STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 wa sent electronically on 11/01/22.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/01/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

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DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 656	Continued From page 1	F 656		

desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents, with one reviewed for smoking. Based on observation, record review and interview, the facility failed to develop a comprehensive care plan for smoking for Resident (R) 72. This placed the resident at risk for smoking related injury.

Findings included:

- The Electronic Medical Record (EMR) for R72 documented diagnoses of hemiplegia (paralysis of one side of the body), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), diabetes mellites type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS), dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 656	Continued From page 2 09/12/22, documented R72 had moderately impaired cognition and required extensive assistance with one staff for transfers, toileting, and personal hygiene, and limited assistance of one staff for bed mobility and dressing. The MDS further documented R72 did not ambulate. The "Smoking Assessment" dated 04/07/22 documented R72 was not cognitively impaired, was able to call for help is a lit cigarette fell, was supervised by staff in a designated area, and had been instructed in the facility's smoking policy. R72's EMR lacked documentation of a smoking care plan. On 10/18/22 at 04:10 PM, observation revealed R72 sat outside in the designated smoking area, with other residents and staff, smoking. On 10/24/22 at 10:05 AM, Administrative Nurse E verified R72 did not have a care plan for smoking. On 10/24/22 at 01:00 PM, Administrative Nurse D stated R72 should have a care plan for smoking. The facility's "Care Management" policy, dated December 2020, documented a comprehensive plan of care, based on interdisciplinary assessments, are developed and implemented within 21 days of admission for permanent residents. The facility failed to develop a comprehensive care plan for smoking for R72. This placed the resident at risk for smoking related injury.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 657	Continued From page 3	F 657		

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to update the care plan with interventions for Resident (R) 51, and R111's falls, and R35 for behaviors. This practice placed the residents at risk for injury from falls and unmet care needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 657	Continued From page 4	F 657		

Findings included:

- The Electronic Medical Record (EMR) for R51 documented diagnoses of astrocytoma (brain cancer), epilepsy (brain disorder characterized by repeated seizures), and hypokalemia (deficiency of potassium in the bloodstream).

The "Admission Minimum Data Set," (MDS), dated 12/08/21, documented R51 had severely impaired cognition and required extensive assistance of two staff for transfers, toileting, and extensive assistance of one for bed mobility, personal hygiene, and locomotion on and off the unit. The assessment further documented R51 had unsteady balance, no upper or lower functional impairment, and had no falls.

The "Quarterly MDS," dated 09/11/22, documented R51 had moderately impaired cognition and required extensive assistance of two staff for transfers, toileting, and extensive assistance of one staff for bed mobility, personal hygiene, and locomotion on and off the unit. The MDS further documented R51 had unsteady balance, no upper or lower functional impairment, and had no falls.

The "Fall Risk Assessments," dated 06/08/22, and 09/15/22 documented R51 was a high risk for falls and on 10/17/22, a low risk for falls.

The "Care Plan," originally dated 10/27/21, documented R51 was a high risk for falls and directed staff to minimize the risk of falls and encouraged R51 to wait for assistance and not transfer herself, ensure the call light was within reach and educate on the use of the call light, and physical therapy to evaluate and treat. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 657	Continued From page 5	F 657		

update, dated 12/29/21, directed staff to ensure her plant was within reach to enable her to care for her plant in a safe way. The update, dated 01/29/22, directed staff to provide frequent checks on the resident. The update, dated 03/17/22, documented R51 was on therapy caseload, and directed staff to encourage or offer toileting more frequently. The update, dated 05/22/22, directed staff to obtain therapy screen to assess for safety with adaptive equipment use. The update, dated 06/11/22, documented R51 was on therapy caseload and assess the ability to use a reacher tool (an adaptive device for people with limited range of motion grab out of reach items).

The "Post -Fall Assessment," dated 12/29/21 at 07:45 AM, documented R51 rolled out of bed while she reached for her plant to water it. The plant had been on her heater unit and R51 was unable to reach it. The assessment further documented staff reeducated R51 to utilize her call light for assistance and moved the resident's plant within reach.

The "Post-Fall Assessment," dated 01/29/22 at 11:00 PM, documented R51 was unable to communicate what had occurred but the nurse anticipated the resident tried to pick up something off the floor and fell. The assessment further documented staff reeducated R51 to call for assistance and to provide frequent checks related to unsafe behavior.

The "Post-Fall Assessment," dated 03/07/22 at 10:43 AM, documented R51 stated she fell while taking herself to the bathroom. The assessment further documented the resident was on therapy caseload and directed staff to encourage or offer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 657	Continued From page 6	F 657		

toileting more often.

The "Post-Fall Assessment," dated 05/22/22 at 10:00 PM, documented R51 was in her room on the floor, and stated she had dropped her ipad (a touchscreen electronic device) under her bed and tried to pick it up. The assessment documented staff reeducated R51 to call for assistance and the resident was on therapy caseload and have therapy assess for safety with adaptive equipment use.

The "Post-Fall Assessment," dated 06/11/22 at 01:30 PM, documented R51 was in her room on the floor and she did not know what had happened. The assessment further documented R51 was uninjured and R51 was on therapy caseload and would have therapy assess R51 to use a reacher tool.

