

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

PRINTED: 08/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2022
NAME OF PROVIDER OR SUPPLIER CLARIDGE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 8101 MISSION ROAD PRAIRIE VILLAGE, KS 66208		
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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00165056.	F 000			
F 655 SS=D	The 2567 was sent electronically on 08/16/22. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655			

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

TITLE

(X6) DATE

08/16/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 655	Continued From page 1 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. The sample included 15 residents with one resident reviewed for death. Based on record review, and interviews, the facility failed to complete a baseline care plan for R42, which placed her at risk of impaired cares related to unidentified or uncommunicated care needs. Findings included: - R42's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The "Entry Minimum Data Set" (MDS) recorded R42 admitted on 05/06/22. R42's "Baseline Care Plan" was not initiated after	F 655			

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F 655	Continued From page 2 her admission. Review of the EMR lacked a baseline care plan. On 08/03/22 at 11:33 AM Administrative Nurse D stated a baseline care plan was not started for R42 after admission. Administrative Nurse stated R42 was admitted on a Friday and then passed away Monday morning before the 48 hours had expired. On 08/04/22 at 03:50 PM Licensed Nurse (LN) G stated a baseline care plan was opened in the EMR upon a new admission. LN G stated that every department had a part to fill out for the new admission's baseline care plan. LN G stated that the admission coordinator or the director of nursing notified the staff of open baseline care plan that were to be completed within the 48 hours. On 08/04/22 at 02:20 PM Administrative Nurse E stated a baseline care plan was completed in 48 hours. Administrative Nurse E stated the admission nurse would open the baseline care plan in the EMR for the new admission and every department would complete their portion of the baseline care. Administrative Nurse E stated she would review the baseline care plan after the 48 hours. The facility "Baseline Care Plan "policy last reviewed 05/31/19 documented any resident admitted to the facility would have a Baseline Care Plan formulated and developed within 48 of admission. The facility failed to develop a baseline care plan for R42, which placed her at risk for impaired	F 655			

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F 655	Continued From page 3 cares related to unidentified or uncommunicated care needs.	F 655			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. The sample included 15 residents with one resident reviewed for hospice and end of life. Based on observation, record review, and	F 657			

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F 657	Continued From page 4 interviews, the facility failed to revise the care plan with the correct hospice company for Resident (R) 20, which placed her at risk of delayed services for end of life comfort. Findings included: - R20's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure) and cerebrovascular accident (CVA-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 12/06/21 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented that R20 required extensive assistance of one staff member for activities of daily living (ADLs). The MDS documented R20 received hospice services during the look back period and prior to admission. The "Quarterly MDS" dated 06/08/22 documented a BIMS score of seven which indicated severely impaired cognition. The MDS documented that R20 required extensive assistance of one staff member for ADLs. The MDS documented R20 received hospice services during the look back period. R20's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 12/55/10/21 documented R20 required assistance with her ADLs and was recently admitted onto hospice services.	F 657			

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F 657	Continued From page 5 R20's "Care Plan" dated 12/16/21 documented the facility and hospice staff would coordinate bath days to provide comfort and hygiene for R20. The "Care Plan" revised on 02/08/22 documented R20 was admitted onto hospice services before admission. Review of the hospice communication book for R20 revealed the hospice provider was different than what was listed on R20's current care plan. On 08/03/22 at 12:22 PM nursing staff pushed R20 into the dining room; she ate lunch without assistance. On 08/03/21 at 10:22 AM Licensed Nurse (LN) H stated R20 was not on the hospice listed on the "Care Plan". LN H retrieved the communication book for the correct hospice provider for R20. On 08/04/22 at 02:20 PM Administrative Nurse E stated the social services staff completed the care plan related to hospice services. On 08/04/22 at 02:38 PM Social Services X stated she completed the hospice care plan for R20. Social Service X stated R20 was admitted to the facility on hospice services. Social Services X verbalized the correct hospice provider for R20's services. Social Services X reviewed R20's care plan in the EMR and stated the hospice company listed on the care plan was a mistake and she corrected the name of the hospice. The facility "Comprehensive Care Plan" policy dated 09/30/19 documented the comprehensive care plan would describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and	F 657			

