

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2022
NAME OF PROVIDER OR SUPPLIER SHAWNEE POST ACUTE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 ANTIOCH ROAD OVERLAND PARK, KS 66204		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Licensure Resurvey and Complaint Investigation #172526. The 2567 was electronically sent to the facility on 10/14/22.	F 000			
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585			

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

TITLE

(X6) DATE

10/14/2022

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

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F 585	Continued From page 1 facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions	F 585			

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F 585	Continued From page 2 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to ensure a system that all staff implemented for residents to file grievances . This placed residents at risk for unresolved concerns. Findings included: - Review of the resident council meeting minutes for the past year, lacked documentation residents reported grievances concerning Resident (R) 2's behaviors. Review of the facility's grievance log for the past year, lacked documentation residents reported	F 585			

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F 585	Continued From page 3 grievances concerning R2's behaviors. The facility's "Progress Note," dated 10/04/22 at 09:35 PM, recorded R2 had disruptive yelling behaviors throughout the afternoon, staff were not able to redirect the resident's behaviors, and other residents voiced complaints and threatened to call the police about R2's behaviors. The "Progress Note" also recorded a resident's family contacted the nurse, complained their family member was not able to sleep due to R2's yelling, and demanded a room change for their family member. On 10/03/22 at 12:28 PM, observation revealed R2 persistently screamed from her room many times over a 16-minute interval "I'm hungry," "bring me my food," and "my diaper needs changed." Continued observation revealed R2's screaming comments could be heard in the dining room where 15 residents were eating lunch. On 10/04/22 at 10:33 AM, observation revealed R2 persistently screamed from her room over a 21-minute interval, and staff attempted three times to redirect her screaming behaviors. Continued observation revealed R2's persistent screaming disrupted a bingo activity for 16 residents. On 10/03/22 at 01:52 PM, Certified Medication Aide (CMA) R stated R2 had screaming behaviors every day that disrupted other residents' meals, activities, and sleep. CMA R stated staff were not able to prevent or redirect R2's screaming and yelling behaviors. On 10/03/22 at 02:57 PM, R64 stated R2's yelling	F 585			

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F 585	Continued From page 4 often disrupts meals and activities, and he has reported complaints about the resident's behaviors to multiple staff. On 10/03/22 at 03:10 PM, R125 stated staff were aware R2's behaviors disrupt all the residents' lives on the unit and she has reported complaints to the administrative staff. On 10/03/22 at 03:18 PM, R48 stated staff were not able to control R2's yelling, and R2's yelling about her dirty diapers during mealtime was very unpleasant. R48 stated he has individually and with a group of resident reported complaints about R2's disruptive behaviors. On 10/03/22 at 03:25 PM, R26 stated he has observed R2's persistent yelling make other residents in the dining room uncomfortable, and he has reported R2's behaviors to multiple staff. On 10/03/22 at 03:48 PM, R27 stated R2's persistent yelling disrupts meals and activities, and he has complained to staff about not being able to sleep or watch TV due to R2's behaviors. On 10/04/22 at 11:30 AM, R32 stated R2's screaming ruined the bingo activity for residents today, and he does not appreciate hearing about R2's "nasty diapers" during mealtime. R32 stated he has compassion for the residents who are unable to voice complaints, and he has reported complaints about R2 to administrative staff many times. R32 stated, outside the facility, R2's behaviors would be against the law and neighbors would call the police. On 10/04/22 at 11:30 AM, R51 stated she keeps her room door closed due to R2's frequent yelling,	F 585			

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F 585	Continued From page 5 and she still has difficulty sleeping and watching TV. R51 stated she has complained to staff many times about R2's behaviors. On 10/04/22 at 01:27 PM, R44 stated R2's screaming frequently disrupts his sleep and watching TV, and he had reported R2's behaviors to staff many times. On 10/04/22 at 02:10 PM, Licensed Nurse (LN) H stated R2 had frequent disruptive behaviors that agitated other residents, was difficult to redirect and staff should record and monitor the resident's behaviors. LN G stated R2 spent most of her time in her room in bed, and when R2 had behaviors outside her room other residents often confronted her with angry comments. On 10/05/22 at 07:56 AM, R30 stated he spends most of the time in bed due to pain, and R2's yelling often disrupts his sleep and watching TV. R2 stated his family told him to call the police on R2 or ask the facility to move to a different room away from R2. R30 stated he has complained to multiple staff about R2's behaviors, and nothing happens. On 10/05/22 at 08:51 AM, Social Service Staff X verified the facility had no grievances concerning R2's behaviors and staff should assist residents with the grievance process if the resident reports concerns. On 10/05/22 at 09:27 AM, Administrative Nurse D stated grievance forms were available at the nurse station on each unit and staff should assist the resident with the grievance form when the resident reports concerns. Administrative Nurse D verified a problem with the grievance system	F 585			

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F 585	Continued From page 6 since no grievances were filed concerning R2's behaviors. The facility's "Resident Rights Policy," dated 10/04/16, directed staff to provide an environment that enhances quality of life and residents have the right to report grievances in the facility. The facility failed to provide a system for residents to file grievances. This placed residents at risk for unresolved concerns.	F 585			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609			

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F 609	Continued From page 7 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to report Resident (R) 4's allegation of verbal, emotional, and physical abuse to State Agency (SA) as required. This deficient practice placed R4 at risk of ongoing abuse. Findings included: -The "Medical Diagnosis" section withing R4's Electronic Medical Record (EMR) included diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), post-traumatic stress disorder (PTSD- psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture), somatization (the production of recurrent and multiple medical symptoms with no	F 609			

