

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

PRINTED: 10/03/2022  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175355</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/19/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN COMMUNITY OF JOHNSON COUNTY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11875 S SUNSET DRIVE, SUITE 100<br/>OLATHE, KS 66061</b>                     |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 000                                                                            | INITIAL COMMENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F 000                                                                      |                                                                                                                          |                            |                                                        |
| F 550<br>SS=D                                                                    | <p>The following citations are the result of a health resurvey and complaint investigation KS00174471, KS00174475 and KS00174028.</p> <p>The 2567 was sent electronically on 10/03/22.</p> <p>Resident Rights/Exercise of Rights<br/>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights.<br/>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.<br/>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the</p> | F 550                                                                      |                                                                                                                          |                            |                                                        |

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.

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| F 550                                                                            | <p>Continued From page 1</p> <p>resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <ul style="list-style-type: none"> <li>- On 09/14/22 at 12:03 PM R15 sat in a Broda chair (special wheelchair) in the dining room. Her drink on the table was placed out of her reach. R15 sat in the dining room table from 12:03 PM to 12:25 PM with a drink she was unable to reach until staff sat down next R15 to assist her with lunch.</li> <li>On 09/14/22 at 12:14 PM Certified Nurse Aide (CNA) M stood beside R68 in the dining room as she assisted R68 with her lunch.</li> <li>On 09/19/22 at 02:01 PM Certified Medication Aide (CMA) R stated staff should sit down next to the resident that they are assisting at meals times and talk to the resident not other staff members. CMA R stated the staff try to deliver the food to everyone at the table around the same time.</li> <li>On 09/19/22 at 02:18 PM Licensed Nurse (LN) H stated staff should always sit next to the residents at meal time to encourage and assist them if needed. LN H stated the staff tried to serve everyone at the same table at the same time.</li> <li>On 09/19/22 at 04:35 PM Administrative Nurse D stated staff should sit down next to the resident</li> </ul> | F 550                                                                      |                                                                                                                          |                            |                                                        |

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| F 550                                                                            | <p>Continued From page 2</p> <p>when they assist with a meal. Administrative Nurse D stated staff should deliver every resident seated at a table their meal as close together as possible.</p> <p>The facility "Right to Dignity" policy lasted revised 01/11/17 documented staff would provide each resident with independence and dignity during dining experience regardless of the amount of assistance the resident required. Staff would sit next to the resident to assist with their meal.</p> <p>The facility failed to ensure R15, who required assistance, did not wait for long periods of time at the table without staff assistance and failed to ensure R68 was treated in a dignified manner when staff stood over the resident to assist with dining, instead of sitting next to the resident. This had the risk for an undignified dining experience. The facility identified a census of 72 residents. The sample included 18 residents with four reviewed for resident rights. Based of observations, record review, and interviews, the facility failed to provide dignified urinary catheter care while transferring R9's to the spa. The facility further failed to ensure a dignified dining experience for R15 and R68. This deficient practice placed the affected residents at risk for impaired psychosocial well-being.</p> <p>- The "Medical Diagnosis" section within R9's Electronic Medical Records (EMR) included diagnoses of urinary tract infection (UTI's), bladder obstruction, abdominal pain, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and pyelonephritis (sudden and severe inflammation of kidney due to a bacterial infection).</p> | F 550                                                                      |                                                                                                                          |                            |                                                        |

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| F 550                                                                            | <p>Continued From page 3</p> <p>R9's "Quarterly Minimum Data Set (MDS)" dated 07/18/22 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated that he had an indwelling catheter (tube placed in bladder to facilitate urine drainage). The MDS indicated that he was taking antibiotic (medication used to fight bacterial infections) medication.</p> <p>A review of R9's "Indwelling Catheter Care Area Assessment (CAA)" dated 09/20/21 noted that he was at risk for complications related to his bladder obstruction and required staff to monitor signs of infections and urine retention.</p> <p>A review of R9's "Care Plan" revised 09/12/22 revealed he had a suprapubic catheter (urinary bladder catheter inserted through the skin) placed on 09/14/21. The care plan indicated that staff were to monitor the catheter for sings of infections, flush the catheter, and provide catheter care as ordered.</p> <p>On 09/13/22 at 10:30AM R9 sat in his room. R9 reported that he often preferred to handle and empty his own catheter, but the facility provided education on hand hygiene before and after use. R9's catheter bag was observed inside a black privacy barrier (bag) located underneath his wheelchair.</p> <p>On 09/15/22 at 03:32PM staff pushed R9 in a wheelchair on the "Mount Chalet" hallway towards the spa room. R9's catheter urine collection bag hung loosely off the left side of his wheelchair with the bottom of the collection bag and the tubing dragging on the hallway floor. The bag contained visible urine with no dignity bag in place.</p> | F 550                                                                      |                                                                                                                          |                            |                                                        |

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| F 550                                                                            | Continued From page 4<br><br>In an interview completed on 09/19/22 at 02:30 PM with Certified Nurses Aid (CNA) M, she stated that even though R9 liked to empty and manage his catheter, staff were still responsible for ensuring the it was placed properly and emptied on a regular basis. She stated that the resident should always have a dignity or privacy bag in place.<br><br>In an interview on 09/19/22 at 09/19/22 at 02:40 PM Licensed Nurse (LN) G stated that R9's catheter bag should be positioned lower than the level of his bladder and should never touch a soiled surface. She stated that the residents should have two dignity/privacy bag for both the bed and the wheelchair. She stated that the catheter bag should always be covered to protect the resident's privacy.<br><br>A review of the facility's "Dignity" policy revised 01/2017 indicated that staff will refrain from any practice considered demeaning to a resident including leaving urinary catheters uncovered, refusing to comply with the resident's toileting request, or not providing privacy during clinical or personal cares.<br><br>The facility failed to provide dignified urinary catheter management while transferring R9 to the spa. This deficient practice placed R9 at risk for complications related to decreased psychosocial well-being. | F 550                                                                      |                                                                                                                          |                            |                                                        |
| F 558<br>SS=D                                                                    | Reasonable Accommodations Needs/Preferences<br>CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | F 558                                                                      |                                                                                                                          |                            |                                                        |

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| F 558                                                                            | <p>Continued From page 5</p> <p>accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 72 residents. The sample included 18 residents with two reviewed for accommodation of needs. Based of observations, record review, and interviews, the facility failed to ensure R10's Broda chair (specialized wheelchair with the ability to tilt and recline) had foot pedals/rests. This deficient practice placed R10 at risk for injuries related to the lack of foot pedals.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The "Medical Diagnosis" section within R10's Electronic Medical Records (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (inability to sleep), major depressive disorder (major mood disorder), and morbid obesity (severely overweight).</li> </ul> <p>R10's " Quarterly Minimum Data Set (MDS)" dated 07/20/22 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe cognitive impairment. The MDS indicated that she required extensive assistance from two staff to move to areas off the unit.</p> <p>A review of R10's " Falls Care Area Assessment (CAA)" dated 12/06/21 indicated that she was a</p> | F 558                                                                      |                                                                                                                          |                            |                                                        |

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| F 558                                                                            | <p>Continued From page 6</p> <p>high risk for injuries related to medication use, medical diagnoses, impaired mobility and weakness.</p> <p>R10's "Care Plan" dated 05/24/21 noted the she required extensive assistance from two staff for transfers, dressing, personal hygiene, toileting, and bathing. The care plan noted that she required a Hoyer lift (total body mechanical lift used to transfer residents) for all transfers. The care plan indicated that she utilized a pedaled Broda chair. The plan noted that R10 could propel herself around but needed assistance from staff when going to the dining room.</p> <p>On 09/15/22 at 07:55AM Certified Nurses Aid (CNA) O propelled R10 in her Broda chair from her room to the "Mount Chalet" dining hall. R10's chair had no foot pedals or foot rest and her feet were drug on the floor as staff pushed her to the dining area. R10 wore slip-on house shoes.</p> <p>In an interview on 09/19/22 at 04:30PM with CNA O, she stated that a resident's leg/feet should never drag on the floor while being propelled in the chair. She stated that the wheelchairs should have pedals for the residents to rest their legs.</p> <p>In an interview on 09/19/22 at 04:45PM, Administrative Nurse D stated that staff should never allow a resident's feet to drag or slide while being transferred or assisted with locomotion in a wheelchair. She stated that R10's current chair did not have the foot pedals, but the facility had ordered her a new chair with the pedals.</p> <p>A review of the facility's "Fall Prevention and Management Protocol" revised 02/2019 indicated that each resident's care plan will identify</p> | F 558                                                                      |                                                                                                                          |                            |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN COMMUNITY OF JOHNSON COUNTY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11875 S SUNSET DRIVE, SUITE 100<br/>OLATHE, KS 66061</b>                     |                            |                                                        |
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| F 558                                                                            | Continued From page 7<br>individualized interventions for assessed risks<br>associated with falls. The care plan noted that<br>staff will seek to identify environmental factors<br>that may contribute to falls.<br><br>The facility failed to ensure R10's Broda chair had<br>foot pedals in place to prevent R10's feet from<br>dragging on the floor when staff propelled the<br>wheelchair. This deficient practice placed R10 at<br>risk for injuries related to the lack of the foot<br>pedals.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | F 558                                                                      |                                                                                                                          |                            |                                                        |
| F 661<br>SS=D                                                                    | Discharge Summary<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident<br>must have a discharge summary that includes,<br>but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that<br>includes, but is not limited to, diagnoses, course<br>of illness/treatment or therapy, and pertinent lab,<br>radiology, and consultation results.<br>(ii) A final summary of the resident's status to<br>include items in paragraph (b)(1) of §483.20, at<br>the time of the discharge that is available for<br>release to authorized persons and agencies, with<br>the consent of the resident or resident's<br>representative.<br>(iii) Reconciliation of all pre-discharge<br>medications with the resident's post-discharge<br>medications (both prescribed and<br>over-the-counter).<br>(iv) A post-discharge plan of care that is<br>developed with the participation of the resident<br>and, with the resident's consent, the resident<br>representative(s), which will assist the resident to<br>adjust to his or her new living environment. The<br>post-discharge plan of care must indicate where | F 661                                                                      |                                                                                                                          |                            |                                                        |