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F 657	Continued From page 6 psychosocial well-being.	F 657			
F 675 SS=D	The facility failed to ensure the correct hospice company was listed on R20's care plan, which placed R20 at risk of delayed services for end of life services. Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility reported a census of 44 residents. The sample included 15 residents with 15 reviewed for quality of life. Based on observation, record review, and interviews, the facility failed to ensure all staff, across all shifts, honored Resident (R)14's preferences, requests and choices to ensure R14's quality of life. This deficient practice placed R14 at risk for decreased psychosocial wellbeing. Findings Included: - The "Medical Diagnosis" section within R14's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), osteoarthritis (degenerative changes to one or many joints characterized by	F 675			

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F 675	Continued From page 7 swelling and pain), overactive bladder (frequent urges to urinate), general anxiety disorder (Long-term mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), insomnia (inability to sleep), chronic kidney disease, and type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R14's "Annual Minimum Data Set (MDS)" noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated that she required limited assistance from one staff for bed mobility, transfers, dressing, and personal hygiene. The MDS noted that she required extensive assistance for toileting. A review of R14's "Activities of Daily Living (ADL's) Care Area Assessment" dated 06/06/22 noted that she required help with her ADL's and mobility due to poor muscle strength and endurance, and impaired balance. R14 received medication that may cause side effects for risk of falls. R14's "Care Plan" indicated that she had an ADL self-care deficit related to her medical conditions. The care plan indicated she required extensive assistance by one staff member for locomotion, transfers, toileting, bed mobility, dressing, and bathing. The plan indicated that she utilized a wheelchair for locomotion and staff were to encourage her to activate her call light for assistance. The care plan noted that she required prompt responses to all request for assistance. The care plan noted that that she was able to make her needs known and staff should honor her choices.	F 675			

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F 675	Continued From page 8 On 08/02/22 at 08:23 AM R14 stated that the facility took great care of her except for one staff member. She stated that he often made her feel like she had to do everything for herself and request her to do things that she felt she could not complete due to her physical limitations. A review of a "Complaint Investigation Statement" dated 08/03/22 completed by Social Services X noted that R14 reported a complaint that Certified Nurses Aid (CNA) N asked her to complete care tasks that she could not physically tolerate including pulling her brief off during toileting, putting her slippers on, adjusting her bed linens, and sitting herself up in bed at night. On 08/03/22 at 02:03PM R14 reported that the previous night she activated her call light for assistance to the restroom. She stated that she was extremely weak and tired and needed assistance from staff to help her get out of bed and go to the restroom. She stated she was lying in bed and could not remove her covers. She stated that CNA N made her feel as though she should already be out of bed on her own. She required CNA N to assist her to sit up on the bed, put her slippers on, and transfer her to the restroom. She stated that throughout the provision of assistance, CNA N made her feel as though she asked for too much help and that she should have been able to complete the transfer without CNA N's help. She stated that while preparing to use the restroom, CNA N asked her to pull her own brief down and take it off. R14 stated that she has never been asked to do that by anyone before because she could not physically bend down low enough to remove the brief without falling or hurting herself. She stated	F 675			

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F 675	Continued From page 9 that CNA N could not understand why she could not complete the task. She stated that he never readjusted the bed for her upon laying back down and she had to do it herself. On 08/04/22 at 02:05PM CNA N stated that has worked with R14 for a few months and believed that she should have been able to function during the night at the same level as during the daytime. He stated that during the dayshift, R14 needed very little help with getting out of bed and transferring to the toileting. He stated that every time he answered her call light on previous nightshifts, R14 was already sitting on the side of the bed ready to transfer to her wheelchair but the night of 08/03/22 he stated that something was different with her. CNA N confirmed he did ask R14 to perform some care task independantly as he was just trying to make sure R14 was okay and not declining. A review of the facility's "Resident Right's" policy revised 12/2020 noted that the facility is dedicated to enhancing the quality of life for each resident by treating each resident with dignity, courtesy, and promoting the right to choose the way they live and the care they receive. The facility failed to ensure all staff, across all shifts, honored R14's preferences, requests and choices to ensure R14's quality of life. This deficient practice placed R14 at risk for decreased psychosocial wellbeing.	F 675			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690			

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F 690	Continued From page 10 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. The sample included 15 residents with one resident reviewed for bowel and bladder maintenance Based on observation, record review and interview, the facility failed to ensure	F 690			