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F 609	Continued From page 8 discernible or cause). The "Annual Minimum Data Set" (MDS), dated 07/07/22, documented R4 had intact cognition, had no signs or symptoms of psychosis (any major mental disorder characterized by a gross impairment in reality testing) or exhibited behaviors. R4 required extensive assistance of one staff for activities of daily living, was not steady, but was able to stabilize without staff assistance with transition and balance, and had speech, occupational, and physical therapy treatment. The MDS further documented R4 received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) anticoagulant (class of medication to prevent blood clotting), diuretic (medication to promote the formation and excretion of urine)and an opioid (class of medication to treat moderate to severe pain) medication daily. The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 07/07/22, documented R4 took antidepressants and antianxiety medications. The CAA further documented R4's mood was stable and she saw psychiatry routinely. The "Care Plan", dated 07/08/22, documented R4 had behavioral symptoms related to diagnoses of depression, anxiety, and PTSD. R4 had made statements that blur previous events with current events and thinking that the event happened again or that an event happened in a different way. The "Care Plan" directed staff to identify strengths, positive coping skills, and to reinforce	F 609			

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F 609	Continued From page 9 them. Monitor and record R4's mood to determine if problems seem to be related to external causes. The resident was attention seeking and when R4 got upset, she exhibited impatient and demanding behaviors, and she often felt she was not listened to. Further interventions directed staff to allow R4 opportunity to express herself in a calm manner. The "Care Plan" on 10/02/22, documented R4 will make false accusations about staff and the intervention was to provide care in pairs. Review of the facility's "Investigation" of the event revealed Administrative Nurse D learned of the allegation on 10/02/22. Administrative Nurse D obtained statements from staff which were dated 10/01/22 (which included alleged abuser), and 10/04/22, as well as undated statements. The investigation included a skin assessment signed by Administrative Nurse D on 10/04/22 but dated as effective 10/03/22. On 10/04/22 at 10:04 AM R4 stated she had experienced verbal, emotional, and physical abuse from one of the staff nurses. R4 stated the staff nurse came into her room on 10/02/22 and called her names, stated no one liked R4, then slapped R4 on the upper arm several times. R4 reported the staff nurse shook her finger in her face and would not leave the room when R4 asked her to leave. R4 stated she reported this allegation to Administrative Nurse D but was uncertain which day. On 10/05/22 at 09:24 AM, Administrative Nurse D reported she was notified by staff at 09:00 PM R4 had stuck a nurse with her walker and called the nurse bad names. Administrative Nurse D	F 609			

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F 609	Continued From page 10 suspended the nurse on 10/02/22 at approximately 10:00 PM, pending an investigation of the allegation of abuse. Administrative Nurse D stated she had asked R4 if the police should be called and R4 told Administrative Nurse D not to notify the police until R4 had time to discuss the situation with a family member. Administrative Nurse D stated she had not reported the alleged abuse to the state agency due to R4 changing description of the event and did not want the police called. The facility's "Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment" policy, dated 01/2022, documented residents must not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, the resident representative, families, friends or other individuals. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will ensure that alleged violations involving abuse are reported immediately, but not later than two hours after the allegation is made if the event that cause the allegation involves abuse or results in serious bodily injury. Ensure that alleged violations are reported to the administrator, the state survey agency, and adult protective services as appropriate. The policy further documented after receipt of a report of possible abuse, neglect, mistreatment, exploitation or misappropriation of resident property steps are immediately taken to protect the resident. The facility failed delayed report of R4's allegation of abuse to the SA while conducting the investigation (which was not concluded until after the 24 hour reporting window). This failure placed	F 609			

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F 609	Continued From page 11			F 609			
F 686	the resident at risk of further abuse.			F 686			
SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)						
	§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 19 residents of which seven were reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review and interview, the facility failed to implement a soft heel boot as directed by the provider to treat a facility-acquired pressure ulcer for Resident (R)71. This placed R71 at risk for further skin breakdown and delayed healing. Findings included: - R71's "Physician Order Sheet" dated 10/03/22, included diagnoses of anxiety (mental or emotional reaction characterized by						