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| F 661                                                                            | <p>Continued From page 8</p> <p>the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 79 residents. The sample included 18 residents. Based on record review and interviews, the facility failed to document a recapitulation of the facility stay upon discharge from the facility for Resident (R) 74, sampled for discharge. This placed R74 at risk for an interruption in the continuity of care and/or unidentified care needs.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R74's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure) and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).</li> </ul> <p>The "Annual Minimum Data Set" (MDS) dated 04/04/22 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R74 required supervision of one staff member for activities of daily living (ADL's).</p> <p>R74's " Psychotropic Drug Use Care Area Assessment" (CAA) dated 04/07/22 documented she received an antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).</p> | F 661                                                                      |                                                                                                                          |                            |                                                        |

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| F 661                                                                            | <p>Continued From page 9</p> <p>R74's "Care Plan" dated 02/02/22 documented R74 would like to be asked about returning to the community.</p> <p>Review of the EMR under "Progress Note" tab documented on 06/21/22 at 09:36 AM R74 left the facility at 09:20 AM. R74 and her representative signed the inventory form, removed R74's personal belongs and were given a copy of the community transfer form.</p> <p>The facility was unable to provide the recapitulation of R74's stay.</p> <p>On 09/19/22 at 02:08 PM Licensed Nurse (LN) H stated the charge obtained a discharge order from the physician for a resident's discharge from the facility, which would include all the resident's current orders. LN H stated the charge nurse then completed the discharge summary under the "Assessment" tab and documented the discharge under the "Progress Notes" tab.</p> <p>On 09/19/22 at 04:34 PM Administrative Nurse D stated the charge nurse on the unit obtained a physician order to discharge the resident with current medication and treatments, then notified the receiving facility of the current orders. Administrative Nurse D stated the charge nurse completed the discharge summary and recapitulation of the resident's stay at the facility.</p> <p>The facility "Move In, Transfer, and Move Out" policy last revised 11/14/17 documented staff would complete the transform form and discharge summary.</p> <p>The facility failed to document a recapitulation for R74's stay at the facility after her discharge to</p> | F 661                                                                      |                                                                                                                          |                            |                                                        |

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| F 661                                                                            | Continued From page 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | F 661                                                                      |                                                                                                                          |                            |                                                        |
| F 684                                                                            | another facility. This placed her at risk for an<br>interruption in the continuity of care and/or<br>unidentified care needs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                          |                            |                                                        |
| SS=D                                                                             | Quality of Care<br>CFR(s): 483.25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F 684                                                                      |                                                                                                                          |                            |                                                        |
|                                                                                  | <p>§ 483.25 Quality of care</p> <p>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:</p> <p>The facility identified a census of 72 residents. The sample included 18 residents with two reviewed for quality of care. Based on observations, record review, and interviews, the facility failed to follow the physician's orders to complete daily weights for Resident (R)6 and weekly weights for R17 in order to monitor for fluid retention related to heart disease. This deficient practice placed the residents at risk for complications related to heart failure.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- The "Medical Diagnosis" section within R6's Electronic Medical Records (EMR) included diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), hypertension (high blood failure), chronic kidney disease, heart failure, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), type</li> </ul> |                                                                            |                                                                                                                          |                            |                                                        |

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| F 684                                                                            | <p>Continued From page 11</p> <p>two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cardiovascular disease (any abnormal condition characterized by dysfunction of the heart and blood vessels), 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).</p> <p>R6's "Quarterly Minimum Data Set (MDS)" dated 07/14/22 noted a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS indicated no weight changes within the last six months. The MDS noted he received diuretic (medication to promote the formation and excretion of urine) medication. The MDS noted he required extensive assistance from two staff for all activities of daily living (ADL's)</p> <p>A review of R6's "Urinary Incontinence Care Area Assessment (CAA)" dated 04/19/22 indicated he was taking diuretic medication with a diagnosis of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).</p> <p>R6's "Care Plan" initiated 04/04/22 indicated that he was at risk for weight fluctuations related to his heart failure and medications. The care plan noted that R6 was on furosemide (diuretic medication) for congestive heart failure and staff were to obtain and monitor his weights as ordered. The care plan noted that he required a Hoyer Lift (total body mechanical lift used to transfer residents) and two staff for assistance with all transfers.</p> <p>A review of R6's EMR under "Physician's Orders"</p> | F 684                                                                      |                                                                                                                          |                            |                                                        |

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| F 684                                                                            | <p>Continued From page 12</p> <p>revealed an order dated 04/15/22 for staff to obtain daily weights related to his heart failure.</p> <p>A review of R6's EMR under "Medication Administration Record (MAR)" and "Tasks" between 05/01/22 through 09/15/22 (77 days reviewed) revealed 27 missed daily weight occurrences for tracking weight loss related to his heart failure.</p> <p>On 09/13/22 at 08:20AM R6 was in his room talking to his roommate. R6 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) with his feet resting on the foot pedals. He had his lower left leg foot brace on and reported that he had already ate his breakfast.</p> <p>In an interview completed on 09/19/22 at 02:30 PM with Certified Nurses Aid (CNA) M, she stated that the nurses created the daily weights list for the CNA staff to follow. She stated that the list was made based on the residents' care plan and physician orders. CNA M stated that each morning the nurse printed out a communication sheet for the CNA staff that contained the residents' required assistance levels, transfer status, weights, and individual care needs.</p> <p>On 09/19/22 at 02:51 PM Licensed Nurse (LN) G stated that the daily weight list was printed out and given to the direct care staff each morning. She said the residents were weighed based upon what their physicians order indicated. She noted that all residents were weighed monthly, but some residents may be weighed weekly or daily. She stated nurses and CNA staff could review the residents' care plans to see how a resident was transferred for weighing.</p> | F 684                                                                      |                                                                                                                          |                            |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175355</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/19/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN COMMUNITY OF JOHNSON COUNTY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11875 S SUNSET DRIVE, SUITE 100<br/>OLATHE, KS 66061</b>                     |                            |                                                        |
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| F 684                                                                            | <p>Continued From page 13</p> <p>On 09/19/22 at 04:40 PM Administrative Nurse D stated that all weights obtained should have been documented. She stated that if a resident missed a weigh-in or was not available to be weighed, the nurse should have completed a progress note showing why it was missed. She stated that it could have also been noted on the MAR.</p> <p>The facility did not provide a weight monitoring policy.</p> <p>The facility failed follow the physician's orders to complete daily weights for R6. This deficient practice placed R6 at risk for complications related to congestive heart failure and fluid overload.</p> <p>- The electronic medical record for R17 documented diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (an elevated blood pressure), and atrial fibrillation (A-fib: a rapid, irregular heartbeat).</p> <p>The "Admission Minimum Data Set" (MDS) dated 05/10/22 documented R17 had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R17 required supervision to limited assistance of one staff for her activities of daily living (ADLs). R17 received a diuretic (a medication used to promote the formation and excretion of urine).</p> <p>The "Quarterly MDS" dated 08/06/22 documented R17 had a BIMS score of two which indicated severely impaired cognition. R17 required limited assistance of one staff with her ADLs. R17 received a diuretic on seven of seven days during</p> | F 684                                                                      |                                                                                                                          |                            |                                                        |

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| F 684                                                                            | <p>Continued From page 14<br/>the lookback period.</p> <p>The "Cognition Care Area Assessment (CAA)" dated 05/10/22 documented R17 had some confusion and scored a three on her BIMS. R17 needed help at times with decision making.</p> <p>The "Falls Care Area Assessment (CAA)" dated 05/10/22 documented R17 had weakness, impaired mobility and staff assisted with all ADLs and cares as needed.</p> <p>The "Nutritional Care Plan" dated 05/12/22 directed staff to obtain and monitor weights as ordered and notify the physician of significant weight changes.</p> <p>Under the "Orders" tab, R17 had an order dated 07/05/22 for a weekly weight every Wednesday for edema.</p> <p>The "Weights/Vitals" tab for R17 documented weights on 07/07/22, 08/03/22, and 09/08/22.</p> <p>The "Treatment Administration Record (TAR)" lacked documentation for a weekly weight to be obtained.</p> <p>R17's clinical record lacked evidence a weekly weight was obtained.</p> <p>On 09/14/22 R17 laid in her bed asleep. She had her oxygen (O2) canula (a hollow tube used to deliver supplemental oxygen) on.</p> <p>On 09/19/22 at 07:51AM R17 sat in her wheelchair in her room with her O2 canula on.</p> <p>On 09/19/22 at 3:17 PM Licensed Nurse (LN) H</p> | F 684                                                                      |                                                                                                                          |                            |                                                        |