On 10/20/22 at 10:00 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around R51's waist, slowly stood the resident up, and held onto her gait belt as she did not have good balance and CNA N had to slowly assist her to sit in the wheelchair.

On 10/20/22 at 10:00 AM, CNA N stated R51 had previous falls from transferring without calling for assistance and physical therapy was working with her to assist with balance and ambulation.

On 10/24/22 at 10:15 AM, Licensed Nurse (LN) G stated R51 was unable to ambulate and received therapy to assist with balance and ambulation. LN G further stated nurses were able to assist with new interventions after a resident fell but did not remember any of R51 falls or any of her current fall interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 657	Continued From page 7	F 657		

On 10/24/22 at 01:00 AM, Administrative Nurse D stated, there were new interventions for each fall and any resident with cognitive impairment should have new interventions on their care plans.

The facility's "Care Management" policy, dated December 2020, documented a plan of care was continually updated to reflect current residents needs at all times.

The facility failed to revise the care plan with interventions to prevent further falls for cognitively impaired R51. This placed the resident at risk for further falls.

- The Electronic Medical Record (EMR) for R111 documented diagnoses of diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (high blood pressure), chronic kidney disease (disease of the kidneys leading to renal failure), and chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Annual Minimum Data Set," (MDS), dated 01/13/22, documented R111 had moderately impaired cognition and required supervision and one staff assistance for dressing, toileting, and supervision with set up assistance for bed mobility and transfers. The MDS further documented R111 had unsteady balance, independent with set up assistance for ambulation, no functional impairment, and one non-injury fall since the prior assessment.

The "Quarterly MDS," dated 09/23/22,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 657	Continued From page 8	F 657		

documented R111's cognition was not assessed and required extensive assistance of two staff for bed mobility, transfers, toileting, and did not ambulate. The assessment further documented R111 had unsteady balance, no functional impairment, had no falls, and received physical, occupational, and speech therapy services three to five days per week.

The "Fall Risk Assessments," dated 05/16/22, 08/15/22, 09/15/22, documented R111 was a high risk for falls.

The "Fall Care Plan," originally dated, 05/29/21, documented R111 may forget to use her call light, so check on the resident frequently, ensure R111 had nonskid footwear one and assist with keeping room clutter free, wear nonskid socks, educate the resident to use her call light, and monitor and remind the resident not to sit or lay on top of her bedding near the edge of the bed or she was at risk to slip off the bed, The update, dated 01/09/22, directed staff to check on the resident every two hours for bathroom needs, and obtain a therapy screen for balance and gait training. The update, dated 01/15/22, directed staff to ensure non-skid footwear/socks are on the resident. The update, dated 01/18/22, directed staff to obtain therapy screen for balance and strength for safe ambulation. The update, dated 05/18/22, directed staff to use a hoyer lift (a full body lift that allows a person to be lifted and transferred with a minimum of physical effort) for transfers. The update, dated 07/23/22, directed staff to encourage non skid socks, reeducate to use the call light and ask for assistance. The update, dated 07/28/22, directed staff to ensure personal items are within reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 657	Continued From page 9	F 657		

The "Post -Fall Assessment," dated 01/09/22 at 07:12 PM, documented R111 felt weak and fell while attempting to take herself to the bathroom. The resident had poor safety awareness, forgetful, and had a history of falls. The assessment directed staff to obtain a therapy screen for gait training.

The "Post -Fall Assessment," dated 01/15/22 at 03:24 PM, documented R111 ambulated without nonskid sock on by her bathroom sink. The resident had poor safety awareness and were directed to ensure nonskid footwear or socks were on the resident.

The "Post -Fall Assessment," dated 01/18/22 at 10:03 PM, documented R111 was fully dressed, lying on the floor with a blanker under her head. The resident did not have non skid socks on, with the walker lying beside her. The assessment further documented R111 stated she was walking to the bathroom, slipped, and landed on her left knee. The assessment documented R111 obtained a small abrasion (scrape) which measured one-centimeter (cm) x one cm. The resident was reeducated to use her call light for assistance. The assessment directed staff to obtain a therapy screen to continue to work on balance and strengthening and to assist R111 to wear non skid socks.

The "Post -Fall Assessment," dated 03/18/22 at 08:09 PM, documented R111 stated she sat on the edge of her bed and thought she slid off. The resident did not have non skid socks on. The assessment directed staff to ensure R111 had non skid socks on and non skid strips were placed on the floor at the bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 657	Continued From page 10	F 657		

The "Post -Fall Assessment," dated 04/21/22 at 02:30 AM, documented R111 slid off the bed onto the floor while she attempted to transfer herself to go to the bathroom. The assessment directed staff to continue to provide frequent checks on the resident.

The "Post -Fall Assessment," dated 04/25/22 at 01:31 PM, documented R111 slid out of bed onto the floor while she attempted to take herself to the bathroom. the assessment directed staff to obtain a therapy screen for bed safety training.

The "Post -Fall Assessment," dated 05/18/22 at 10:40 AM, documented R111 fell while staff assisted her with a transfer. The assessment documented R111 obtained a small abrasion to her left knee which measured one cm x a half cm. The assessment further documented staff were educated on R111 increased weakness and weight bearing status and she was assisted to bed with three staff assistance.