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F 686	Continued From page 12 apprehension), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cerebrovascular accident (CVA- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and right-side hemiplegia (paralysis of one side of the body). R71's "Quarterly Minimum Data Set" (MDS) assessment, dated 09/22/21, recorded the resident had a Brief Interview for Mental Status (BIMS) score of seven which indicated severely impaired cognition. The assessment revealed the resident required extensive assistance of one staff for bed mobility, transfers, locomotion on and off the unit, toilet use, personal hygiene, and had functional impairment of upper and lower extremities on one side. The MDS further documented the resident had no skin issues. The 07/22/22 "Activities of Daily Living (ADL) Care Area Assessment" (CAA) did not trigger. The "Pressure Ulcer" CAA documented the resident required extensive staff assistance with bed mobility, and staff to encourage the resident to turn and reposition while in bed. The CAA documented the resident had no skin issues. The "Fall CAA" documented the resident had unsteady balance, had a recent hospitalization for a stroke with right sided weakness. The "Braden Scale Assessment" for predicting pressure ulcer risk, dated 07/20/22, documented a score of 15.0 which indicated the resident was at low risk for pressure ulcer development. The "ADL Care Plan," dated 07/21/22 directed the staff to monitor for skin for redness, open areas,	F 686			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2022
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F 686	Continued From page 13 scratches, cuts, bruises and report changes to the nurse. The "Care Plan" documented the resident required a Hoyer lift (total body mechanical lift used to transfer residents) with two staff for transfer and physical assistance to turn and reposition with bed mobility. The "Progress Notes," dated 09/16/22 at 05:43 PM, recorded R71 was up in her wheelchair and propelled with her feet in the hall. The "Progress Notes," dated 09/26/22 at 07:21 PM, recorded R71 was noted with a pressure area on her right heel. The area was cleansed with wound cleanser, prepped with skin prep (liquid skin barrier) and covered with border gauze. Staff notified the provider to evaluate in the morning. The "Skin Evaluation," dated 09/27/22, documented R71 had a fluid filled area on her right heel, measuring 1.5 (cm) centimeters by 1.3 cm. Staff notified the provider who ordered staff to apply skin prep to the area twice daily and directed the resident to wear a soft boot at all times. The "Skin Pressure Ulcer Weekly Evaluation," dated 10/03/22, documented R71 had an unstageable pressure ulcer (term that refers to an ulcer that has full thickness tissue loss but is either covered by extensive dead tissue or skin) of the right heel which was tender when touched, and not present on admission. The Nurse Practitioner ordered the staff to apply skin prep twice daily and continue with the soft boot. The "Progress Notes," dated 10/03/22 at 10:05 AM, recorded the provider saw the resident and	F 686			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

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F 686	Continued From page 14 ordered skin prep twice daily to the right heel, no dressing, and a soft boot on at all times. On 09/28/22 at 01:30 PM, R71 sat in a wheelchair at the nurse's station dressed in street clothes drinking apple juice. Observation revealed the resident had on gripper socks and did not have a pressure relieving boot (soft boot) to the right heel. Continued observation revealed the resident frequently took her right foot off the metal wheelchair pedal and then put it back on the pedal while sitting at the nurse's station. On 10/03/22 at 09:45 AM, R71 sat at the nurse's station complaining of her right heel hurting. R71 was not wearing a soft boot on either foot. Licensed Nurse (LN) G removed the resident's non slip sock on the right foot and stated "oh, you don't have a dressing on either." The nurse took R71 to her room, cleansed the right heel with wound cleanser, applied skin prep and placed the pressure relieving boot on R71's right foot. The wound measured 1.08 cm by 1.51 cm and was fully covered with eschar (dead tissue). On 10/03/22 at 10:00 AM, LN G verified the resident developed a facility acquired unstageable pressure ulcer on the right heel. On 10/04/22 at 09:00 AM, Administrative Nurse D verified the resident developed the unstageable pressure ulcer on the right heel on 09/26/22. Administrative Nurse D stated according to the resident's Braden assessment on admission, the resident was not at risk for skin breakdown and the resident did not require any preventative boots due to the admission skin assessment. The "Skin Management System, " policy dated	F 686			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

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F 686	Continued From page 15 December 2019, documented it was the policy of the facility that any resident who enters the facility without pressure ulcers will have the appropriate preventative measures taken to ensure that the resident does not develop a pressure ulcer, or that the resident admitted with wounds will not develop signs and symptoms of infection, unless the resident's clinical condition makes the development unavoidable. The policy recorded the resident would have a head to toe skin assessment by a licensed nurse at the time of admission and any skin lesions would be documented on the Nursing Admission Assessment. A Braden Scale Assessment would also be completed on admission to identify resident's at risk for skin breakdown and a score of 10 or lower is considered high risk and will have a care plan developed to address particular elements of the assessment that put the resident at risk for skin breakdown. The policy recorded a care plan would be initiated to address areas of actual skin breakdown and the care plan would be reviewed and revised as needed. A report of all wounds and their progress will be updated by the treatment nurse weekly. The Registered Dietician would provide nutritional support when appropriate.	F 686			
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692			

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

PRINTED: 10/14/2022
FORM APPROVED
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F 692	Continued From page 16 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 17 residents with seven reviewed for nutrition. Based on observation, interview, and record review, the facility failed to respond to an unplanned, ongoing weight loss and failed to identify and implement further interventions to prevent weight loss for Resident (R)22 who had a significant unplanned weight loss of 14.29 percent (in six months. Findings included: -The "Medical Diagnosis" section within R22's Electronic Medical Record (EMR) included diagnoses of unspecified severe protein-calorie malnutrition, macular degeneration (progressive deterioration of the retina), glaucoma (abnormal condition of elevated pressure within an eye	F 692			

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

PRINTED: 10/14/2022
FORM APPROVED
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F 692	Continued From page 17 caused by obstruction to the outflow), abnormal weight loss, major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion), dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and weakness. The "Annual Minimum Data Set" (MDS) dated 05/06/22 recorded R22 had a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R22 required extensive assistance for most activities of daily living (ADL) except eating, for which she required limited assistance of one staff. The MDS recorded R22 was 57 inches tall, weighed 91 pounds (lbs.), had no issues with chewing, and no known weight loss. The "Quarterly MDS", dated 07/15/22, documented R22 had moderately impaired cognition, had no delirium (sudden severe confusion, disorientation and restlessness), psychosis (any major mental disorder characterized by a gross impairment reality testing), or behaviors. R22 required limited assistance of one staff with eating. She had no known issues chewing or swallowing but received mechanically altered diet, weighed 86 lbs. and had no known weight loss. The "Nutrition Care Area Assessment" (CAA), dated 05/04/22, documented R22 received a mechanically altered diet and required assistance from staff with feeding and encouragement.	F 692			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