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F 690	Continued From page 11 Resident (R) 39's indwelling catheter (a soft hollow tube inserted into the urethra or bladder) urine collection bag was stored off the floor, and was hung lower than bladder level. This deficient practice placed R39 at increased risk for infection, urinary retention, and other catheter related complications. Findings included: - The electronic medical record (EMR) for R39 documented diagnoses of: urinary tract infection (UTI-an infection in the urinary tract), retention of urine (a condition in which you cannot empty all the urine from your bladder), and benign prostatic hyperplasia (BPH non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections). The "Admission Minimum Data Set" (MDS) dated 07/15/22 documented R39 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R39 required extensive to total assistance of one staff for his activities of daily living. R39 required the use of an indwelling catheter. The "Urinary Care Area Assessment" (CAA) dated 07/19/22 documented R39 had a catheter. R39 was at risk for skin breakdown and UTI's. Nursing provided catheter care. The "Urinary Catheter Care Plan" revised on 07/19/22 directed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance of room door; secure the catheter bag to resident's leg with stat lock (a device used to secure the catheter tubing) and be	F 690			

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F 690	Continued From page 12 sure to keep the bag off the floor. A "Physician Progress Note" on 08/02/22 at 12:22 PM documented R39 was seen for reports of a positive urine culture. R39 would continue with the catheter indefinitely. R39 would start linezolid (an antibiotic medication used to treat infections) per sensitivity. On 08/02/22 at 09:44 PM R39 laid in bed. His catheter bag laid on the floor in his room on the left side of his bed, with no dignity cover present. On 08/03/22 at 11:26 AM R39 sat in his recliner. The catheter bag hung on the bedside table, above bladder level, and urine was visible moving back (backflow) in the catheter tubing. No dignity bag was in use. In an interview on 08/04/22 at 02:18 PM Certified Nurse Aide (CNA) P stated the catheter should never be on the floor. It should be hung on the side of the bed away from the door. The bag should be below the level of the bladder. A cover should be placed when the resident was in the wheelchair, out in public or when using the walker. In an interview 08/04/22 at 02:23 PM Licensed Nurse (LN) H stated the catheter bag should never touch the floor. If a catheter bag had been on the floor the bag should be changed. The catheter should not be hung at a level higher than the bladder such as the bedside table as that would place a resident at risk to develop and infection. On 08/04/22 at 04:23 PM Administrative Nurse D stated the catheter bag should never be on the	F 690			

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F 690	Continued From page 13 floor, the catheter bag should be changed if found on the floor. Administrative Nurse D said the bag should be hung at a level lower than the bladder and should never be attached/hung from the bedside table. The "Catheter Care" policy dated 2001 documented: Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. The urinary drainage bag must always be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The facility failed to ensure staff kept R39's catheter bag off the floor and failed to ensure the bag was maintained at a level below the bladder to prevent backflow. This put R39 at increased risk for complications related to catheter use.	F 690			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692			

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F 692	Continued From page 14 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility reported a census of 44 residents. The sample included 15 residents with one reviewed for nutrition and hydration . Based on observation, record review, and interviews, the facility failed to promote adequate hydration and nutrition when staff failed ensure accessible drinking water within reach for Resident (R)12. This deficient practice placed R12 at risk for altered hydration. Findings Included: - The "Medical Diagnosis" section within R12's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), muscle weakness, unsteadiness on feet, and history of falling. R12's "Quarterly Minimum Data Set (MDS)" noted to Brief Interview for Mental Status (BIMS) score of ten indicating moderate cognitive impairment. The MDS noted that she required limited assistance from one staff for transfers, toileting, and bathing. The MDS noted that she was independent for eating. The MDS noted no significant weight loss or gain within the last six months.	F 692			

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F 692	Continued From page 15 R12's "Nutritional Care Area Assessment (CAA)" indicated that she was on a regular diet. The CAA noted that she had memory loss from dementia and suffered from confusion at times. A review of R12's "Care Plan" revised 06/14/22 indicated that she was at risk for dehydration and malnutrition related to her medical diagnoses. The care plan indicated that staff should encourage fluid intake throughout the day. The care plan noted that she often asked the dietary aids to order her meals during meal services. On 08/04/22 at 07:20 AM R12's drinking water sat on the bedside table, located at the foot of her bed and out of reach. R12 was awake and awaiting her breakfast. R12's water remained out of reach until breakfast arrived at 08:45AM On 08/04/22 at 04:02 PM in an interview, Certified Nurses Aid (CNA) O stated that staff should be ensuring that the residents are comfortable and have what they need in reach at all times. She stated that water should be within reach and refilled when needed. On 08/04/22 at 04:22 PM in an interview, Administrative Nurse D stated that staff should be frequently checking on resident's needs during each interaction and ensuring that the resident's have what they need and easily accessible. She stated that R12's water should have been within reach and not positioned at the foot of the bed. A review of the facility's "Hydration Management" policy revised 11/2013 noted that nurses will provide and encourage fluid intake at bedside, mealtime, and on routine basis as part of cares.	F 692			