The "Post -Fall Assessment," dated 06/04/22 at 11:14 AM, documented R111 stated she fell while she tried to get out of bed. R111 was dressed in her night gown, was incontinent, and had no shoes or socks on. The staff reeducated R111 on the importance to use her call light and to put on non skid socks. The assessment documented R111 was non-compliant with all previous fall interventions and a medical evaluation would be completed.

The "Post -Fall Assessment," dated 07/23/22 at 01:36 PM, documented R111 stated she tried to shut off her light and fell. The assessment documented staff reeducated R111 on the use of non skid socks and call for assistance. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 657	Continued From page 11	F 657		

assessment directed staff to continue current plan of care.

The "Post -Fall Assessment," dated 07/28/2 at 04:17 PM, documented R111 stated she leaned over to grab an envelope, lost control and fell. The assessment documented R111 obtained rug burns to both of her knees. The assessment directed staff to continue current plan of care.

On 10/20/22 at 08:45 AM, observation revealed R111 in bed with pressure reducing boots on both feet. Further observation revealed Certified Nurse Aide (CNA) O and CNA QQ in room to assist with a transfer out of bed and into her wheelchair. Further observation revealed the sling for the lift was already under R111 and CNA O attached it to the lift. Continued observation revealed R111 was raised up off the bed with the lift and taken to her wheelchair and lowered into the seat as CNA QQ tilted the wheelchair back so the resident would sit comfortably in the wheelchair. Observation revealed there were no non skid strips beside the resident's bed.

On 10/20/22 at 08:45 AM, CNA O stated R111 had a lot of falls because she did not use her call light and they always tell her she needs to use her call lights.

On 10/24/22 at 10:15 AM, Licensed Nurse G stated they reeducate her to call, check on her hourly, and tell her not to get up by herself. LN G further stated R111 thinks she can get up by herself but her functional status has changed, staff put non skid socks are her, lower her bed, and she is a two person mechanical lift.

On 10/24/22 at 01:00 PM, Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 657	Continued From page 12	F 657		

stated all falls should have new interventions after review of the fall. Administrative Nurse D further stated, all falls are reviewed weekly during fall huddle.

The facility's "Care Management" policy, dated December 2020, documented a plan of care was continually updated to reflect current residents needs at all times.

The facility failed to revise the care plan with interventions to prevent further falls for R111. This placed the resident at risk for further falls.

- The Electronic Medical Record (EMR) documented R35 had diagnoses of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), psychosis (any major mental disorder characterized by a gross impairment in reality testing), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS), dated 08/22/22, documented R35 had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R35 had no behaviors and received an antidepressant (a class of medication used to treat mood disorders and relieve symptoms of depression) six days during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 657	Continued From page 13	F 657		

the look back period.

The "Care Plan," dated 09/06/22, directed staff to administer medications as ordered, when agitated ask R35 about his pain level, and if he would like a snack, encourage him to talk about his past life, and experiences. The care plan lacked interventions related to R35's repeated calls to 911 (a phone number used to contact the emergency services).

The "Nurse's Note," dated 01/05/22 at 06:14 AM, documented R35 continued to call 911 from a phone in his room, four times in 10 minutes, and about 20 times in total. The nurse's note further documented R35 had delusions that the hospital, his former employer, tried to reach him. The note documented staff attempted to explain to him that he was retired but R35 was non receptive and continued to yell and scream at staff.

The "Nurse's Note," dated 05/02/22 at 09:51 PM, documented the facility received a call from the local police department and stated R35 had called and requested assistance in his room. The note further documented staff asked R35 not to call police.

The "Nurse's Note," dated 05/19/22 at 10:47 PM, documented R35 called 911 and told them someone was on the floor. The note further documented R35 told nursing staff he had been on the floor.

The "Nurse's Note," dated 08/16/22 at 11:42 PM, documented the facility received a call from 911 twice and were told R35 had called 911 ten times for assistance into his wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 657	Continued From page 14 The "Nurse's Note," dated 09:32 AM, documented R35 called 911 because his roommate yelled for help. The note further documented R35 was agitated and wanted his roommate removed from the room. On 10/18/22 at 03:50 PM, observation revealed R35 in bed watching television. On 10/20/22 at 11:44 AM, Certified Nurse Aide (CNA) M stated R35 had always been pleasant with her and had never called 911 when she had been there. CNA M further stated R35 did not like his roommate and would often get mad at him but they moved the resident to a different room. On 10/24/22 at 10:05 AM, Administrative Nurse E verified there was not an intervention for when R35 called 911. On 10/24/22 at 10:15 AM, Licensed Nurse (LN) G stated she would not know if R35 called 911 unless other staff hear him and informed her. The facility's "Care Management" policy, dated December 2020, documented a plan of care was continually updated to reflect current residents needs at all times. The facility failed to revise the care plan with interventions to address R35's behavior of placing multiple calls to 911 placing the resident at risk for further distress.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 688	Continued From page 15	F 688		

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 of motion is unavoidable; and

§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.

§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:
The facility had a census of 118 residents. The sample included 25 residents with one reviewed for positioning. Based on observation, interview and record review the facility failed to ensure proper positioning and utilize a neck pillow or collar as care planned for sampled Resident (R) 101. This deficient practice placed the resident at risk for further decrease in range of motion.