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F 692	Continued From page 18 R22's "Care Plan" recorded an intervention dated and last revised on 03/16/22 which directed R22 could hold her cup, feed herself, and eat finger foods independently. R22's "Care Plan" initiated on 03/02/21 and last revised on 07/12/22 recorded she had a nutritional problem related to protein calorie malnutrition (PCM), gastro-esophageal reflux (GERD, backflow of stomach contents to the esophagus), dysphagia; she needed supplements and a mechanically altered diet. The care plan documented nutrition diagnoses of impaired chewing/swallowing related to dysphagia as evidenced by need for mechanical soft diet with nectar thick liquids. R22 had a history of weight loss and overall decline in condition, advanced age with suboptimal oral intake evidenced by the need for nutritional supplements. R22's "Care Plan" documented on 07/05/22, R22 triggered for weight loss of 7.5 percent in 90 days and 10% in 180 days . R22's "Care Plan" recorded interventions dated 03/09/21 which directed staff to monitor, document and report to the medical doctor signs and symptoms of malnutrition, emaciation, significant weight loss. R22's "Care Plan" revised on 04/11/21 further directed staff to offer and encourage snacks and fluids between meals and directed staff to assist and cue at meals as needed. The care plan recorded an intervention revised on 01/06/22 which directed staff to provide supplements as ordered; Med Pass (liquid high calorie nutritional supplement) 120 milliliters three times daily (TID), nectar thick fluids and liquid protein TID. On 01/06/22 Magic cup (fortified nutritional ice cream product) two times daily for 10 days was added . On 03/03/21 a "Physician Order" directed Med	F 692			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 692	Continued From page 19 Pass (a dietary supplement) 120 milliliters (ml) three times a day. On 07/20/21 a "Physician Order" directed liquid protein 30 ml, three times a day with thickened liquids in beverage of choice. A "Nutrition Progress Note" dated 01/14/22 recorded staff notified the RD of R22's continued poor oral intake. The note recorded the Magic Cup was increased to three times a day and continue to monitor . A "Weight Change Note" dated 01/25/22 documented a weight warning with a weight of 87.6 lbs., which indicated a loss of 7.5%. The note recorded R22 triggered for weight loss, had Covid (potentially life-threatening respiratory infection) and was on Magic Cup twice daily for 10 days. The note recorded the registered dietician (RD) would restart the Magic Cup and monitor. On 01/25/22 a "Physician Order" directed staff to administer to R22 the dietary supplement Magic Cup, two times a day for weight loss. On 02/01/22 a "Physician Order" directed staff to provide a pureed (food blended until smooth) textured diet with thin liquids consistency for R22. R22's EMR recorded the following weights: 03/01/22: 98.0 lbs. 04/04/22: 94.0 lbs. 05/02/22: 90.8 lbs. 05/17/22: 90.0 lbs. A "Nutrition Evaluation" dated 04/04/22 by Consultant GG recorded R22 had a weight drop	F 692			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 692	Continued From page 20 that month. R22 had weight loss and abnormal nutrition-related labs due to overall decline in condition, and advanced age with suboptimal oral intake. The note directed to encourage oral intake, and monitor weight trends. The "Weight Warning Progress Note", dated 05/18/22, documented a significant weight loss of 7.5 % noted in 90 days. R22's base line weight was 95-100 lbs. Nutrition interventions in place included multiple supplements: liquid protein, Magic Cup and Med Pass. R22 received a regular pureed diet. No new recommendations were made. R22's EMR recorded a weight of 86.4 lbs. on 06/01/22 which indicated a 11.84% loss in 90 days. The "Weight Warning Progress Note", dated 06/07/22, documented a 7.5% change and 10% change. R22 triggered for continued slow weight loss. R22 was a variable eater, received liquid protein and Med Pass three times a day, and Magic cup twice a day. The note lacked any new recommendations or interventions to address the loss. R22's EMR recorded a weight of 86 lbs. on 07/01/22. A "Nutrition Evaluation" dated 07/03/22 by Consultant GG recorded R22 had a wound to her buttocks and coccyx (area at the base of the spine). R22's weight was 86 lbs. and intake at meals varied but was usually greater than 50%. R22 had weight loss and abnormal nutrition-related labs due to overall decline in condition, and advanced age with suboptimal oral	F 692			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 692	Continued From page 21 intake. The note directed to encourage oral intake, and monitor weight trends, continue current diet and supplements as ordered. The "Weight Warning Progress Note", dated 07/05/22, documented a 7.5% change and 10% change. R22 was at risk for continued weight loss with 7.5% loss for three months. R22 was a variable eater and received liquid protein and Med Pass three times a day, and Magic Cup twice a day. The note lacked new interventions for continued weight loss. R22's EMR recorded a weight of 85.5 lbs. on 08/01/22. The "Weight Warning Progress Note", dated 08/02/22, documented a 10% weight change. R22 was at risk for weight loss and was down 10% since March. R22 continued supplements. The physician and resident's representative were updated on R22's weight loss of 10% in 180 days. No new orders were received. The note lacked new interventions to address the continued weight loss. R22's EMR recorded a weight of 84 lbs. on 09/06/22 which indicated a 14.29 % loss in six months. The "Weight Warning Progress Note", dated 09/07/22, documented R22 had a weight loss of 10% in five months. R22 continued supplements; her appetite varied. The note directed staff to continue to monitor. The note lacked new interventions to address the significant weight loss. A "Nutrition Evaluation" dated 09/28/22 by	F 692			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 692	Continued From page 22 Consultant GG recorded R22 had a current weight of 84 lbs. and intake at meals varied but was usually greater between 50-75%. R22 had weight loss and abnormal nutrition-related labs due to overall decline in condition, and advanced age with suboptimal oral intake. The note directed to encourage oral intake, and monitor weight trends, continue current diet and supplements as ordered. On 10/04/22 at 12:20 PM, observation revealed R22 sat in the dining room in a wheelchair. R22 requested help because she could not find her silverware. Staff brought R22's silverware. R22 asked for help. Staff spooned several bites of chili into the resident's mouth, then left the table. R22 then asked for assistance again and staff stood next to R22 and spooned several more bites of chili and then left the table again . On 10/04/22 at 12:28 PM, observation revealed R22 repeatedly stated "I can't reach you, could you help me?" Staff responded and said they would help her but walked away briefly before returning to the table to assist the resident with eating. On 10/05/22 at 08:35 AM, Certified Nurse Aide (CNA) M reported staff must cue and encourage R22 with each bite at all meals. The CNA said R22 was able to drink independently. On 10/05/22 at 07:46 AM, Licensed Nurse (LN) G reported R22 received three different supplements due to weight loss. LN G reported an interdisciplinary team reviewed the weights and notified the physician of weight changes. On 10/05/22 at 09:33 AM, Administrative Nurse D	F 692			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 692	Continued From page 23 verified R22 had weight loss of 10% in the past six months. Administrative Nurse D verified the interdisciplinary team monitored the weight loss but had not implemented new intervention to prevent R22's continued loss. On 10/05/22 at 11:31 AM, Consultant GG verified R22 received three dietary supplements for weight loss. She verified R22 had a significant weight loss and noted the lack of new intervention to attempt to prevent further weight loss. On 10/06/22 at 09:25 AM, Consultant HH said R22 had weight loss and the facility should attempt interventions to prevent further weight loss. The facility's "Weight Monitoring" policy, dated 01/2022, documented the facility to regularly monitor the weight of all residents and address those residents at risk or that experience a variance in weight, either unintended loss, or unanticipated gain. Significant weight loss/gain is monitored monthly by the Dietary Manager and/or the Registered Dietician. Additionally, the resident is referred to the weight committee, an interdisciplinary team that meets weekly to identify individuals' interventions that may be beneficial in maintaining current weight and avoid further weight loss or gain. A weight variance protocol is completed to ensure a systematic review that ranges resident meal/food choices, meal monitoring, current diet and hydration, medication, commercial supplements, and ability to perform ADL's (meal assistance) as necessary adaptive devices of potentially contributing factors to weight loss. Alternatives such as prescribed appetite stimulants may be considered for those residents that continue to lose weight, after	F 692			