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F 692	Continued From page 16 The policy noted that resident with high risk of dehydration will have specific interventions related to maintaining hydration in the care plan. The facility failed to promote adequate hydration for R12 when staff placed R12's water out of her reach. This deficient practice placed R12 at increased risk for altered hydration.	F 692			
F 744 SS=G	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. The sample included 15 residents with two residents reviewed for dementia care. Based on record review and interviews, the facility failed to ensure staff provided person-centered care and services as related to dementia for Resident (R) 192. As a result, staff's inappropriate response to dementia-related behaviors resulted in a broken wrist for R192. Findings included: - R192 admitted to the facility on 04/13/22 and discharged on 06/24/22. The Electronic Medical Record (EMR) for R192 documented the following diagnoses: dementia with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function), encephalopathy (damage	F 744	Past noncompliance: no plan of correction required.		

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F 744	Continued From page 17 or disease that affects the brain), major depressive disorder major mood disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and Parkinson's disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement). The "Admission Minimum Data Set" (MDS) dated 04/17/22 documented R192 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R192 required extensive assistance of one staff for his activities of daily living (ADLs). The MDS recorded R192 had no behaviors during the look back period. The "ADL Care Area Assessment" dated 04/20/22 documented R192 needed help with ADLs and mobility. R192 had poor safety awareness, poor decision-making skills, poor strength/endurance, muscle weakness, impaired balance, and impaired mobility. Contributing factors include deconditioning, Parkinson's disease with Lewy body dementia and encephalopathy. Factors that placed him at risk included poor safety awareness, impaired balance, impaired mobility, and gait difficulty. The "Mood CAA" dated 04/20/22 documented R192 was significantly more depressed than his last stay in the health center. R192 reported feeling sad, having trouble concentrating, speaking slower, and having thoughts he would be better off dead all of these on most days. R192 reported feeling tired and feeling bad about himself about half the time. R192 was not as	F 744			

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F 744	Continued From page 18 functional or helpful as he once was. R192 felt he had no purpose and thought of no longer being alive would lessen him being a burden to his spouse. R192 would never do anything to harm himself because he did not believe in that. R192's "Care Plan" initiated on 04/15/22 recorded R192 required extensive assistance of one person for personal hygiene. The care plan problem dated 04/15/22 listed R192 was at risk for impaired communication. An intervention dated 04/15/22 directed staff to allow adequate time for the resident's response, incorporate alternate of communication such as music, song, or visual demonstration and directed staff to incorporate visual prompting, cues, or gestures. It further directed staff to minimize environmental stimuli, and provide clear, simple instructions. R192's "Care Plan" recorded an intervention dated 05/02/22 which directed staff to converse with the resident while providing cares. R192's "Care Plan" lacked direction to staff, prior to incident on 05/15/22, with regards to dementia related behaviors or resident centered interventions on redirection. A "Behavior Note" dated 04/18/22 documented R192 had aggressive behaviors and was noncompliant with everything. He was delusional and combative with staff and required one to one supervision. A "Physician Note" dated 04/19/22 recorded R192 had debility (physical weakness, especially as a result of illness) and dementia and staff were directed to continue supportive care. The note lacked mention of behaviors, delusions, or aggression.	F 744			

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F 744	Continued From page 19 A "Behavior Note" dated 04/19/22 at 01:23 AM recorded R192 was combative when staff attempted to redirect. At 11:30 PM, R192 tried to crawl out of bed, staff assisted him back to bed, and R192 was unhappy. He accepted several sips of thickened water. A "Behavior Note" dated 04/19/22 at 01:29 AM recorded R192 was almost out of bed. When staff tried to reposition him, he hit the aide's hand during the process. R192 was asking about his relative and not making sense when he spoke. He stated he was ok. The note recorded R192 was on frequent checks due to a risk for falls and had visual hallucinations (perception of having seen something that was not actually there). The record lacked evidence of physician notification. A "Behavior Note" dated 04/22/22 at 09:40 PM recorded R192 was verbally and physically abusive to staff and noted hitting and kicking behaviors while staff tried to provide cares. He insisted he could take care of himself. R192 cursed and refused to be moved by placing his feet hard on the floor so staff were unable to move the wheelchair. A "Behavior Note" dated 04/22/22 at 09:54 PM documented R192 exhibited psychotic (mental disorder characterized by a disconnection from reality) behaviors such as seeing people in his room and imagining things that were not true. The record lacked evidence of physician notification. A "Physician Note" dated 04/26/22 recorded R192 had debility dementia and directed to continue supportive care. The note lacked mention of	F 744			