Findings included:

- R101's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (type of dementia that affects memory, thinking and behavior).

The "Significant Change Minimum Data Set" (MDS), dated 09/26/22, documented R101 had severe cognitive impairment, impaired range of motion (ROM) in all extremities, and required extensive staff assistance with eating, dressing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 688	Continued From page 16	F 688		

bed mobility and total staff assistance with transfers, locomotion, toileting, and hygiene.

The "Skin Care Area Assessment" (CAA), dated 09/26/22, documented R101 was at risk of skin breakdown due to decreased mobility and incontinence.

The "Skin Care Plan," dated 09/20/22, directed staff to transfer R101 with a total lift for meals only, and plan for her to be the last resident up and first down (to bed) to limit daily transfers and limit time in her wheelchair due to fragile skin. The care plan directed staff to utilize a neck collar or pillow while in her wheelchair, assist her with repositioning frequently, and use positioning devices as needed.

The 08/03/22 "Event Investigation" documented R101 had bruising due to the total lift pad cradling her during transfers. She had contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and fragile skin and the yellowish/green bruise to her left neck, right cheek and eye area were consistent with where the resident positioned her hand. The investigation stated the schedule was changed so she was last up and first down for meals and activities.

The 08/30/22 "Hospice Note" documented the nurse provided a bed bath and found redness and yeast under R101's chin and neck. The hospice nurse notified the physician who ordered antifungal treatment to the area.

The 10/15/22 "Occupational Therapy (OT) Assessment" documented R101 had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 688	Continued From page 17	F 688		

long-standing history of contractures though they appear to have increased with potential for decreased skin integrity and increased assistance during care. Contractures were severe and R101 presented with hypertonicity (resistance to passive movement), and severe contractures of both upper extremities. The OT assessment documented R101 required skilled therapy services to address the following: develop/train/educate caregivers in techniques and strategies, facilitate sitting tolerance and postural control, decrease painful condition of upper extremities and improve range of motion in order to enhance this patient's quality of life by improving the ability to relieve pressure for decreased risk of skin breakdown and preserve skin integrity. The assessment documented the resident was at risk for further decline in function, decreased skin integrity and contractures.

On 10/18/22 at 04:05 PM, observation revealed R101 in her wheelchair in her room. Her right hand was by her cheek, in a fist shape. R101 had no neck collar or pillow. The lift sling was under her, and she had thick bootie socks on her feet.

On 10/19/22 at 08:45 AM, observation revealed R101 in her wheelchair in the dining room, facing the windows, with her arms folded across tummy and her neck tilted to the right without a neck pillow or collar. Further observation revealed at 08:50 AM, Nurse Aide (NA) Q took R101 to her room and left her in the wheelchair with her head tilted to the right and no neck pillow placed. Continued observations at 09:40 AM, 10:38 AM, and 11:15 AM, revealed the resident had not been moved or cares provided. At 11:30 AM, NA P wheeled the resident in the wheelchair to the dining room without providing any cares. After

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 688	Continued From page 18	F 688		

staff fed the resident, R101 sat in the wheelchair in the dining room with her head tilted down and to the right side, resting on her right shoulder. At 12:25 PM, NA P fed R101 ice cream and a shake. At 12:35 PM, observation revealed NA P took the resident to her room, and with NA Q assisted to transfer R101 with a total lift from her wheelchair to her bed. The aides provided incontinent care, placed a pillow between R101's knees, and positioned the resident on her right side with a pillow under head.

On 10/20/22 at 07:50 AM, observation revealed R101 in her wheelchair at the dining table. She had her legs drawn up partially, her hands clenched, and she had no neck pillow or collar.

On 10/24/22 at 09:22 AM, observation revealed R101 sat in her wheelchair in the hall outside her room with her eyes closed, and her knees drawn up. Her head lay to her right, resting on her shoulder without a neck pillow or collar. At 09:23 AM, NA PP wheeled R101 into her room, attempted to wash her face but R101 refused to allow her. NA PP left R101 in her wheelchair in her room. At 10:00 AM, observation revealed NA OO and NA PP used the total lift to transfer R101 from her wheelchair to her bed. After providing incontinence cares the aides used the total lift to transfer R101 back into her wheelchair. R101 leaned to her right side, legs pulled up, right hand in a fist under her right chin. When asked if R101 had a neck pillow, NA PP replied, "she does need one" and she looked and found a hand splint, but no neck pillow in the resident's room.

On 10/19/22 at 10:25 AM, Licensed Nurse (LN) H stated R101's skin became reddened occasionally but she had no open areas. LN H

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 688	Continued From page 19	F 688		

stated staff toileted the resident after lunch.

On 10/19/22 at 1:00 PM, NA Q stated R101's next care would be provided around 03:00 PM for incontinent care and then staff would get R101 up in her wheelchair about 04:30 PM.

On 10/20/22 at 07:55 AM NA P stated she did not provide restorative exercises for R101 or any resident on the hall. She stated she did not know if any staff did.

On 10/20/22 at 09:30 AM, Administrative Nurse D stated the facility provided restorative for some residents, but they tried to use Medicare Part B if needed. She did not provide further information.