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| F 684                                                                            | Continued From page 15<br><br>stated the aides normally got the resident's weight. LN H said some of the residents did have parameters with their weights which directed when the physician should be notified if there was a significant change.<br><br>On 09/19/22 at 3:34 PM Certified Nurse Aide (CNA) P stated that the aides were responsible for obtaining the weights and the care plan should tell staff how often each resident should be weighed. CNA P said after staff obtained the weight, the weights were turned in to the nurse.<br><br>On 09/19/22 at 04:29 PM Administrative Nurse D stated that weights were normally only obtained monthly unless a resident had a specific order from the physician that required a more frequent weight. Administrative Nurse D said the nurse gave the aides a list of the residents that needed weights.<br><br>The facility failed to provide a policy addressing weights.<br><br>The facility failed to ensure R17 had a weekly weight for edema as ordered by the physician. This deficient practice put R17 at increased risk for excess weight/fluid retention and adverse side effects. | F 684                                                                      |                                                                                                                          |                            |                                                        |
| F 688<br>SS=D                                                                    | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | F 688                                                                      |                                                                                                                          |                            |                                                        |

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| F 688                                                                            | <p>Continued From page 16<br/>of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:<br/>The facility identified a census of 70 residents. The sample included 18 residents with two residents reviewed for limited range of motion (ROM). Based on observation, record review and interview the facility failed to ensure that staff obtained and applied Resident (R)66's physician ordered splint to her right hand. This placed R66 at risk for further decrease in ROM.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The electronic medical record (EMR) documented diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), hypertension (elevated blood pressure), hemiplegia (paralysis of one side of the body, and kidney failure (the kidney is no longer able to function on its own).</li> </ul> <p>The "Annual Minimum Data Set" (MDS) dated 08/14/22 documented R66 had both long and short-term memory loss. R66 required extensive assist of two staff members for her activities of daily living (ADLS). R66 required the use of a wheelchair for mobility. R66 had one fall since the</p> |                                                                            |  | F 688                                                                                                |                                                                                                                          |                                                        |                            |

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| F 688                                                                            | <p>Continued From page 17<br/>last assessment.</p> <p>The "Fall Care Area Assessment" (CAA) dated 08/20/22 documented R66 was at the facility for long-term care service care with a history of acute kidney failure. Staff anticipated and met R66's needs, followed facility fall protocol in the event of a fall, and provided a safe environment.</p> <p>The "ADL Care Plan" dated 11/23/21 for R66 directed staff that R66 was to wear a resting splint on her right hand with a pillow to elevate. Team member should place splint to R66's right hand for up to three hours every morning as tolerated making sure it was snug but not tight. Staff were to check skin integrity when splint was applied and removed. R66 also wore a compression glove to her right hand to decrease edema that was to be applied in the morning and removed at night. R66 used an arm tray for her right arm to rest on when she was up in her wheelchair to help elevate her right arm and decrease edema.</p> <p>Under the "Orders" tab in the EMR R66 had an order dated 05/18/22 to place resting splint to right hand for up to three hours every morning as tolerated to decrease risk of contracture (an abnormal permanent fixation of a joint).</p> <p>On 09/14/22 at 07:48 AM an observation revealed a sign taped to R66's wall next to her bed that said "Apply resting splint to right hand for three hours in the morning. Apply edema splint under if edema present."</p> <p>On 09/14/22 at 08:52 AM R66 sat in her wheelchair in her room watching tv, her right arm rested on the arm tray attached to her wheelchair.</p> | F 688                                                                      |                                                                                                                          |                            |                                                        |

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| F 688                                                                            | <p>Continued From page 18</p> <p>R66's resting splint was not present on R66's right hand. Further observations revealed R66 did not wear the splint during the AM hours on this date.</p> <p>On 09/15/22 at 08:47 AM R66 did not wear her splint. R66 stated that she had not had her splint since she returned from the hospital on 09/02/22 and she had told staff that it was missing. R66 further stated that she was unsure if the facility ordered or tried getting her a new one.</p> <p>On 09/19/22 at 3:15PM Licensed Nurse (LN) H stated as far as she knew, R66 had her splint on everyday in the morning. LN H was not aware that if the splint was missing.</p> <p>On 09/19/22 at 3:34 PM Certified Nurse Aide (CNA) P stated that R66 should wear her splint in the morning for three hours but R66's splint was missing since she returned from the hospital.</p> <p>On 09/19/22 at 4:29 PM Administrative Nurse D stated she was aware that R66 had not had her splint for her right hand since her return from the hospital; the facility ordered R66 a new one that had not arrived yet.</p> <p>The facility policy for splint application was not provided by the facility.</p> <p>The facility failed to ensure the splint was available and applied to R66's right hand which placed R66 at risk for development of contractures and further loss of use of her right hand.</p> | F 688                                                                      |                                                                                                                          |                            |                                                        |
| F 689<br>SS=D                                                                    | <p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F 689                                                                      |                                                                                                                          |                            |                                                        |

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| F 689                                                                            | <p>Continued From page 19</p> <p>§483.25(d) Accidents.<br/>The facility must ensure that -<br/>§483.25(d)(1) The resident environment remains<br/>as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate<br/>supervision and assistance devices to prevent<br/>accidents.<br/>This REQUIREMENT is not met as evidenced<br/>by:<br/>The facility identified a census of 72 residents.<br/>The sample included 18 residents with five<br/>residents reviewed for accidents. Based on<br/>observation, record review and interview the<br/>facility failed to ensure resident (R)36's bed was<br/>placed at a safe level while occupied. The facility<br/>failed to ensure R67 was transferred with the<br/>required assistance as directed in the plan of<br/>care. This deficient practice placed R36 and R67<br/>at risk for accidents and related injuries.</p> <p>Findings included:</p> <p>-The electronic medical record for R36<br/>documented diagnoses of obstructive and reflux<br/>uropathy (obstruction prevents flow of urine),<br/>benign prostatic hyperplasia (BPH-a<br/>non-cancerous enlargement of the prostate which<br/>can lead to interference with urine flow, urinary<br/>frequency and urinary tract infections), spinal<br/>stenosis (a degenerative condition of the spine<br/>that could cause weakness and loss of use of<br/>extremities), and malignant neoplasm of prostate<br/>(a cancerous tumor of the prostate).</p> <p>The "Annual Minimum Data Set "(MDS) dated<br/>04/12/22 documented R36 had a Brief Interview<br/>for Mental Status (BIMS) score of 14 which</p> | F 689                                                                      |                                                                                                                          |                            |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175355</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/19/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN COMMUNITY OF JOHNSON COUNTY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11875 S SUNSET DRIVE, SUITE 100<br/>OLATHE, KS 66061</b>                     |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 689                                                                            | <p>Continued From page 20</p> <p>indicated intact cognition. R36 required extensive assistance of one to two staff members for his activities of daily living (ADLs). R36 had no history of falls.</p> <p>The "Quarterly MDS" dated 07/09/22 documented R36 had a BIMS score of 14. R36 required extensive assistance of one to two staff for ADLs. R36 had no history of falls since the prior assessment.</p> <p>The "Fall Care Area Assessment" (CAA) dated 04/14/22 for R36 documented weakness and impaired mobility. R36 was at risk for falling. Staff assisted R36 with all ADLs and cares. R36 used a wheelchair for mobility.</p> <p>The "ADL Care Plan" revised 09/09/22 documented R36 had quarter rails on the bed to assist with repositioning and transfers. R36 needed assistance of one for his ADLs and transfers and if R36 was tired or weak, he may need assistance of two. The care plan lacked information regarding any documented preference for R36 to have his bed in the highest position.</p> <p>A 07/22/22 a "Fall Risk Assessment" documented a score of 13 which indicated moderate risk.</p> <p>On 08/05/22 at 07:55 AM a "Health Status Note" documented R36 was confused at night, kept singing and was ready to get up and go to work. No agitation noted.</p> <p>On 8/17/22 at 06:44 AM a "Health Status Note" documented R36 was singing at night in his sleep. R36 stated that he was experiencing weird dreams at night. He also felt like he was in a</p> | F 689                                                                      |                                                                                                                          |                            |                                                        |