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

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F 692	Continued From page 24 careful consideration and other measures have been exhausted. The facility failed to respond to an unplanned, ongoing weight loss and failed to identify and implement further interventions to prevent weight loss for R22 who had a significant unplanned weight loss of 14.29% in six months .	F 692			
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 19 residents with two reviewed for behaviors. Based on observation, record review and interview, the facility failed to provide the necessary behavioral health services and interventions for one of two sampled residents, Resident (R) 2. This placed the resident at risk for continued and worsened behaviors. Findings included: - The "Physician Order Sheet," dated 09/02/22, recorded R2 had diagnoses of mild cognitive impairment, metabolic encephalopathy (chemical	F 740			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2022
NAME OF PROVIDER OR SUPPLIER SHAWNEE POST ACUTE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 ANTIOCH ROAD OVERLAND PARK, KS 66204		
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F 740	Continued From page 25 imbalance in the blood that impairs brain function), anxiety (mental health disorder characterized by worry and fear that interferes with daily life), and depression (abnormal emotional state characterized by exaggerated feelings of sadness and worthlessness). The "Quarterly Minimum Data Set" (MDS), dated 09/21/22, recorded R2 had a Brief Interview for Mental Status score of 15 (cognitively intact) and no behaviors. The MDS recorded R2 required extensive staff assistance with activities of daily living (ADLs), used a wheelchair for mobility, and was incontinent of bowel and urine. The "Behavior Care Plan," dated 09/21/22, recorded R2 had a potential for behavior problems due to her yelling for cares and services. The care plan directed staff to monitor R2's target behaviors (yelling/screaming, aggression toward staff, inappropriate language), responses to interventions and notify the physician of increased or worsened behaviors. R2's "Care Plan" lacked documentation of new behavior interventions after 06/16/22 (admission care plan). Review of R2's behavior monitoring on the "Medication Administration Record" for agitation/delusions revealed the following: June 2022: no behaviors recorded July 2022: behaviors recorded on 07/15/22 August 2022: behaviors documented for 08/25/22 in the morning and 08/27/22 in the morning. September: behavior recorded on 09/06/22 October: no behaviors recorded A "Physician's Order," dated 07/14/22, directed staff to obtain a psychiatry consult for R2's	F 740			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2022	
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F 740	Continued From page 26 increased anxiety and yelling. A "Weekly Clinical/IDT [interdisciplinary team] Review" dated 07/28/22 recorded R2 had daily behavior of yelling out staff names and continued with behavior monitoring. A "Social Service Summary" note on 08/19/22 recorded R2 was able to make her needs known to others. R2 often yelled out repeatedly for someone to help her. R2 often started yelling out at the same time she pushed the call light, or at times would not use the call light and only yell out. A "Nurse Note" dated 08/24/2022 recorded R2 continued to call for staff after being changed several times. Staff tried to reassure R2 that the staff would ensure R2's safety but R2 continued to yell out. Staff called the provider on call and asked to reinstate R2's as needed Ativan (medication used to treat agitation and/or anxiety). The provider declined to reinstate the Ativan because the psychiatrist was trying other medications. The Initial "Psychiatric Evaluation," dated 08/30/22 (47 days after the physician order for the consult), recorded R2 had behaviors of persistent yelling and agitation, and required consistent behavior interventions and medication regimen. On 10/03/22 at 12:28 PM, observation revealed R2 persistently screamed from her room many times over a 16-minute interval "I'm hungry," "bring me my food," and "my diaper needs changed." Continued observation revealed R2's screaming comments could be heard in the dining room where 15 residents ate lunch.			F 740			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