On 10/24/22 at 10:35 AM, Administrative Nurse E stated R101's family brought a neck pillow in for the resident for positioning and that was placed on the care plan. She stated the hand splint was on the care plan and then verified it was not in the current care plan. Administrative Nurse E stated staff were to take R101 to the dining room right before meals and back to bed right after the meals. Administrative Nurse E stated nurses and aides can see the care plan and verified staff were to follow care plan.

On 10/24/22 at 11:17 AM, LN I stated staff were to get R101 up into her wheelchair one hour before lunch. He was unsure if R101 had a neck pillow or collar and looked it up on the "Medication Administration Record (MAR)" but was unable to find it. He looked in R101's room and did not find a neck pillow or collar. He concluded the regular bed pillow was used for support.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 688	Continued From page 20 On 10/24/22 at 01:47 PM, Administrative Nurse D stated staff were to follow the care plan and place a neck pillow or collar on R101 when she is up in her wheelchair. The facility's "Positioning Resident" policy, date May 2021, documented residents must be repositioned at least every two hours to maintain good body alignment and reduce excessive pressure on any one area of the body. The policy documented good positioning along with range of motion exercises would go a long way to prevent deformities and if not done it becomes difficult to wash the contracted areas and sores may develop. The facility failed to ensure proper positioning and utilize a neck pillow or collar as care planned for R101, placing the resident at risk for further decrease in range of motion to her neck.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 118 residents. The sample included 25 residents, with seven reviewed for accidents. Based on observation, record review, and interview, the facility failed to indentify and /or implement resident centered	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 689	Continued From page 21	F 689		

interventions to prevent falls for Resident (R) 51, and R111. This placed the residents at risk for further falls and injury.

Findings included:

- The Electronic Medical Record (EMR) for R51 documented diagnoses of astrocytoma (brain cancer), epilepsy (brain disorder characterized by repeated seizures), and hypokalemia (deficiency of potassium in the bloodstream).

The "Admission Minimum Data Set," (MDS), dated 12/08/21, documented R51 had severely impaired cognition and required extensive assistance of two staff for transfers, toileting, and extensive assistance of one for bed mobility, personal hygiene, and locomotion on and off the unit. The assessment further documented R51 had unsteady balance, no upper or lower functional impairment, and had no falls.

The "Quarterly MDS," dated 09/11/22, documented R51 had moderately impaired cognition and required extensive assistance of two staff for transfers, toileting, and extensive assistance of one staff for bed mobility, personal hygiene, and locomotion on and off the unit. The MDS further documented R51 had unsteady balance, no upper or lower functional impairment, and had no falls.

The "Fall Risk Assessments," dated 06/08/22, and 09/15/22 documented R51 was a high risk for falls and on 10/17/22, a low risk for falls.

The "Care Plan," originally dated 10/27/21, documented R51 was a high risk for falls and directed staff to minimize the risk of falls and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 689	Continued From page 22	F 689		

encouraged R51 to wait for assistance and not transfer herself, ensure the call light was within reach and educate on the use of the call light, and physical therapy to evaluate and treat. The update, dated 12/29/21, directed staff to ensure her plant was within reach to enable her to care for her plant in a safe way. The update, dated 01/29/22, directed staff to provide frequent checks on the resident. The update, dated 03/17/22, documented R51 was on therapy caseload, and directed staff to encourage or offer toileting more frequently. The update, dated 05/22/22, directed staff to obtain therapy screen to assess for safety with adaptive equipment use. The update, dated 06/11/22, documented R51 was on therapy caseload and assess the ability to use a reacher tool (an adaptive device for people with limited range of motion grab out of reach items).

The "Post -Fall Assessment," dated 12/29/21 at 07:45 AM, documented R51 rolled out of bed while she reached for her plant to water it. The plant had been on her heater unit and R51 was unable to reach it. The assessment further documented staff reeducated R51 to utilize her call light for assistance and moved the resident's plant within reach.

The "Post-Fall Assessment," dated 01/29/22 at 11:00 PM, documented R51 was unable to communicate what had occurred but the nurse anticipated the resident tried to pick up something off the floor and fell. The assessment further documented staff reeducated R51 to call for assistance and to provide frequent checks related to unsafe behavior.

The "Post-Fall Assessment," dated 03/07/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 689	Continued From page 23	F 689		

10:43 AM, documented R51 stated she fell while taking herself to the bathroom. The assessment further documented the resident was on therapy caseload and directed staff to encourage or offer toileting more often.

The "Post-Fall Assessment," dated 05/22/22 at 10:00 PM, documented R51 was in her room on the floor, and stated she had dropped her ipad (a touchscreen electronic device) under her bed and tried to pick it up. The assessment documented staff reeducated R51 to call for assistance and the resident was on therapy caseload and have therapy assess for safety with adaptive equipment use.

The "Post-Fall Assessment," dated 06/11/22 at 01:30 PM, documented R51 was in her room on the floor and she did not know what had happened. The assessment further documented R51 was uninjured and R51 was on therapy caseload and would have therapy assess R51 to use a reacher tool.

On 10/20/22 at 10:00 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around R51's waist, slowly stood the resident up, and held onto her gait belt as she did not have good balance and CNA N had to slowly assist her to sit in the wheelchair.