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F 744	Continued From page 20 behaviors, hallucinations, or psychotic episodes. An "Incident Note" dated 05/15/22 recorded R192 was complaining of "pressure" on his right wrist after an incident with the [unidentified] aid. At about 06:00 AM the aide tried to clean the resident's face when the resident grabbed her hand. He told the aide to go away but held on to her hand. The aide asked the resident to let go, but he did not. The aide then got ahold of the resident's right arm and, as she tried to free her hand, the aid heard a pop at the resident's wrist. The resident stated that he had no pain unless he tried to twist his hand. There was mild redness at the wrist. Staff notified the physician and received an order for an x-ray (diagnostic picture) of the right forearm. An "Incident Note" dated 05/15/22 recorded R192 denied pain, but reported pressure and stated it hurt to rotate his wrist out, and his pinkie finger was bothering him. Staff advised R192 not to move the hand. Staff asked R192 if he was afraid of his caregivers and he stated that he was not. The note further documented when staff asked R192 if he felt that it [no further explanation noted] was under malicious intent, R192 stated that it was "lack of education and experience." The X-ray was completed and R192 went to breakfast. Upon receipt of the report, the physician was notified as well as Administrative Nurse D. Staff received a new order to send R192 to the emergency room (ER). The "General Diagnostic" radiology (x-ray) report dated 05/15/22 for R192 documented an acute spiral type of fracture with 1-millimeter displacement and minimal angulation. nondisplaced fracture of the right distal ulna (wrist	F 744			

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F 744	Continued From page 21 bone). The "Facility Investigation" dated 05/19/22 documented R192 admitted to the facility for short term rehabilitation. He had diagnoses of Parkinson's disease and Lewy body dementia. The investigation recorded R192 had a history of being combative with team members during cares. The investigation recorded at approximately 06:00 AM on 05/15/22 Certified Nurse Aid (CNA) M went into R192's room to assist him to the restroom; R192 said he did not need to use the bathroom and did not need any help. CNA M noted saliva dripping from R192's mouth so she grabbed a tissue to assist him. R192 grabbed CNA M's arm and commanded her to get out. CNA M told R192 she would be glad to leave if R192 would let go of her arm. The investigation recorded CNA M asked R192 to let go three times, and each time R192 grabbed her harder and yelled louder for to leave. CNA M reached for R192's hand to try to pry it off hers and she heard a "popping" noise. The CNA then went to notify Licensed Nurse (LN) I. The investigation further documented LN I asked R192 what happened and R192 told LN I "she broke it." The "Witness Statement" from CNA M recorded she went to the resident's room to offer him the toilet because earlier that morning he had refused. R192 said "no" he did not need to go, and he did not need CNA M's help. CNA M recorded she noted saliva falling from R192's mouth. She grabbed a tissue to clean it and R192 grabbed her hand and told her to get out. CNA M documented she told R192 she just wanted to clean his face and help him to the bathroom because he did not go earlier, but also told him	F 744			

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F 744	Continued From page 22 he did not have to. CNA M recorded she told R192 to let go of her hand and she would leave and R192 tightened his grip. CNA M then told R192 he was hurting her arm and to let her go. R192 continued to squeeze harder so CNA M grabbed R192's hand and fingers to pry R192's hand away while CNA M pulled her arm back. During this action, CNA recorded she heard R192's s wrist pop. In an interview with CNA M on 08/04/22 at 01:50 PM, she stated on 05/15/22 she went in to R192's room to ask if R192 needed to go to the bathroom. R192 was in his wheelchair with his back towards her. As CNA M approached R192, she noticed he had saliva drooling from his mouth. CNA M then went into the bathroom to grab a washcloth to wipe the saliva from R192's mouth. CNA M said while attempting to wipe R192's mouth, she must have startled R192, and R192 grabbed her arm and told her to get out of his room. CNA M stated she repeatedly asked R192 to let go of her arm. R192 continued to grip her arm tighter, so she took her other hand and tried to pry R192's fingers loose from her arm. As she tried to pry R192's fingers off of her arm, both R192 and CNA M heard a pop. CNA M stated R192 had never acted this way before this incident. CNA M stated after the incident she immediately went and told the nurse about the incident. CNA M said she was suspended immediately and upon return to work, was educated on dementia training and how to handle a combative resident. CNA M stated she had dementia training/education when she was hired in 2020 and the facility did dementia training annually. CNA M stated the incident on 05/15/22 all happened so fast. CNA M said she felt she should have tried to calm him down before she	F 744			