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F 740	Continued From page 27 On 10/04/22 at 10:33 AM, observation revealed R2 persistently screamed from her room over a 21-minute interval, and staff attempted three times to redirect her screaming behaviors. Continued observation revealed R2's persistent screaming disrupted a bingo activity for 16 residents. On 10/03/22 at 01:52 PM, Certified Medication Aide (CMA) R stated R2 had screaming behaviors every day that disrupted other residents' meals, activities, and sleep. CMA R stated staff were not able to prevent or redirect R2's screaming and yelling behaviors. On 10/04/2 at 02:10 PM, Licensed Nurse (LN) H stated R2 had frequent disruptive behaviors that agitated other residents, was difficult to redirect and staff should record and monitor the resident's behaviors. LN G stated R2 spent most of her time in her room in bed, and when R2 had behaviors outside her room other residents often confronted her with angry comments. On 10/05/22 at 09:27 AM, Administrative Nurse D stated R2 had frequent disruptive behaviors that impacted other residents. Administrative Nurse D stated staff should monitor the resident's behaviors to identify causative factors and develop new interventions to prevent and/or redirect R2's behaviors. The facility's "Behavior Policy," dated 01/02/22, directed staff to record and monitor the residents' behaviors, complete accurate assessments, and implement intervention to prevent and/or redirect the behaviors.	F 740			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

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F 740	Continued From page 28 The facility failed to provide the necessary behavioral health services and interventions for R2, placing the resident at risk for continued and worsened behaviors.	F 740			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

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F 756	Continued From page 29 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 19 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure a system where staff acknowledged, reported to the physician, and acted upon the Consultant Pharmacist (CP) recommendations for Resident (R) 6 who received routine insulin (medication used to lower blood sugar). This placed the resident at risk for complications related to high or low blood sugar levels. Findings included: - R6's "Medical Diagnosis" section withing the Electronic Medical Record (EMR) included diagnoses of chronic pain syndrome, major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (nerve damage) and multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord). The "Quarterly Minimum Data Set" (MDS), dated 08/19/22, documented R6 had moderately impaired cognition, required extensive to total	F 756			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2022
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F 756	Continued From page 30 assistance of one to two staff for activities of daily living. The MDS further documented R6 received insulin. The "Nutrition Care Plan," dated 08/15/22, documented R6 had nutritional problem related to acute and chronic illness, had diabetes type two, needed a therapeutic diet, insulin and glipizide (oral medication to stabilize blood sugar). The care plan further documented R6 had nutritional diagnoses of obesity and impaired nutrient utilization related to lifestyle choices, decreased physical activity with excess calorie intake. The care plan directed staff to administer medications as ordered, obtain and monitor lab/diagnostic word as ordered. The "Physician Order Sheet", dated 09/14/22, directed staff to administer: Glipizide 5 milligrams (mg) by mouth once daily related to type diabetes mellitus. Glargine Insulin Solution (long acting insulin) inject eight units at bedtime for diabetes mellitus. Linagliptin (mediation used to treat diabetes mellitus type 2) 5 mg by mouth once daily for diabetes mellitus. Lispro Insulin Solution (fast acting insulin) inject eight units before meals and at bedtime for diabetes mellitus. Novolog Solution (fast acting insulin) inject eight units before morning meal and at bedtime for diabetes mellitus. The "Pharmacy Review", dated 02/20/22, documented to consider blood glucose parameters for the use of Lispro insulin. The medical record lacked evidence staff acknowledge/addressed the CP's recommendations.	F 756			

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

PRINTED: 10/14/2022
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2022
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F 756	Continued From page 31 On 10/03/22 at 09:35 AM, observation revealed staff providing personal cares for R6. R6 stated she took several medications to control her blood sugar levels. On 10/04/22 at 08:59 AM, Licensed Nurse (LN) G verified the medical record lacked blood sugar parameter for the use blood sugar levels. On 10/05/22 at 09:10 AM, Administrative Nurse D stated the pharmacist review and recommendations should be followed and blood sugar parameter should have been obtained from the physician. The facility 's "Medication Regimen Review" (MMR), dated 08/2017, documented the pharmacist reviews each resident's medication regimen at least monthly in order to identify irregularities and to identify clinical significant risks and/or adverse consequences resulting from or associated with medications. The MMR includes identification or irregularities, medication related errors, adverse consequences, and use of unnecessary drugs. The facility failed to ensure a system where staff acknowledged, reported to the physician, and acted upon the CP recommendations for R6 who received routine insulin. This placed the resident at risk for complications related to high or low blood sugar levels.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757			