On 10/20/22 at 10:00 AM, CNA N stated R51 had previous falls from transferring without calling for assistance and physical therapy was working with her to assist with balance and ambulation.

On 10/24/22 at 10:15 AM, Licensed Nurse (LN) G stated R51 was unable to ambulate and received therapy to assist with balance and ambulation. LN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 689	Continued From page 24	F 689		

G further stated nurses were able to assist with new interventions after a resident fell but did not remember any of R51 falls or any of her current fall interventions.

On 10/24/22 at 01:00 AM, Administrative Nurse D stated, there were new interventions for each fall and any resident with cognitive impairment should have new interventions on their care plans.

The facility "Fall Risk/Prevention" policy, dated April 2021, documented the interdisciplinary fall review team would meet at least weekly and formally address each resident that had fallen during the previous week. The discussion would focus on interventions that have been implemented and other interventions that may be required to reduce falls and meet the resident's needs. The policy further documented, interventions are to be updated on the resident care plan.

The facility failed to implement interventions to prevent or reduce falls for cognitively impaired R51, placing the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) for R111 documented diagnoses of diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (high blood pressure), chronic kidney disease (disease of the kidneys leading to renal failure), and chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Annual Minimum Data Set," (MDS), dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 689	Continued From page 25	F 689		

01/13/22, documented R111 had moderately impaired cognition and required supervision and one staff assistance for dressing, toileting, and supervision with set up assistance for bed mobility and transfers. The MDS further documented R111 had unsteady balance, independent with set up assistance for ambulation, no functional impairment, and one non-injury fall since the prior assessment.

The "Quarterly MDS," dated 09/23/22, documented R111's cognition was not assessed and required extensive assistance of two staff for bed mobility, transfers, toileting, and did not ambulate. The assessment further documented R111 had unsteady balance, no functional impairment, had no falls, and received physical, occupational, and speech therapy services three to five days per week.

The "Fall Risk Assessments," dated 05/16/22, 08/15/22, 09/15/22, documented R111 was a high risk for falls.

The "Fall Care Plan," originally dated, 05/29/21, documented R111 may forget to use her call light, so check on the resident frequently, ensure R111 had nonskid footwear one and assist with keeping room clutter free, wear nonskid socks, educate the resident to use her call light, and monitor and remind the resident not to sit or lay on top of her bedding near the edge of the bed or she was at risk to slip off the bed, The update, dated 01/09/22, directed staff to check on the resident every two hours for bathroom needs, and obtain a therapy screen for balance and gait training. The update, dated 01/15/22, directed staff to ensure non-skid footwear/socks are on the resident. The update, dated 01/18/22, directed staff to obtain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 689	Continued From page 26	F 689		

therapy screen for balance and strength for safe ambulation. The update, dated 05/18/22, directed staff to use a hoyer lift (a full body lift that allows a person to be lifted and transferred with a minimum of physical effort) for transfers. The update, dated 07/23/22, directed staff to encourage non skid socks, reeducate to use the call light and ask for assistance. The update, dated 07/28/22, directed staff to ensure personal items are within reach.

The "Post -Fall Assessment," dated 01/09/22 at 07:12 PM, documented R111 felt weak and fell while attempting to take herself to the bathroom. The resident had poor safety awareness, forgetful, and had a history of falls. The assessment directed staff to obtain a therapy screen for gait training.

The "Post -Fall Assessment," dated 01/15/22 at 03:24 PM, documented R111 ambulated without nonskid sock on by her bathroom sink. The resident had poor safety awareness and were directed to ensure nonskid footwear or socks were on the resident.

The "Post -Fall Assessment," dated 01/18/22 at 10:03 PM, documented R111 was fully dressed, lying on the floor with a blanker under her head. The resident did not have nonskid socks on, with the walker lying beside her. The assessment further documented R111 stated she was walking to the bathroom, slipped, and landed on her left knee. The assessment documented R111 obtained a small abrasion (scrape) which measured one-centimeter (cm) x one cm. The resident was reeducated to use her call light for assistance. The assessment directed staff to obtain a therapy screen to continue to work on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 689	Continued From page 27	F 689		

balance and strengthening and to assist R111 to wear non skid socks.

The "Post -Fall Assessment," dated 03/18/22 at 08:09 PM, documented R111 stated she sat on the edge of her bed and thought she slid off. The resident did not have non skid socks on. The assessment directed staff to ensure R111 had non skid socks on and non skid strips were placed on the floor at the bedside.

The "Post -Fall Assessment," dated 04/21/22 at 02:30 AM, documented R111 slid off the bed onto the floor while she attempted to transfer herself to go to the bathroom. The assessment directed staff to continue to provide frequent checks on the resident.

The "Post -Fall Assessment," dated 04/25/22 at 01:31 PM, documented R111 slid out of bed onto the floor while she attempted to take herself to the bathroom. the assessment directed staff to obtain a therapy screen for bed safety training.

The "Post -Fall Assessment," dated 05/18/22 at 10:40 AM, documented R111 fell while staff assisted her with a transfer. The assessment documented R111 obtained a small abrasion to her left knee which measured one cm x a half cm. The assessment further documented staff were educated on R111 increased weakness and weight bearing status and she was assisted to bed with three staff assistance.