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F 744	Continued From page 23 attempted to pry him hand off her arm. On 08/04/22 at 02:18 PM CNA N stated she had completed dementia training/education. She said the Administrative Nurse D provided educational sheets on dementia care recently. CNA N stated she had never taken care of R192. On 08/04/22 at 03:50 PM Licensed Nurse (LN) G stated R192 had some behaviors while he was at the facility and usually, they were mild in nature. She completed dementia training annually as required and Administrative Nurse D occasionally passed out dementia education pamphlets to staff to review. On 08/04/22 at 04:23 PM Administrative Nurse D stated she became aware of the incident that happened with R192 and CNA M on 05/15/22, but was not in the facility at the time it happened. Administrative Nurse D stated CNA M was educated on dementia training, and how to care for a combative resident. The facility also held a mandatory staff meeting after the incident for the dementia education. R192 had been known to have some behaviors while he was a resident. The facility did not provide a policy for dementia care. The facility failed to ensure person centered care and services related to dementia and dementia related behaviors for R192, who had a history of aggressiveness and combativeness. As a result, staff 's inappropriate response to R192's dementia-related behaviors resulted in a wrist fracture for R192. On 05/16/22 the facility implemented the following	F 744			

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F 744	Continued From page 24 corrective actions: Staff education on the following topics: How to respond too Combative Behavior in Dementia How to respond to Anger and Aggression in Dementia Understanding challenging Behaviors in Dementia The Difference Between Alzheimer's and Dementia Stages and Progression Lewy Body Dementia R192's plan of care was updated with resident-specific interventions that addressed his behaviors. The deficient practice, corrected prior to the survey, was cited as past noncompliance.	F 744			
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 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	F 880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2022
NAME OF PROVIDER OR SUPPLIER CLARIDGE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 8101 MISSION ROAD PRAIRIE VILLAGE, KS 66208		
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F 880	Continued From page 25 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. §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	F 880			

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F 880	Continued From page 26 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 44 residents. The sample included 15 residents. Based on observation, record review and interview, the facility failed to ensure the catheter bag of resident (R)39 was kept off the floor. The facility failed ensure that clean laundry was covered while being delivered to resident rooms and clean laundry was kept off the floor. These deficient practices placed the residents at risk for increased infection and transmission of communicable disease. Findings included: - On 08/02/22 at 09:1 AM staff propelled the clean laundry/linens cart down the hallway uncovered. - On 08/02/22 at 09:44 PM R39 laid in bed. His catheter bag laid on the floor in his room. - On 08/03/22 09:14 AM a bag of clean hospital gowns and bed pads sat on floor right outside of R14's room. - On 08/04/22 at 02:08 PM Housekeeping Staff U stated that any clean laundry transported on or in a cart from the basement up to resident rooms should be covered. Bags of clean linen should never be put on the floor.	F 880			

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F 880	Continued From page 27 In ann interview on 08/04/22 at 02:18 PM, Certified Nurse Aide (CNA) P stated the catheter should never be on the floor. It should be hung on the side of the bed away from the door. In an interview 08/04/22 at 02:23 PM, Licensed Nurse (LN) H stated the catheter bag should never touch the floor. If a catheter bag had been on the floor the bag should be changed. On 08/04/22 at 4:23 PM Administrative Nurse D stated the catheter bag should never be on the floor, the bag should be changed if found on the floor. The facility "Housekeeping and Laundry Quality and Service" policy reviewed 7/10/12 lacked any documentation regarding the transporting of clean linens. The facility failed to ensure R39's catheter bag was kept off the floor. The facility failed to ensure that clean laundry was covered while being delivered and clean laundry was kept off the floor. This placed facility residents at increased risk for infection and transmission of communicable disease.	F 880			