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| F 689                                                                            | <p>Continued From page 21<br/>different place.</p> <p>On 09/13/22 at 01:35 PM observation revealed R36 laid in his bed. The bed was in the high position (equal to or greater than three feet high). R36 said he did not request his bed to be left in the high position, but he was "ok" with it.</p> <p>On 09/14/22 at 09:00AM R36 laid in bed asleep; his bed height was at a level equal to three feet or less.</p> <p>On 09/15/22 at 07:16 AM R36 laid in bed resting; his bed was at the high position.</p> <p>On 09/19/22 at 02:38 PM Licensed Nurse (LN) H stated the height of the bed should be at a knee to thigh high level while occupied. LN H said a resident's bed should not normally be in real high position, but R36 has been known to move his bed up to a high level. R36 had been educated on the risk of falling when his bed was in a high position.</p> <p>On 09/19/22 at 3:34 PM Certified Nurse Aide (CNA) P stated that at times R36 moved his bed height into a high raised position; staff had talked with R36 about the potential risk of him falling due to the bed being so high.</p> <p>On 09/19/22 at 4:29PM Administrative Nurse D stated that the bed height really depended on the resident's preference and the bed height should not be high in the air. Administrative Nurse D said some residents liked the bed to be at a height where their feet touch the floor while sitting on the bed. She further stated R36 did raise his bed to a high position now and then and R36 had been told about the risk of falling when his bed was that</p> | F 689                                                                      |                                                                                                                          |                            |                                                        |

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| F 689                                                                            | <p>Continued From page 22<br/>high.</p> <p>The facility policy "Fall Prevention and Management Protocol updated 02/23/19 documented that each resident would be assessed for the risk factors for falling at move in, return from a health care facility and after a fall in the neighborhood. The interdisciplinary team (IDT) will develop a plan for care with interventions that would reduce the resident's risk for falls. The plan would include specific information about the resident's routine and personal habits that may place the resident at risk for falls.</p> <p>The facility failed to ensure that R36's bed was maintained at an safe level. This deficient practice placed R36 at risk of an injury related to falls.</p> <p>- R67's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of difficulty walking, cognitive communication deficit, muscle weakness, hemiplegia (paralysis of one side of the body) affecting left nondominate side, depending on other enabling machines and devices.</p> <p>The "Annual Minimum Data Set" (MDS) dated 01/29/22 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R67 required extensive assistance of two staff members for transfers. The MDS documented walking and moving from a seated to a standing position did not occur during the look back period for R67.</p> <p>The "Quarterly MDS" dated 07/23/22 documented a BIMS score of 15 which indicated intact</p> | F 689                                                                      |                                                                                                                          |                            |                                                        |

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| F 689                                                                            | <p>Continued From page 23</p> <p>cognition. The MDS documented that R67 was totally dependent on two staff members for transfers. The MDS documented walking and moving from a seated to a standing position did not occur during the look back period for R67.</p> <p>R67's "Fall Care Area Assessment" (CAA) dated 02/03/22 documented R67 had impaired mobility, weakness, and medications which increased his risk for falls. Staff assisted R67 with all his cares as needed. R67 had impaired mobility, weakness, use of an antidepressant, and risk for falling.</p> <p>R67's "Care Plan" last revised 10/13/21 directed staff he required assistance of two staff members and a Hoyer (total body mechanical lift) lift for transfers.</p> <p>On 09/14/22 12:12 AM Certified Nurse Aide (CNA) O and Licensed Nurse (LN) J left the Hoyer lift in the hallway out side R67's door. Staff entered the room to dress R67 prior to transfer into his wheelchair.</p> <p>On 09/14/22 at 12:26 PM LN O exited R67's room and stated R67 was in his wheelchair. LN O stated he walked R67 to the wheelchair and staff did not use the Hoyer lift. Observation revealed R67 sat upright in a wheelchair next to the bedside table.</p> <p>On 09/15/22 at 03:40 PM CNA N stated she was the restorative aide and was currently worked with R67 for strengthening and walking. CNA N stated not all staff had been trained for safe transferring without the use of the Hoyer for R67.</p> <p>On 09/19/22 at 02:01 PM Certified Medication Aide (CMA) R stated the care plan contained the</p> | F 689                                                                      |                                                                                                                          |                            |                                                        |

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| F 689                                                                            | <p>Continued From page 24</p> <p>information for how to care for each resident and how much assistance each resident required for activities of daily living (ADLs). CMA R stated staff should follow the care plan for safety. CMA R stated staff were able to view the care plan on the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change).</p> <p>On 09/19/22 at 02:18 PM LN H stated all staff had access to the care plan on the Kardex and the nurses could make changes to the care plan when needed. LN H stated the staff refer to the care plan to find out how much assistance was needed for each resident.</p> <p>On 09/19/22 at 04:34 PM Administrative Nurse D stated staff had access to the care plan from the Kardex on the computer to review the assistance each resident need for their ADL's. Administrative Nurse D stated therapy assessed the resident for safety related to transfers.</p> <p>The facility "Fall Prevention and Management Protocol" policy last revised 02/23/19 documented each resident would be assessed for the risk factors for falling at move in, return from a health care facility and after a fall in the neighborhood. The interdisciplinary team (IDT) will develop a plan for care with interventions that would reduce the resident's risk for falls. The plan would include specific information about the resident's routine and personal habits that may place the resident at risk for falls. Each resident would be assessed after each fall by a licensed nurse. The nurse will attempt to identify the cause of the fall and document in the nursing notes. The</p> | F 689                                                                      |                                                                                                                          |                            |                                                        |

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| F 689                                                                            | Continued From page 25<br>staff would seek to identify environmental factors that may contribute to falls. The plan of care would be reviewed, and a new intervention would be added to help prevent future falls if indicated. The IDT would review the fall in the Risk Meeting for two weeks to ensure appropriate interventions were working to help prevent falls.<br><br>The facility failed to follow the care plan for transfers for R67, which placed him at risk of injury from falls.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F 689                                                                      |                                                                                                                          |                            |                                                        |
| F 690<br>SS=D                                                                    | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(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;<br>(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;<br>and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to | F 690                                                                      |                                                                                                                          |                            |                                                        |

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| F 690                                                                            | <p>Continued From page 26</p> <p>prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 72 residents. The sample included 18 residents with two reviewed for urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) care. Based on observations, record review, and interviews, the facility failed to provide care and services required for catheter care for Residents (R) 9 and R36. This deficient practice placed both residents at risk for complications related to urinary tract infections and catheter related complication.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- The "Medical Diagnosis" section within R9's Electronic Medical Records (EMR) included diagnoses of urinary tract infection (UTI's), bladder obstruction, abdominal pain, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and pyelonephritis (sudden and severe inflammation of kidney due to a bacterial infection).</li> </ul> <p>R9's "Quarterly Minimum Data Set (MDS)" dated 07/18/22 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated that he had an indwelling catheter.</p> | F 690                                                                      |                                                                                                                          |                            |                                                        |

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| F 690                                                                            | <p>Continued From page 27</p> <p>The MDS indicated that he was taking antibiotic (medication used to fight bacterial infections) medication.</p> <p>A review of R9's "Indwelling Catheter Care Area Assessment (CAA)" dated 09/20/21 noted that he was at risk for complications related to his bladder obstruction and required staff to monitor signs of infections and urine retention.</p> <p>A review of R9's "Care Plan" revised 09/12/22 revealed he had a suprapubic catheter (urinary bladder catheter inserted through the skin) placed on 09/14/21. The care plan indicated that staff were to monitor the catheter for sings of infections, flush the catheter, and provide catheter care as ordered.</p> <p>A review of R9's "Health Status" note dated 05/06/22 indicated that he acquired a MRSA (Methicillin-resistant Staphylococcus aureus- a type of bacteria resistant to many antibiotics) in his urine and took Macrobid (antibiotic medication).</p> <p>A "Health Status" note dated 08/28/22 indicated that R9's catheter became clogged and was replaced.</p> <p>On 09/06/22 a "Health Status" note indicated that R9 complained that his catheter needed to be flushed because it was hurting. The note indicated that staff attempted to flush the tubing without success and the catheter had to be removed. The note stated that once the catheter was removed a large amount of urine drained from the ostomy site (surgical opening in the abdominal wall). The note indicated that the catheter was reinserted with immediate urine flow</p> | F 690                                                                      |                                                                                                                          |                            |                                                        |

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| F 690                                                                            | <p>Continued From page 28</p> <p>into the tubing with R9 expressing immediate relief.</p> <p>On 09/10/22 a "Status Note" indicated that staff identified "thick looking urine" and completed a urinalysis.</p> <p>On 09/12/22 R9's "Health Status" notes indicated positive culture of bacteria in his urine and he was started on antibiotics for seven days.</p> <p>On 09/15/22 at 03:32PM staff pushed R9 in a wheelchair on the "Mount Chalet" hallway towards the spa room.</p> <p>R9's catheter bag was loosely hanging off the left side of his wheelchair with the bottom of the collection bag and the tubing dragging on the hallway floor. The bag contained visible urine with no dignity bag in place.</p> <p>In an interview completed on 09/19/22 at 02:30 PM with Certified Nurses Aid (CNA) M, she stated that even though R9 liked to empty and manage his indwelling catheter, staff were still responsible for ensuring the it was placed properly and emptied on a regular basis. She stated that the facility did not track output on urinary catheters. She stated that the urinary catheter bags should be positioned below the resident's bladder and never should touch the floor or soiled surfaces.</p> <p>In an interview on 09/19/22 at 04:05PM with Administrative Nurse E, she stated that the facility recently has increased training towards ensuring infection control practices are being followed to prevent infections from poor hand hygiene and cares provided to the residents. She stated that staff should have ensured that the catheter never touched the ground and was placed properly.</p> | F 690                                                                      |                                                                                                                          |                            |                                                        |