The "Post -Fall Assessment," dated 06/04/22 at 11:14 AM, documented R111 stated she fell while she tried to get out of bed. R111 was dressed in her night gown, was incontinent, and had no shoes or socks on. The staff reeducated R111 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 689	Continued From page 28	F 689		

the importance to use her call light and to put on non skid socks. The assessment documented R111 was non-compliant with all previous fall interventions and a medical evaluation would be completed.

The "Post -Fall Assessment," dated 07/23/22 at 01:36 PM, documented R111 stated she tried to shut off her light and fell. The assessment documented staff reeducated R111 on the use of non skid socks and call for assistance. The assessment directed staff to continue current plan of care.

The "Post -Fall Assessment," dated 07/28/2 at 04:17 PM, documented R111 stated she leaned over to grab an envelope, lost control and fell. The assessment documented R111 obtained rug burns to both of her knees. The assessment directed staff to continue current plan of care.

On 10/20/22 at 08:45 AM, observation revealed R111 in bed with pressure reducing boots on both feet. Further observation revealed Certified Nurse Aide (CNA) O and CNA QQ in room to assist with a transfer out of bed and into her wheelchair. Further observation revealed the sling for the lift was already under R111 and CNA O attached it to the lift. Continued observation revealed R111 was raised up off the bed with the lift and taken to her wheelchair and lowered into the seat as CNA QQ tilted the wheelchair back so the resident would sit comfortably in the wheelchair. Observation revealed there were no nonskid strips beside the resident's bed.

On 10/20/22 at 08:45 AM, CNA O stated R111 had a lot of falls because she did not use her call light and they always tell her she needs to use her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 689	Continued From page 29 call lights. On 10/24/22 at 10:15 AM, Licensed Nurse G stated they reeducate her to call, check on her hourly, and tell her not to get up by herself. LN G further stated R111 thinks she can get up by herself but her functional status has changed, staff put nonskid socks are her, lower her bed, and she was a two person mechanical lift. On 10/24/22 at 01:00 PM, Administrative Nurse D stated all falls should have new interventions after review of the fall. Administrative Nurse D further stated, all falls are reviewed weekly during fall huddle. The facility "Fall Risk/Prevention" policy, dated April 2021, documented the interdisciplinary fall review team would meet at least weekly and formally address each resident that had fallen during the previous week. The discussion would focus on interventions that have been implemented and other interventions that may be required to reduce falls and meet the resident's needs. The policy further documented, interventions are to be updated on the resident care plan. The facility failed to implement interventions to prevent or reduce falls for R111, placing the resident at risk for further falls and injury.	F 689		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	F 745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 745	Continued From page 30	F 745		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents with one reviewed for medically related social service needs. Based on observation, interview and record review the facility failed to provide routine social services visits as care planned for Resident (R) 13. This deficient practice placed her at risk for further behavior and potential for rehospitalization.

Findings included:

- Resident (R) 13's Electronic Medical Record included diagnoses of stroke, hemiparesis (paralysis of one side of the body), diabetes mellitus (an impairment in the way the body regulates and uses sugar (glucose), chronic pain, bipolar disorder (mental illness that causes unusual shifts in mood, energy), post traumatic stress disorder (PTSD- disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

The "Significant Change Minimum Data Set" (MDS), dated 07/17/22, documented R13 had moderate cognitive impairment and behaviors including physical, verbal and rejection of care every one to three days of the lookback period. The MDS documented the behaviors placed the resident at risk for illness or injury. R13 required limited staff assistance with eating and extensive staff assistance for all other activities of daily living (ADL). R13 had range of motion (ROM) impairment in one upper and one lower extremity, was always incontinent, no pain management,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 745	Continued From page 31	F 745		

and received antianxiety (medication used to treat anxiety), antidepressant (medication used to treat mood disorders), antibiotic (medication used to treat bacterial infections), diuretic (substance that promotes diuresis, the increased production of urine, opioids (narcotic pain medication) and insulin (hormone that helps control your body's blood sugar level and metabolism).

The "ADL Care Area Assessment" (CAA), dated 07/17/22, recorded a history of a stroke with left hemiparesis. R13 needed extensive assist of two staff members to complete all ADL tasks. She was bedbound by choice and refused to be transferred (out of bed) despite being educated regarding skin breakdown. She has had episodes of incontinence with staff assisting with incontinence care as needed. Staff will continue to assist with ADL completion and mobility. She was recently hospitalized for altered mental status and urinary tract infection.

The "Behavior Care Plan," dated 07/19/22, documented R13 resisted care such as bathing, linen changes, up/down schedule, position changes, and other cares. R13 has anxiety which could manifest as clinical symptoms. She had multiple hospitalizations possibly due to high anxiety. The care plan directed staff to ensure routine visits from the Social Worker.

The "Psychiatric Practitioner Visit Note," dated 07/25/22, documented R13 had a history of wanting to go to the emergency room multiple times. At that time, she was calm, without pain, and no acute nursing concerns. Psychological services were provided via telehealth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 745	Continued From page 32	F 745		

R13's medical record contained only two social services notes for 2022. The March 2022 note was related to a snack issue and the August 2022 note was related to a room change. The medical record contained no documentation of social services visits provided by the facility for psychosocial concerns.