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

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

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F 757	Continued From page 32 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 19 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to obtain blood sugar parameters for Resident (R) 6 who received routine insulin (medication used to lower blood sugar). This placed the resident at risk for complications related to high or low blood sugar levels. Findings included: - R6's "Medical Diagnosis" section withing the Electronic Medical Record (EMR) included diagnoses of chronic pain syndrome, major depressive disorder (abnormal emotional state characterized by exaggerated feelings of	F 757			

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

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FORM APPROVED
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F 757	Continued From page 33 sadness, worthlessness, emptiness and hopelessness), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (nerve damage) and multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord). The "Quarterly Minimum Data Set" (MDS), dated 08/19/22, documented R6 had moderately impaired cognition, required extensive to total assistance of one to two staff for activities of daily living. The MDS further documented R6 received insulin. The "Nutrition Care Plan," dated 08/15/22, documented R6 had nutritional problem related to acute and chronic illness, had diabetes type two, needed a therapeutic diet, insulin and glipizide (oral medication to stabilize blood sugar). The care plan further documented R6 had nutritional diagnoses of obesity and impaired nutrient utilization related to lifestyle choices, decreased physical activity with excess calorie intake. The care plan directed staff to administer medications as ordered, obtain and monitor lab/diagnostic word as ordered. The "Physician Order Sheet", dated 09/14/22, directed staff to administer: Glipizide 5 milligrams (mg) by mouth once daily related to type diabetes mellitus. Glargine Insulin Solution (long acting insulin) inject eight units at bedtime for diabetes mellitus. Linagliptin (mediation used to treat diabetes mellitus type 2) 5 mg by mouth once daily for diabetes mellitus. Lispro Insulin Solution (fast acting insulin) inject eight units before meals and at bedtime for	F 757			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 757	Continued From page 34 diabetes mellitus. Novolog Solution (fast acting insulin) inject eight units before morning meal and at bedtime for diabetes mellitus. The "Pharmacy Review", dated 02/20/22, documented to consider blood glucose parameters for the use of Lispro insulin. The medical record lacked the pharmacist recommended blood glucose parameters. On 10/03/22 at 09:35 AM, observation revealed staff providing personal cares for R6. R6 stated she took several medications to control her blood sugar levels. On 10/04/22 at 08:59 AM, Licensed Nurse (LN) G verified the medical record lacked blood sugar parameters for the use blood sugar levels. On 10/05/22 at 09:10 AM, Administrative Nurse D stated the pharmacist review and recommendations should be followed and blood sugar parameter should have been obtained from the physician. The facility 's "Medication Regimen Review" (MMR), dated 08/2017, documented the pharmacist reviews each resident's medication regimen at least monthly in order to identify irregularities and to identify clinical significant risks and/or adverse consequences resulting from or associated with medications. The MMR includes identification or irregularities, medication related errors, adverse consequences, and use of unnecessary drugs. The facility failed to obtain blood sugar parameters which placed R6 at risk of adverse	F 757			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 757	Continued From page 35 consequences related to blood sugar levels and insulin use.	F 757			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 19 residents. Based on observation, record review , and interview, the facility failed to secure a treatment cart and appropriately store and label multiple-dose insulin (medication to lower blood sugar) pens (an	F 761			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2022
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F 761	Continued From page 36 injection device) located on the second-floor nursing unit for Resident (R) 59, R24 and R53. This deficient practice placed the residents at risk for ineffective medication and allowed unsafe access to medications. Findings included: - On 09/28/22 at 08:09 AM, during initial tour, observation revealed the medication cart had insulin pens which were not dated when opened for R59 and R24. On 09/28/22 at 08:25 AM, during initial tour, observation revealed an unattended treatment cart located in the hall, which was unlocked and unattended. The unlocked treatment cart drawers contained multiple insulin pens. R53's multidose insulin pen lacked a date when opened. On 09/28/22 at 08:09 AM, Licensed Nurse (LN) G verified R59 and R24 lacked opened dates on the insulin pens. LN G stated the pens should have been labeled with a date when put in use. On 09/28/22 at 08:29 AM, LN H entered the hallway where the unlocked treatment cart was parked. LN H verified the cart had been unlocked and unsupervised as LN H had been in a residents' room with the door shut to the hallway. LN H stated the treatment cart should have been locked while unsupervised. LN H verified insulin pens stored in the top drawer and R53's two insulins pens which lacked opened dates. On 10/05/22 at 09:18 AM, Administrative Nurse D verified insulin pens should be labeled with opened dates and the treatment cart should had been locked when not supervised.	F 761			

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER SHAWNEE POST ACUTE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 ANTIOCH ROAD OVERLAND PARK, KS 66204		
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F 761	Continued From page 37 The facility's "Storage and Controlling Medication" policy, dated 07/2017, documented to store medications safely, securely, and proper following manufacture's recommendations or those the supplier, and in accordance with federal and state laws and regulations. The medication supply is accessible only to authorized personnel. The facility's "Medication Labels" policy, dated 03/2022, documented insulins after being opened for the first-time use, will have the date the medications was opened labeled on the pen, box or vial. The facility failed to secure an unattended treatment care on one hall and failed to appropriately date insulin pens for R59, R24, and R53 which placed the residents at risk of ineffective medications and unsafe access to medications.	F 761			
F 804 SS=D	Nutritive Value/Appeal, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 19 residents. Based on observation, record review and interview, the	F 804			

