's station. Walkie talkies are used to communicate to each other.

On 09/16/19 10:19 AM "Administrative Staff B" stated she does monitor the call lights on her computer. Observation of receptionist computer revealed the call light application was not open on her computer. She needed someone to come up and log in for her because she uses another staff members log in information and that she needs to get her own login username and password. When asked how she communicated a call light was on to the staff, "Administrative Staff B" stated after three minutes she will send it out over the

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F 919	Continued From page 44	F 919		

walkie talkie to let the staff know which call light is going off. "Administrative Staff B" works 08:00 AM to 05:00 PM.

On 09/16/19 10:15 AM "Administrative Staff D" stated there were pagers at one point. We are trying to recalibrate them and redistribute them to staff. The receptionist monitors the call light monitor and radio's to staff when a call light goes off. She stated at night there was always someone at the nurse's station and monitoring was not an issue.

On 09/16/19 10:05 AM "Administrative Staff A" stated staff do have pagers they use to know whose call light needs answered. They checked call lights last week to make sure the call light system and pagers were working. he stated staff should always have pagers with them.

Review of the call light response time log on 09/16/19 for Resident (R)21. R21's call light went off for 56 minutes on 08/20/19 from 05:12 PM until approximately 06:08 PM. R21 had a non-injury fall on 08/20/19 at 05:57 PM while the call light was going off for 56 minutes.

The facility's "Call Light" policy revised 08/2019 documented it is the policy of this facility to provide the resident a means of communication with nursing staff. Answer the call light as soon as possible (goal is within five minutes).

The facility failed to provide all staff with a functional pager and failed to ensure each staff carried a working pager.