On 10/19/22 at 09:21 AM, observation revealed R13 in bed using an iPad device. Staff provided incontinence care and noted numerous bloody scratch marks on her left hip and bloody area on left upper buttock.

On 10/19/22 at 10:25 AM, Licensed Nurse (LN) H stated R13 was not very cooperative with the skin treatment and yelled. She stated she washed R13's hands and trimmed her fingernails. She stated staff were to provide care for R13 with two present due to R13's behaviors.

On 10/24/22 at 01:23 PM, Social Services X verified she discussed R13 at the care plan meeting, but the resident was not present. She stated R13 refused psychosocial services from a provider and stated R13's spouse relayed any concerns the resident had. Social Services Staff X verified she had not performed routine visits to R13 for psychosocial or mental health.

On 10/24/22 at 01:24 PM, Social Services Y verified she had not performed routine visits to R13 for psychosocial or mental health and asked if she was supposed to document any interaction she had with R13.

On 10/24/22 at 01:30 PM, Administrative Nurse D stated the social services staff should have visited R13 routinely, as care planned, for mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 745	Continued From page 33 health and well-being. The facility's "Care Management" policy, dated May 2021, documented responses to therapeutic interventions would be recorded in the progress notes. The facility failed to provide routine social services visits as care planned for R13, placing her at risk for further behavior and potential for hospitalization.	F 745		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 755	Continued From page 34	F 755		

receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§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:
- R70's "Electronic Medical Record," (EMR) documented the resident had a diagnosis of hyperkalemia (greater than normal amount of potassium in the blood).

R70's "Quarterly Minimum Data Set" (MDS), dated 10/02/22, documented the resident had a Brief Interview of Mental Status (BIMS) of 13, which indicated intact cognition. The MDS documented R70 required staff supervision with activities of daily living (ADLs).

R70's "Medication Care Plan," revised 10/02/22, instructed staff to administer her medications as the physician ordered.

R70's EMR documented her potassium level was out of normal range (3.5-5.1millimoles per liter (mmol/L) of blood) on the following dates:
04/22/22-6.2 mmol/L
05/31/22-5.4 mmol/L

The "Physician Order, dated 06/09/2022, instructed staff to administer to R70 Lokelma (medication used to treat high levels of potassium in the blood) 5 gram (g) packet, daily.

The "Nurse's Note," dated 09/19/2022 at 01:50 PM, documented R70 did not receive the physician ordered Lokelma, 5g daily, for the last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 755	Continued From page 35	F 755		

two days related to the pharmacy failed to deliver it.

On 10/24/22 at 8:00 AM, observation revealed R70 sat in a wheelchair at the nurse's station.

On 10/24/22 at 12:19 PM, Licensed Nurse (LN) G stated she reordered residents' medication seven to 10 days before it ran out. LN G stated if a resident was out of a medication, she called the pharmacy and asked the pharmacy to send it stat (right away). LN G stated the facility had been having trouble with the pharmacy failing to send residents medications on time; the medications were often sent to a sister facility or not sent at all.

On 10/24/22 at 01:29 PM, Administrative Nurse D stated if a resident was out of a medication, she expected staff to call the physician, family and pharmacy. If the medication continued to be unavailable, she expected staff to keep calling the physician and pharmacy. Administrative Staff D stated the facility had been having trouble with the pharmacy delivering R70's Lokelma; first it was trouble with insurance, then they were not stocking it.

The undated "Pharmacy Services Policy," documented the facility would provide routine and emergency medications and biologicals (medications developed from blood, proteins, viruses, or living organisms) to its residents through an agreement with United Scripts Pharmacy.

The facility failed to ensure availability of physician ordered medications for R70, which placed the resident at risk for ineffective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 755	Continued From page 36	F 755		

medication management.

The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to ensure consistent reconciliation of controlled drugs at the end of daily worked shifts for two of six medication carts and failed to ensure availability of physician ordered medication for two days for Resident (R) 70, which placed residents at risk for misappropriation of medications by staff and unmet therapeutic medication regimen.

Findings included:

- On 10/18/22 at 10:26 AM, observation on the 200-hall medication cart revealed a lack of staff signatures on the "Controlled Drug Record" at the beginning of the day shift 10/04/22 through 10/07/22 (four days). Certified Medication Aide (CMA) S verified the lack of signatures and stated the "Controlled Drug Record" should have been signed to indicate the reconciliation was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(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 755	Continued From page 37 On 10/18/22 at 04:11 PM, observation on the 700-hall medication cart lacked staff signatures on the "Controlled Drug Record" on day shift 10/02/22, 10/10/22, 10/16/22 and evening shift 10/07/22, 10/11/22, and 10/17/22. CMA R verified lack of signatures the "Controlled Drug Record". On 10/18/22 at 04:20 PM, Administrative Nurse D verified staff should complete a reconciliations and sign the "Controlled Drug Record" at the end of each shift to show the count was completed. The facility's "Medications, Controlled Drugs" policy, dated 06/2021, documented when controlled keys change hands during a shift, controlled drugs are recounted and the "counted record" is signed by nurse/certified medication aide. Monitoring of accuracy will be completed routinely by Nursing Administration and Pharmacy. The facility failed to ensure consistent reconciliation of controlled drugs for two of six medication carts which placed residents at risk for misappropriation of medications by staff.	F 755		