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| F 690                                                                            | <p>Continued From page 29</p> <p>A review of the facility's "Catheter Care" policy (no revision date) indicated that catheter care will be provided to all residents with indwelling catheter as least twice daily. The policy noted that the purpose of catheter care is to prevent possible urinary tract infections from bacteria spreading into the bladder. The policy noted that staff were to monitor for signs of UTI's, blockages within the tubing, and placement of the tubing and catheter bag.</p> <p>The facility failed to provide sanitary urinary catheter care for R9, who had a history of UTI. This deficient practice placed both residents at risk for complications related to urinary tract infections and catheter related complication.</p> <p>-The electronic medical record for R36 documented diagnoses of obstructive and reflux uropathy (obstruction prevents flow of urine), benign prostatic hyperplasia (BPH-a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), spinal stenosis (a degenerative condition of the spine that could cause weakness and loss of use of extremities), and malignant neoplasm of prostate (a cancerous tumor of the prostate).</p> <p>The "Annual Minimum Data Set "(MDS) dated 04/12/22 documented R36 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R36 required extensive assistance of one to two staff members for his activities of daily living (ADLs). R36 required the use of an indwelling catheter for urinary continence. R36 had no history of falls.</p> | F 690                                                                      |                                                                                                                          |                            |                                                        |

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| F 690                                                                            | <p>Continued From page 30</p> <p>The "Quarterly MDS" dated 07/09/22 documented R36 had a BIMS score of 14. R36 required extensive assistance of one to two staff for ADLs. R36 required the use of an indwelling catheter for urinary continence. R36 had no history of falls since the prior assessment.</p> <p>The "Urinary Catheter Care Area Assessment" (CAA) dated 04/14/22 for R36 documented weakness and impaired mobility. R36 had a Foley catheter in place which place him at risk for infection. Staff managed all cares.</p> <p>The "Catheter Care Plan" revised 07/20/21 directed staff that R36 had a 16 French (fr) 10 cubic centimeters (CC)Foley catheter. A licensed nurse would change the catheter every month and as needed. Position the catheter bag and tubing below the level of the bladder. Change the urinary leg bag and bedside drainage bag every seven days on Sunday night and as needed. Monitor/record/report to the physician for signs and symptoms of urinary tract infection (UTI) such as: blood tinged urine, cloudiness, and no urine output.</p> <p>The July "Treatment Administration Record" (TAR) documented orders dated 06/27/22 to change urinary leg bag and bedside drainage bag every seven days on Sunday night and as needed due to catheter.</p> <p>The July TAR documented an order dated 12/15/21 for a catheter 16 fr 10 cc. Change every month and as needed every evening shift on the 16th of the month for infection prevention.</p> <p>The clinical record lacked documentation staff monitored urine output.</p> | F 690                                                                      |                                                                                                                          |                            |                                                        |

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| F 690                                                                            | <p>Continued From page 31</p> <p>On 07/15/22 at 10:00 AM a "Health Status Note" documented R36 had complaints of pain down in lower umbilical area stated it may be around catheter area. Staff noted the catheter drainage bag was empty. The nurse had not received report of no urine output for R36. Staff attempted to reach the night shift Certified Nurse Aid (CNA) but were unable. The nurse changed the catheter with no comfort or relief noted. The morning nurse received report of the issue and was advised of R36's baseline and that he may need to be sent to the hospital after an assessment.</p> <p>On 07/15/22 at 11:47 AM a "Health Status Note" documented the nurse assisted with trouble shooting the lack of urine output. The nurse received report that the catheter had just been changed by the night shift nurse and irrigated with but still had no urine output. The resident was uncomfortable with a visibly distended abdomen. Bladder irrigation was performed with two to three cubic centimeters (cc) of sterile water, which caused the resident to be in increased discomfort. The catheter balloon was emptied, and the catheter was repositioned. Urine was visualized in the catheter tubing and approximately 500-600 ccs of urine drained and the resident verbalized relief. Emergency Medical Services (EMS) arrived on scene; R36 verbalized a desire to stay at the facility and not go to hospital.</p> <p>On 07/15/2022 06:15 PM a "Health Status Note" documented at approximately 06:00 PM the nurse sent R36 out via EMS to be further evaluated due to the resident's complaints of abdominal pain and unstable vital signs. The nurse noted 1250 cc of output of urine from</p> | F 690                                                                      |                                                                                                                          |                            |                                                        |

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| F 690                                                                            | <p>Continued From page 32</p> <p>resident's Foley catheter. This nurse administered as needed pain medication but the medication was not effective in treating the resident's abdominal pain almost one hour after administration. The nurse notified the doctor and family and called EMS to transport the resident to the hospital. The resident left the facility at 06:15 PM via stretcher with EMS to the hospital.</p> <p>A "Physician's Report" dated 09/07/22 documented R36 had several UTIs since April 2022 (April, July, August).</p> <p>On 09/13/22 at 07:55 AM an R36 laid in his bed, the bed was in a high position (equal to or greater than three feet high). R36's catheter bag that hung from his bed was visibly full of urine.</p> <p>On 09/15/22 at 12:01 AM R36 laid in bed. His catheter bag was in a shopping bag on the floor.</p> <p>On 09/19/22 at 01:35 PM Certified Medication Aide (CMA) R stated that the facility does not record the urine output on residents with a catheter unless there is a specific order from the physician. Staff should be checking the urine output from the catheter frequently throughout the shift and report any excessive or decrease output to the nurse.</p> <p>On 09/19/22 at 02:38 PM Licensed Nurse (LN) H stated that typically the facility does not keep track of urine output on residents with a catheter unless there was a specific order from their physician to do so.</p> <p>On 09/19/22 at 04:29 PM Administrative Nurse D stated that as a rule the facility generally did not document or keep a record of a resident's urine</p> | F 690                                                                      |                                                                                                                          |                            |                                                        |

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| F 690                                                                            | Continued From page 33<br>output. Administrative Nurse D said she expected the aides to let the nurse know if a resident had a change in the amount of urine output noted.<br><br>On 09/19/22 at 05:43 PM Administrative Nurse F stated that the night shift nurse on 07/14/22 changed R36's catheter, but had not been made aware that R36 had no urine output until later that morning when she went to assist with reinserting/adjust R36's catheter. R36 had complaints of discomfort and his abdomen was distended. EMS was called initially but R36 did not want to go. The facility did not keep a record of urine output for the residents that have a catheter unless a physician specifically asked for one.<br><br>A review of the facility's "Catheter Care" policy (no revision date) indicated that catheter care will be provided to all residents with indwelling catheter as least twice daily. The policy noted that the purpose of catheter care is to prevent possible urinary tract infections from bacteria spreading into the bladder. The policy noted that staff were to monitor for signs of UTI's, blockages within the tubing, and placement of the tubing and catheter bag.<br><br>The facility failed to provide adequate care and services related to R36's catheter which resulted in no urine output for many hours and subsequently R36 required treatment at the hospital. The deficient practice placed R36 at risk for infection or further urinary problems. | F 690                                                                      |                                                                                                                          |                            |                                                        |
| F 692<br>SS=D                                                                    | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | F 692                                                                      |                                                                                                                          |                            |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175355</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                 |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/19/2022</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN COMMUNITY OF JOHNSON COUNTY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11875 S SUNSET DRIVE, SUITE 100<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |                            |
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| F 692                                                                            | <p>Continued From page 34</p> <p>(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-</p> <p>§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;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§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:</p> <p>The facility identified a census of 72 residents. The sample included 18 residents which two residents reviewed for hydration. Based on observation, record review, and interviews, the facility failed ensure fluids were available within reach for Resident (R) 68, which placed her at risk of dehydration and adverse consequences.</p> <p>Findings included:</p> <p>- R68's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), lack of coordination, and need for personal care.</p> |                                                                            |  | F 692                                                                                                |                                                                                                                          |                                                        |                            |

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| F 692                                                                            | <p>Continued From page 35</p> <p>The "Admission Minimum Data Set" (MDS) dated 03/27/22 documented a Brief Interview of Mental Status (BIMS) score of 99, staff interview documented moderately impaired cognition. The MDS documented that R68 required supervision of one staff member assistance for consumption of nourishment and fluids. The MDS documented R68 pocketed food in her mouth during the look back period.</p> <p>The "Quarterly MDS" dated 06/23/22 documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R68 required extensive assistance of one staff member to provide nourishment and fluids. The MDS documented R68 pocketed food in her mouth during the look back period.</p> <p>R68's "Activities of Daily Living [ADLs] Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 03/31/22 documented she required assistance for ADL's.</p> <p>R68's "Care Plan" dated 03/08/22 directed staff to keep a blue coffee cup with a lid and straw with ice water at her bedside; R68 did better with lighter weight cups.</p> <p>Review of the EMR under the "Orders" tab revealed and order for regular diet with regular texture dated 03/21/22.</p> <p>On 09/15/22 at 07:34 AM R68 laid on her right side on the bed with her eyes closed. R68's water cup was on the bedside table located across the room by the recliner and out of reach of R68.</p> <p>On 09/15/22 at 11:28 AM R68 sat in a wheelchair in her room and watched TV. R68's water cup</p> | F 692                                                                      |                                                                                                                          |                            |                                                        |