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

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F 804	Continued From page 38 facility failed to prepare a pureed diet using professional standards to maintain nutritive and palatable value for three residents, Resident (R)22, R23, and R52. This placed the residents at risk for inadequate nutrition. Findings included: - On 10/03/22 at 11:00 AM, observation revealed Dietary Staff (DS) CC prepared three pureed diets. DS CC placed three servings (approximately three ounces each serving) of lemon peppered chicken in a food processor/blender. DS CC blended the chicken, added an unmeasured amount of chicken broth, to the pureed texture, then emptied the chicken into three stainless-steel food storage pans, then stored the pans in the oven. DS CC placed three servings (approximately four ounces each serving) of macaroni salad in a food processor/blender. DS CC blended the macaroni salad, added one half cup of milk, then blended to the correct pureed texture, emptied the macaroni salad on to the divided plates. Continued observation revealed DS CC placed three servings (approximately four ounces each serving) of pickled beets in a food processor/blender. DS CC blended the beets, with no added liquids needed, to the correct pureed texture, and emptied the beets on to the divided resident plates. DS CC placed three servings of brownie (approximately 2 inches by 2 inches) in a food processor/blender. DS CC blended the brownies with one-half cup of milk and the texture was too thin DS CC added two squirts of thickener (amount not measured) to the desired consistency. On 10/03/22 at 11:30 AM, DS CC stated she was	F 804			

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F 804	Continued From page 39 aware she needed to follow a pureed recipe but said she did not have one available. DS CC stated the facility had a book in the kitchen but it was not for the specific meal she was preparing. DS CC verified she had added a certain amount of the milk and some chicken broth but did not follow a recipe. On 10/05 at 09:30 PM, Dietary Staff BB verified the dietary staff were expected to use a pureed recipe when preparing a pureed diet and the facility had a 3-ring binder that had the recipes available. Dietary Staff BB verified the binder did not have the recipe for the lemon peppered chicken, beets, macaroni salad or brownies. Dietary Staff BB verified the Registered Dietician would provide the recipes for the food prepared. The facility's "Dietary Services meals and Food" policy, dated June 2017, recorded it is the policy of this facility to ensure dietary services are provided to our residents operating within the confines of state regulations. The policy recorded the CDM is responsible for the total food services of this facility. Menus are planned at least one week in advance and variations from the posted menus are documented. The policy documented therapeutic diets as ordered by the resident's physician are provided according to the service plan and food prepared for consumption by our residents is prepared according to all applicable food service regulations. The facility failed to prepare a pureed diet using professional standards to maintain nutritive and palatable value for R22, R23, and R52. The placed the residents at risk for inadequate nutrition.	F 804			

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F 812	Continued From page 40	F 812			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. Based on observation, record review, and interviews, the facility failed to serve food in a safe and sanitary manner for two of the five kitchenettes in the facility. This placed the affected residents at risk for food-borne illness. Findings Included: - On 10/03/22 at 08:30 AM, during tour of the facility kitchenette, observation of the temperature logs of Willow one and Maple two daily food temperature logs lacked evidence staff assessed temperature of the following meals:	F 812 F 812			

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F 812	Continued From page 41 Willow one: Review of the weekly unit temperature logs from September 25 until October 1, 2022 revealed the 09/26/22 supper meal lacked documented temperatures. Review of the weekly unit temperature logs form August 28 until September 3, 2022 revealed the 09/28/22 supper meal lacked documented temperatures. Review of the weekly temperature logs from August 14 -20, 2022 revealed the 08/17/22 supper meal lacked documented temperatures. Maple two: Review of the weekly temperature logs from July 20-30, 2022 lacked temperatures of the lunch meal on 07/24/22 and the supper meals on 07/24/22, 07/25/22 and 07/29/22 lacked documented temperatures. Review of the weekly temperature logs from July 31 -August 06, 2022 lacked documentation of temperatures on 08/01/22, and 08/06/22 for the supper meals. Review of the weekly temperature logs from August 7-13, 2022 lacked documented temperatures on 08/07/22, 08/10/22 and 08/12/22 for the supper meals. Review of the weekly temperature logs from August 14 -20, 2022 revealed no documented temperatures for the supper meals on 08/15/22 and 08/18/22. Review of the weekly temperature logs from August 21-27,2022 revealed no documented	F 812			

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F 812	Continued From page 42 temperatures for the supper meals on 08/23/22, 0825/22, and 08/27/22. Review of the weekly temperature logs from September 04 -10, 2022 revealed the 09/04/22 and 09/06/22 supper meals lacked documented temperatures. 09/01/22 lacked documented temperatures for the breakfast and lunch meal. Continued review of the kitchenette temperature logs revealed no evidence staff assessed food temperatures from the two kitchenettes at the facility from September 2021 until July 2022. Dietary Staff BB verified she started work at the facility one month ago and was unable to find the logs for the past temperatures. On 10/05/22 at 09:30 AM, Dietary Staff BB stated staff should assess and document the food temperature before serving the residents their meals with each meal served. The facility's "General Food Handling/Storage/Prepare" policy, dated 2021, (no month identified) recorded it is the policy of the facility to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors. Additionally, the facility procures food from sources approved or considered satisfactory by federal, state or local authorities. This includes the storage, preparations, distributing, and serving food in accordance with professional standards for food service safety. Overview of food safety practices the Long-Term Care facility follows to ensure resident safety are to cook foods to the appropriate temperature to kill microorganisms and keep food hot at 135 degrees and cold foods at 41 degrees. Take food			F 812			

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F 812	Continued From page 43 temperatures during and after cooking and keep temperature logs, food safety monitoring software can help ensure compliance. The facility failed to serve food in a safe manner when staff failed to assess and log food temperatures for each meal, placing the residents at risk for food borne illnesses.	F 812			