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| F 692                                                                            | <p>Continued From page 36</p> <p>was located on the bedside table out of reach.</p> <p>On 09/19/22 at 08:34 AM R68 laid on the bed with her water cup on the bedside table which was pushed up against the wall out of her reach.</p> <p>On 09/19/22 at 03:11 PM Licensed Nurse (LN) I stated every resident should be offered the fluids of their choice. LN I stated residents should not be forced to drink fluids. LN I stated fluids of their choice should be in reach of the resident when in their rooms.</p> <p>On 09/19/22 at 03:36 PM Certified Nurses Aide (CNA) N stated fluids of the resident's choice should be offered at meals. CNA N stated several cups should be offered to each resident or refilled after the resident had consumed the fluids. CNA N stated their water pitcher or fluids should be in reach when the resident was in their room.</p> <p>On 09/19/22 at 04:34 PM Administrative Nurse D stated the resident should be offered the drinks of their choice. Administrative Nurse D stated the care plans should document the resident's favorite beverage. Administrative Nurse D stated the resident's water should always be in their reach when they are in their rooms.</p> <p>The facility "Resident Hydration" policy last revised 2022 documented since most elder residents are at risk of dehydration, team members who work in the neighborhoods would be provided education about the signs and symptoms of dehydration. Offering fluids to residents who are at risk for dehydration would be the responsibility of all neighborhood team that are qualified to assist a resident with fluid intake. Nursing staff would offer and assist residents with</p> | F 692                                                                      |                                                                                                                          |                            |                                                        |

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| F 692                                                                            | Continued From page 37<br>fluids before and after ADL care and between<br>meals.<br><br>The facility failed to ensure R68's fluids were<br>within her reach which placed her at increased<br>risk of dehydration and other unwanted adverse<br>consequences.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | F 692                                                                      |                                                                                                                          |                            |                                                        |
| F 755<br>SS=D                                                                    | Pharmacy Srvc/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency<br>drugs and biologicals to its residents, or obtain<br>them under an agreement described in<br>§483.70(g). The facility may permit unlicensed<br>personnel to administer drugs if State law<br>permits, but only under the general supervision of<br>a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide<br>pharmaceutical services (including procedures<br>that assure the accurate acquiring, receiving,<br>dispensing, and administering of all drugs and<br>biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility<br>must employ or obtain the services of a licensed<br>pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all<br>aspects of the provision of pharmacy services in<br>the facility.<br><br>§483.45(b)(2) Establishes a system of records of<br>receipt and disposition of all controlled drugs in<br>sufficient detail to enable an accurate<br>reconciliation; and | F 755                                                                      |                                                                                                                          |                            |                                                        |

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| F 755                                                                            | <p>Continued From page 38</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to ensure consistent reconciliation of controlled drugs at the end of daily work shifts. This placed residents at risk for misappropriation of medications by staff.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- On 09/13/22 observation on the 200-hall medication room revealed a binder with reconciliation sheets. The sheets, reviewed from 09/06/22 through 09/13/22, revealed lack of documentation of signed reconciliation on 09/06/22, 09/08/22, 09/09/22, 09/11/22, 09/13/22.</li> <li>On 09/19/22 further review of the 200-hall controlled medication reconciliation sheets revealed lack of evidence of reconciliation, 09/14/22, 09/16/22, and 09/17/22.</li> <li>On 09/19/22 at 02:08 PM Licensed Nurse (LN) H stated the expectation was for the off going LN or Certified Medication Aide (CMA) count the scheduled controlled medication with the oncoming LN or CMA.</li> <li>On 09/19/22 at 04:34 PM Administrative Nurse D stated she expected the off going LN or CMA to count the scheduled controlled medication with the oncoming LN or CMA. Administrative Nurse D stated CMA's did not pass as needed controlled medications.</li> </ul> |                                                                            |  | F 755                                                                                                |                                                                                                                          |                                                        |                            |

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| F 755                                                                            | Continued From page 39<br><br>The facility "Storage of Medication" policy last revised 03/18/17 documented facility would store all drugs in a safe, secure, and orderly manner.<br><br>The facility failed to ensure reconciliation of controlled drugs at the end of daily work shifts, placing residents at risk for misappropriation of medications by staff.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | F 755                                                                      |                                                                                                                          |                            |                                                        |
| F 756<br>SS=D                                                                    | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§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.<br>(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.<br>(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, and the irregularity the pharmacist identified.<br>(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 | F 756                                                                      |                                                                                                                          |                            |                                                        |

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| F 756                                                                            | <p>Continued From page 40</p> <p>be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§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:</p> <p>The facility identified a census of 72 residents. The sample included 18 residents with seven sampled residents reviewed for unnecessary medication review. Based on observation, record review and interview the facility failed to acknowledge and/or act upon the Consultant Pharmacist (CP) recommendation to obtain a hold pulse rate parameter for digoxin (a medication used to treat heart failure and certain types of irregular heartbeats) for Resident (R)17. This deficient practice had the potential risk for unnecessary medication administration and unwarranted side effects for those two sampled residents.</p> <p>Findings included:</p> <p>-The electronic medical record for R17 documented diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (an elevated blood pressure), and atrial fibrillation (A-fib: a rapid, irregular heartbeat).</p> <p>The "Admission Minimum Data Set" (MDS) dated</p> | F 756                                                                      |                                                                                                                          |                            |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175355</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                 |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/19/2022</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN COMMUNITY OF JOHNSON COUNTY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11875 S SUNSET DRIVE, SUITE 100<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |                            |
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| F 756                                                                            | <p>Continued From page 41</p> <p>05/10/22 documented R17 had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R17 required supervision to limited assistance of one staff for her activities of daily living (ADLs). R17 received a diuretic (a medication used to promote the formation and excretion of urine).</p> <p>The "Quarterly MDS" dated 08/06/22 documented R17 had a BIMS score of two which indicated severely impaired cognition. R17 required limited assistance of one staff with her ADLs. R17 received a diuretic on seven of seven days during the lookback period.</p> <p>The "Cognition Care Area Assessment (CAA)" dated 05/10/22 documented R17 had some confusion and scored a three on her BIMS. R17 needed help at times with decision making.</p> <p>The "Falls Care Area Assessment (CAA)" dated 05/10/22 documented R17 had weakness, impaired mobility and staff assisted with all ADLs and cares as needed.</p> <p>The "Medication Care Plan" dated 05/04/22 directed staff to monitor pulse, blood pressure, orthostatic BP, headache, dizziness, unresolved peripheral edema (swelling), respiratory difficulty or new cough, unresolved fatigue, or unusual weight gain.</p> <p>The "Medication Administration Record" (MAR) for R17 documented an order with a start date of 05/04/22 for digoxin tablet to 0.0625 milligrams (mg) by mouth daily for irregular heartbeat. The MAR did not have a pulse parameter for the digoxin.</p> |                                                                            |  | F 756                                                                                                |                                                                                                                          |                                                        |                            |

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| F 756                                                                            | <p>Continued From page 42</p> <p>The 05/25/22 monthly "Medication Regimen Review" (MRR) CP recommendation documented a nursing recommendation to obtain a heart rate hold parameter for digoxin.</p> <p>On 09/14/22 R17 laid in her bed asleep. She had her oxygen (O2) canula (a hollow tube used to deliver supplemental oxygen) on.</p> <p>On 09/19/22 at 03:17 PM Licensed Nurse (LN) H stated that unless a resident had a specific order for the blood pressure or pulse reading then the blood pressure and pulse was only obtained on a weekly or monthly basis. LN H said some residents had parameters for their medications. LN H stated she was not positive if R17 had any parameters for her digoxin. LN H stated that she would only receive the pharmacy recommendations after they had been addressed by Administrative Nurse D and would only chart them after she received them.</p> <p>On 09/19/22 at 04:29 PM Administrative Staff D stated that she had overlooked the CP recommendation for a parameter for R17's digoxin. The administrative staff received the CP recommendations monthly and forwarded to the physicians; when received back, the recommendations were handed out to the unit nurses.</p> <p>The facility policy "Pharmacy Consultant Expectations Policy" updated 01/30/18 documented: the CP will provide expertise and oversight in all aspect of pharmaceutical services in the community. The CP will conduct MRR's for each resident in the community. The CP will address the expected time frames for conducting the review and reporting the findings. The CP will</p> | F 756                                                                      |                                                                                                                          |                            |                                                        |

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| F 756                                                                            | Continued From page 43<br>address irregularities and document and report<br>the results of the review.<br><br>The facility failed to ensure nursing staff<br>acknowledged and/or acted upon the CP<br>recommendation to obtain a pulse rate parameter<br>for the administration of R17's digoxin. This<br>deficient practice put R17 at risk for unnecessary<br>medication administration and adverse side<br>effects.                                                                                                                                                                                                                                                                                                                                                                                                                                             | F 756                                                                      |                                                                                                                          |                            |                                                        |
| F 757<br>SS=D                                                                    | Drug Regimen is Free from Unnecessary Drugs<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from<br>unnecessary drugs. An unnecessary drug is any<br>drug when used-<br><br>§483.45(d)(1) In excessive dose (including<br>duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its<br>use; or<br><br>§483.45(d)(5) In the presence of adverse<br>consequences which indicate the dose should be<br>reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons<br>stated in paragraphs (d)(1) through (5) of this<br>section.<br>This REQUIREMENT is not met as evidenced<br>by:<br>The facility identified a census of 72 residents. | F 757                                                                      |                                                                                                                          |                            |                                                        |

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| F 757                                                                            | <p>Continued From page 44</p> <p>The sample included 18 residents with seven reviewed for unnecessary medication review. Based on observation, record review and interview the facility failed to ensure adequate monitoring for Resident (R) 36's of Metoprolol (a medication used to lower the blood pressure and/or pulse). This placed the resident at risk for adverse medication effects.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>-The electronic medical record (EMR) for R36 documented diagnoses hypertension (HTN-an elevated blood pressure), obstructive and reflux uropathy (obstruction prevents flow of urine), benign prostatic hyperplasia (BPH-a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), spinal stenosis (a degenerative condition of the spine that could cause weakness and loss of use of extremities), and malignant neoplasm of prostate (a cancerous tumor of the prostate).</li> </ul> <p>The "Annual Minimum Data Set "(MDS) dated 04/12/22 documented R36 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R36 required extensive assistance of one to two staff members for his activities of daily living (ADLs).</p> <p>The "Quarterly MDS" dated 07/09/22 documented R36 had a BIMS score of 14. R36 required extensive assistance of one to two staff for ADLs.</p> <p>The "Fall Care Area Assessment" (CAA) dated 04/14/22 for R36 documented weakness and impaired mobility. R36 was at risk for falling. Staff assisted R36 with all ADLs and cares. R36 used</p> | F 757                                                                      |                                                                                                                          |                            |                                                        |

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| F 757                                                                            | <p>Continued From page 45<br/>a wheelchair for mobility.</p> <p>The "Medication Care Plan" revised 06/20/22 did not address staff direction for R36's use of Metoprolol.</p> <p>The "Orders" tab in the EMR for R36 recorded an order dated 07/22/22 to withhold all blood pressure medications for a systolic blood pressure (SBP-the pressure exerted when the heart beats and blood is ejected into the arteries) reading of less than 100.</p> <p>The "Orders" tab for R36 recorded an order dated 07/25/22 for Metoprolol Extended Release 24-hour sprinkle for 25 milligrams (mg) by mouth daily for hypertension.</p> <p>The "Medication Administration Record (MAR)" for July and August 2022 lacked at documented blood pressure or pulse with the administration of Metoprolol.</p> <p>Review of the clinical record for R36's revealed the last documented blood pressure reading was on 07/25/22.</p> <p>On 09/13/22 at 07:55 AM an R36 laid in his bed; the bed was in a high position (equal to or greater than three feet high).</p> <p>On 09/19/22 at 01:35 PM Certified Medication Aide (CMA) R stated some of the doctors did not require a daily blood pressure or pulse reading before administering some medications for hypertension but a resident should be monitored if they were on a beta blocker medication (Metoprolol) and the medication held if the reading was out of parameters.</p> | F 757                                                                      |                                                                                                                          |                            |                                                        |

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| F 757                                                                            | <p>Continued From page 46</p> <p>On 09/19/22 at 03:17 PM Licensed Nurse (LN) H stated that unless a resident had a specific order for the blood pressure or pulse reading then the blood pressure and pulse was only obtained on a weekly or monthly basis. LN H said some residents have parameters for their medications. LN H stated she was not positive if R36 had any parameters for his blood pressure medication.</p> <p>On 09/19/22 at 04:29 PM Administrative Staff D stated a resident that was on Metoprolol should have a parameter and the blood pressure and pulse reading to be taken prior to administration. Administrative Nurse D was not aware that R36 was not getting a daily blood pressure or pulse.</p> <p>Review of the "Evergreen Community of Johnson County Standing Orders" dated 04/21/22 documented "parameters for blood pressure/pulse after 30 days obtained weekly and notify physician if SBP was less than 90 or greater than 200 or pulse less than 50 ...beta-blockers (a blood pressure reducing medication the cause the heart to beat more slowly and with less force) ..."</p> <p>The facility policy "Administering Medications" documented medications shall be administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by the state to prepare, administer, and document the administration of medications may do so.</p> <p>The facility failed to ensure nursing staff monitored blood pressure and pulse for R36 who received Metoprolol. This deficient practice placed R36 at risk for unnecessary medication use and possible harmful side effects.</p> | F 757                                                                      |                                                                                                                          |                            |                                                        |

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| F 758<br>SS=D                                                                    | <p>Free from Unnec Psychotropic Meds/PRN Use<br/>CFR(s): 483.45(c)(3)(e)(1)-(5)</p> <p>§483.45(e) Psychotropic Drugs.<br/>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br/>(i) Anti-psychotic;<br/>(ii) Anti-depressant;<br/>(iii) Anti-anxiety; and<br/>(iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended</p> | F 758                                                                      |                                                                                                                          |  |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN COMMUNITY OF JOHNSON COUNTY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11875 S SUNSET DRIVE, SUITE 100<br/>OLATHE, KS 66061</b>                     |                            |                                                        |
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| F 758                                                                            | <p>Continued From page 48</p> <p>beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 72 residents. The sample included 18 residents with seven residents review for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure an appropriate diagnosis for antipsychotic medication (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions) use for Resident (R)8 and R10, who had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). This placed R8 and R10 at risk for unnecessary medications leading to adverse side effects.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R8's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia (progressive mental disorder characterized by failing memory, confusion).</li> </ul> <p>The "Admission Minimum Data Set" (MDS) dated</p> | F 758                                                                      |                                                                                                                          |                            |                                                        |

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| F 758                                                                            | <p>Continued From page 49</p> <p>07/20/22 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented that R8 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R8 received antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression which is an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) for seven days and diuretic medication (medication to promote the formation and excretion of urine) for six days during the look back period.</p> <p>R8's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 07/27/22 documented he received antidepressant medication and the consultant pharmacist would review the psychotropic (medications which alter mood or thought) medication and make recommendations as needed.</p> <p>R8's "Care Plan" dated 08/17/22 directed staff to monitor for side effects of the antipsychotic medication ordered.</p> <p>Review of the EMR under "Orders" tab revealed the following physician orders:</p> <p>Seroquel (antipsychotic) tablet 25 milligrams (mg) give half of a tablet by mouth at bedtime for dementia with behaviors dated 08/16/22, discontinued 09/01/22.</p> <p>Seroquel Tablet 25 mg give half of a tablet by mouth at bedtime for refractory major depression (major mood disorder) dated 09/01/22.</p> | F 758                                                                      |                                                                                                                          |                            |                                                        |

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| F 758                                                                            | <p>Continued From page 50</p> <p>On 09/14/22 at 07:47 AM R8 walked in the hallway; staff approached R8 and redirected him into his room.</p> <p>On 09/19/22 at 03:33 PM Licensed Nurse (LN) H stated that dementia was not an appropriate diagnosis for an antipsychotic but said she usually would not question the order if it came from the resident's physician. She noted that if an issue occurred with a medication the nurse was responsible for notifying the physician.</p> <p>On 09/19/22 at 04:00 PM Administrative Nurse D stated that dementia was not an appropriate diagnosis for the use of Seroquel. She stated that schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) was an appropriate diagnosis for Seroquel.</p> <p>The facility "Pharmacy Consultant's Expectation" policy lasted revised January 2018 documented the facility will meet the needs of each resident accurately, and safely by collaborating with the CP to guide the community with the system consistent with clinical best practice, quality resident care, and regulatory compliance. The pharmacy consultant will review psychotropic medication utilization and collaborate on the development of an action plan consistent with best practices and regulatory requirements.</p> <p>The facility failed to ensure an appropriate diagnosis for antipsychotic medication use for R8, who had a diagnosis of dementia. This placed R8 at risk for unnecessary medications leading to adverse side effects.</p> | F 758                                                                      |                                                                                                                          |                            |                                                        |

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| F 758                                                                            | <p>Continued From page 51</p> <p>- The "Medical Diagnosis" section within R10's Electronic Medical Records (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (inability to sleep), major depressive disorder (major mood disorder), and morbid obesity (severely overweight).</p> <p>R10's " Quarterly Minimum Data Set (MDS)" dated 07/20/22 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe cognitive impairment. The MDS indicated that R10 received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medications.</p> <p>R10's "Psychotropic (medications that chemically alter behavior, mood, thoughts, or perception) Drug Use Care Area Assessment (CAA)" dated 12/06/21 indicated that she was taking antipsychotic medication and at risk for adverse reactions. The CAA instructed staff to monitor effects and notify the medical doctor as needed. The CAA noted that a gradual dose reduction (GDR) as indicated.</p> <p>R10's "Care Plan" dated 01/12/21 noted the she was on medications with potential reactions and adverse side effects (unintended harmful reaction to a drug administered at normal dosage). The care plan indicated that Risperdal (antipsychotic) had a black box warning noting increased</p> |                                                                            |  | F 758                                                                                                |                                                                                                                          |                                                        |                            |

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| F 758                                                                            | <p>Continued From page 52</p> <p>mortality in elderly patients with dementia related psychosis.</p> <p>R10's EMR under "Physician's Orders" noted an order started on 03/25/21 for staff to give 0.5 milligrams (mg) of Risperdal twice daily related to dementia with behavioral disturbances. The order was discontinued on 07/01/22 and restarted on 07/01/22 with the diagnosis changed to refractory major depression.</p> <p>A review of the R10's "Consulting Pharmacist Recommendation" for 06/2022 indicated that the Consulting Pharmacist (CP) identified that R10 was receiving risperidone (Risperdal) but lacked an allowable diagnosis. The recommendation noted that the use of antipsychotics in elderly patients carries a black box warning for increased risk of death. R10's physician responded by changing the diagnosis to refractory major depression.</p> <p>On 09/13/22 at 11:00AM R10 was in her room watching television. She sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) with drinking water next to her on her bedside table. She was well groomed.</p> <p>On 09/19/22 at 03:33AM Licensed Nurse (LN) H stated that dementia was not an appropriate diagnosis for an antipsychotic but said she usually would not question the order if it came from the resident's physician. She noted that if an issue occurred with a medication the nurse was responsible for notifying the physician.</p> <p>On 09/19/22 at 04:00AM Administrative Nurse D stated that dementia was not an appropriate diagnosis. She stated that medication reviews</p> | F 758                                                                      |                                                                                                                          |                            |                                                        |

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| F 758                                                                            | Continued From page 53<br>were completed monthly on each resident and reviewed by the facility's physician and nursing staff for updates and changes. She stated that schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) was an appropriate diagnosis for Risperdal.<br><br>A review of the facility's "Pharmacy Consultant's Expectation" policy updated 01/2018 indicated that the facility will meet the needs of each resident accurately, and safely by collaborating with the CP to guide the community with the system consistent with clinical best practice, quality resident care, and regulatory compliance. The pharmacy consultant will review psychotropic medication utilization and collaborate on the development of an action plan consistent with best practices and regulatory requirements.<br><br>The facility failed to ensure an appropriate diagnosis for R10's antipsychotic medication. This deficient practice placed R10 at risk for complications related to unnecessary psychotropic medications. | F 758                                                                      |                                                                                                                          |                            |                                                        |
| F 812<br>SS=E                                                                    | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | F 812                                                                      |                                                                                                                          |                            |                                                        |

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| F 812                                                                            | <p>Continued From page 54</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 72 residents. The facility had one main kitchen and three satellite kitchens. Based on observation and interview the facility failed to ensure food stored in the satellite kitchen refrigerator was properly stored, labeled and dated. The facility failed to ensure that expired items in the satellite refrigerators were discarded. The deficient practice left the resident at risk of food borne illnesses.</p> <p>Findings included:</p> <p>- An inspection of a satellite kitchen/dining closest to the main lobby on 09/13/22 at 08:29 AM revealed the following:</p> <p>One gallon jug of milk sat directly on the serving counter without a cooling ice bath or any way to maintain adequate temperature.</p> <p>A large bin of ice sat on a wheeled cart with the ice scoop stuck directly in the ice.</p> <p>A dish storage cart was stored in the dining room with the clean dishes (plates and bowls) stored eating surface up and uncovered.</p> | F 812                                                                      |                                                                                                                          |                            |                                                        |

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| F 812                                                                            | Continued From page 55<br>An inspection of a satellite kitchen area refrigerator on 09/13/22 at 08:49 AM revealed the following:<br>Several pieces of bacon wrapped in a paper towel that was not in a sealed bag and was not labeled or dated.<br>A tomato was stored in sealed plastic zip lock bag that was not labeled or dated.<br>A sealed plastic bag with hard-boiled eggs had an expiration date of 08/27/22 that had not been discarded.<br>A container of cottage cheese had an expiration date of 08/26/22 that had not been discarded.<br>There were four dessert cups with an expiration date of 09/07/22 that had not been discarded.<br><br>On 09/19/22 at 02:47 PM Dietary CC stated that all foods stored in the refrigerator should be labeled and dated. The homemakers and aides were responsible for ensuring that food items were thrown away daily if expired or did not have labels on them.<br><br>The facility failed to ensure that food items stored in the satellite kitchen was stored properly, labeled and dated and discarded when items were expired and failed to ensure sanitary storage of dishes for resident use. This deficient practice placed residents at risk for food borne illnesses. | F 812                                                                      |                                                                                                                          |                            |                                                        |
| F 880<br>SS=D                                                                    | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | F 880                                                                      |                                                                                                                          |                            |                                                        |

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| F 880                                                                            | <p>Continued From page 56</p> <p>development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.<br/>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> <li>(iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> <li>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</li> <li>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</li> </ul> </li> </ul> | F 880                                                                      |                                                                                                                          |                            |                                                        |

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| F 880                                                                            | <p>Continued From page 57</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.<br/>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.<br/>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br/>The facility identified a census of 72 residents. Based on observations, record review, and interviews, the facility failed to ensure infection control practices were followed while providing personal care to Residents (R)9, R10, and R67. The facility additionally failed to ensure infection control practices were followed for laundry services. This deficient practice placed the residents at risk for preventable infections.</p> <p>Findings Included:</p> <p>- On 09/14/22 at 08:15 AM Housekeeping Staff U pushed the laundry cart down the 100's hallway. The cart was full of personal clothing for the residents. The cart was only covered by a small cloth at the top leaving the clothing fully exposed</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |

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| F 880                                                                            | <p>Continued From page 58</p> <p>to the environment during transport. She then hung up a tan pair of pants outside of R20's door. She then hung up a blue shirt and brown pants outside of R11's door.</p> <p>On 09/14/22 at 11:09 AM soiled bed linens were observed on the hall floor outside of R49's room.</p> <p>On 09/15/22 at 08:10 AM R10 sat at the "Mount Chalet" dining hall waiting to be assisted with her breakfast. Certified Nurses Aid (CNA) O donned gloves and pulled up a chair to next to R10. CNA O adjusted R10's wheelchair and then touched the table. Wearing the same gloves, CNA O picked up a slice of toast with her gloved hand and fed R9 her toast. CNA O then picked up the silverware and continued to feed R10 her meal.</p> <p>On 09/15/22 at 11:07 AM CNA O completed hand hygiene and donned a pair of gloves. CNA O picked up food off the floor and threw it away. She then changed her gloves and unfastened R67's brief. CNA O cleaned R67's groin area and rolled him onto his side. She then folded his soaked brief and removed his boots from his feet. Wearing the same gloves, CNA O then cleansed R67's coccyx area with a wipe, folded the wipe, and cleaned his rectal area. CNA O then placed the contaminated wipe on the bed with feces visible on the wipe. CNA O picked up the soiled wipe, folded it, and then wiped R67's rectum three more times. Continuing with the same gloves, she then placed a clean brief under R67's buttocks and rolled him onto his right side. CNA O then fastened the brief and removed her gloves. CNA O completed hand hygiene.</p> <p>On 09/15/22 at 11:24 AM Housekeeping Staff U</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |

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| F 880                                                                            | <p>Continued From page 59</p> <p>stated that she was instructed to hang to clothes outside of resident's room if they were recently on isolation precautions. She stated that during the COVID-19 (highly contagious potentially life-threatening respiratory virus) outbreak all the laundry was left outside the rooms to limit exposure to the residents. She stated that all laundry should be transported covered.</p> <p>On 09/15/22 at 03:32 PM an unidentified staff pushed R9 in a wheelchair on the "Mount Chalet" hallway towards the spa room. R9's catheter bag hung loosely off the left side underneath his wheelchair with the bottom of the collection bag and the tubing dragging on the hallway floor.</p> <p>On 09/19/22 at 03:00PM CNA O reported that hand hygiene should be completed before and after providing care to residents and when visibly soiled. She stated that it also should be complete in between touching soiled surfaces. She stated that hand hygiene should be completed after removing gloves.</p> <p>On 09/19/22 at 04:05PM Administrative Nurse E stated that one of the recent facility goals was to increase hand hygiene awareness. She stated that staff recently started emphasizing infection control practices during personal cares for the residents and providing staff education for preventing urinary tract infections (UTI's) and other contagious disease. She stated that staff completed annual skills checkoffs and frequent in-service training for personal cares provided for the residents.</p> <p>A review of the facility's "Laundry" policy revised 2022 indicated that all personal clothing and linen will be transported in a covered laundry cart. The</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |

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| F 880                                                                            | <p>Continued From page 60</p> <p>policy noted that all laundry will be handled, processed, stored, and transported in a manner designated to prevent transmission of infection.</p> <p>A review of the facility's "Catheter Care" policy (no revision date) indicated that catheter care will be provided to all residents with indwelling catheter as least twice daily. The policy noted that the purpose of catheter care is to prevent possible urinary tract infections from bacteria spreading into the bladder.</p> <p>A review of the facility's "Infection Control" revised 08/2012 noted that staff are required to complete hand hygiene before and after providing cares to the residents, when visibly soiled, immediately after removing gloves, during contact with bodily fluids, and when touching environmental items.</p> <p>The facility failed to ensure infection control practices were followed for R9, R10, and R67. The facility additionally failed to ensure infection control practices were followed for laundry services. This deficient practice placed the residents at risk for preventable infections.</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |