

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

PRINTED: 05/05/2023
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 C 05/02/2023	
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			F 000			
F 676 SS=D	The following citations represent the findings of complaint investigations #KS00179812, KS00179824, KS00179800, and KS00179801. The 2567 was sent electronically on 05/05/23. Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,			F 676			

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

TITLE

(X6) DATE

05/05/2023

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.

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 676	Continued From page 1 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: The facility identified a census of 91 residents. The sample included six residents with one resident sampled for communication. Based on observations, record review, and interview, the facility failed to provide effective communication for Resident (R) 1. This deficient practice had the risk for miscommunication of needs between R1 and facility staff and a risk for a decline in psychosocial well-being related to ineffective and unfulfilling communication. Findings included: - R1 admitted to the facility on 01/31/23. The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and need for assistance with personal care. The "Admission Minimum Data Set (MDS)" dated 02/06/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of two which indicated severe cognitive impairment. R1 was usually able to make herself understood with	F 676			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 676	Continued From page 2 difficulty communicating some words or finishing thoughts but was able if prompted or given time. R1 usually understood others with missing some part or intent of a message but comprehended most of the conversation. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 02/06/23 documented R1 was a new admission to facility after a 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). The "Care Plan" dated 02/01/23, documented R1 was at risk for a communication problem related to a language barrier, was Korean speaking only, and had a recent stroke that altered her speech. The "Care Plan" documented the following interventions: staff anticipated and met R1's needs, assisted with word finding as needed/appropriate, discussed with resident/family any concerns or feelings regarding communication difficulty, monitored the effectiveness of communication strategies and assistive devices, provided a translator as necessary to communicate with resident, and referred to speech therapy for evaluation and treatment as ordered. The "Notes" tab of R1's EMR revealed the following: An "Incident Note" on 03/31/23 at 09:41 PM documented at 06:30 PM, R1 was observed on her bathroom floor by a Certified Nurse Aide (CNA). R1 was last seen in the dining room eating dinner. Due to the language barrier, R1 was not able to make herself completely understood. R1 was assessed and denied pain,	F 676			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 676	Continued From page 3 no injuries noted. All responsible parties were notified, and neurological checks were started. R1 rested in bed at that time with call light in reach, bed in lowest position with fall mat next to bed. A "Nursing Note" on 04/01/23 at 12:50 PM documented at approximately 12:40 PM, R1 dialed 911 as stated by the receptionist. R1 was not in distress and was in her room sitting upright eating lunch. R1 declined to get out of bed for lunch. When staff approached R1, she pointed to a piece of paper next to her bed and stated call. Staff assisted R1 with the call and Emergency Medical Services (EMS) arrived to view resident then departed shortly after. There were no concerns at that time and R1 spoke to who she was trying to call. An "Incident Note" on 04/16/23 at 11:11 PM documented at 03:05 PM, R1 was observed by a CNA on the bathroom floor between her wheelchair and toilet. R1 spoke very little English and was unable to describe events. It appeared R1 was trying to transfer herself to the toilet. There were no injuries noted and all responsible parties were notified with neurological checks started. A "Nursing Note" on 04/21/23 at 09:02 PM documented R1 had a fall in her room. Upon assessment, R1 was lying on her back with her feet towards the door and her head partially under the bed. R1 was alert and verbally expressive. She had no apparent injuries and vital signs were stable. Staff continued to monitor R1. In a statement on 04/26/23 at 08:19 AM, CNA M stated on 04/21/23 at 07:00 PM, another CNA	F 676			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 676	Continued From page 4 came to her and told her R1 was on the floor. CNA M stayed with R1 while the other CNA went to get the nurse. While CNA M stayed with R1, R1 kept requesting CNA M to pick her up as she always did when she was on the floor. CNA M stated R1 was in a safe position, and she could not pick her up because facility policy had to be followed. She stated R1 was furious because CNA M did not pick her up. CNA M kept telling R1 they had to wait for the nurse to do the fall assessment. She stated on 04/24/23 around 04:00 PM, R1's call light was on and CNA M went to answer it because the other CNA was busy. R1 told CNA M, no, since she had remembered what happened on 04/21/23. CNA M stated she thought R1 saw her as mean because she did not understand why CNA M could not help her from the floor. On 05/02/23 at 02:30 PM, R1 laid in her bed with her eyes open. When the surveyor asked R1 how she was today, R1 stated she was good. R1 appeared to have difficulty understanding further questions and only answered with yes. Observation of R1's room did not reveal a communication board or a method to effectively communicate with R1. On 05/02/23 at 11:20 AM, R1's representative stated R1 had a difficult time communicating in English, but she understood what was going on at times. R1's representative stated R1 would not have been able to articulate descriptions of events in English like she did in Korean. On 05/02/23 at 03:04 PM, CNA N stated she communicated with R1 using visual cues and simple questions. She stated R1 does not have a communication board but stated it could be	F 676			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 676	Continued From page 5 helpful. On 05/02/23 at 03:16 PM, Licensed Nurse (LN) H stated she was just in R1's room and was able to talk to her. She stated if she had difficulty communicating with R1, she could use a translator or could communicate with her family. LN H stated the report sheet documented R1 spoke Korean and a little bit of English. On 05/02/23 at 04:21 PM, Administrative Nurse D stated the facility had a language link interpreter available but R1 did speak English and knew what staff were going to do such as when staff would say they needed a blood sugar, R1 put her finger out. On 05/02/23 at 04:22 PM, Administrative Nurse E stated R1 was able to tell where her pain was and articulated her needs such as what she wanted to eat. He stated R1 was very shy and did not talk a lot. The facility's "Communication with Residents of Limited English Proficiency" policy, last revised January 2023, directed the facility provided services for those residents of limited English proficiency for effective communication. Services were provided at the cost of the facility, not the individual with limited English proficiency. The facility failed to provide effective communication for R1. This deficient practice had the risk for miscommunication of needs between R1 and facility staff and a risk for a psychosocial decline related to ineffective and unfulfilling communication.	F 676			
F 697 SS=D	Pain Management	F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 697	Continued From page 6 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 91 residents. The sample included six residents with three sampled for pain management. Based on observations, record review, and interviews, the facility failed to provide effective pain management for Resident (R) 2. This deficient practice had the risk for increased and unnecessary pain and decreased psychosocial well-being for R2. Findings included: - The "Diagnoses" tab of R2's Electronic Medical Record (EMR) documented 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) and spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities) lumbar (low back) region with neurogenic claudication (condition when nerves get pinched within the center of the lumbar spine, causing intermittent leg pain). The "Annual Minimum Data Set (MDS)" dated 07/06/22, documented R2 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R2 received scheduled	F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 697	Continued From page 7 pain medication and complained of occasional pain rated highest of four out of 10 in the last five days of the assessment period. R2 received opioid (pain medication) medications seven days in the seven-day lookback period. The "Quarterly MDS" dated 01/26/23, documented R2 had a BIMS score of 11 which indicated moderate cognitive impairment. R2 received scheduled and as needed (PRN) pain medication and complained of occasional pain rated highest of five out of ten in the last five days of the assessment period. R2 received opioid medications seven days in the seven-day lookback period. The "Pain Care Area Assessment (CAA)" dated 07/07/22, documented R2 reported pain and that she was unable to sleep or do daily activities without pain. The "Care Plan" dated 10/31/18, last revised 05/20/22, documented R2 had chronic pain and used pain medications of Percocet (opioid pain medication) and Xtampza (opioid pain medication). The "Care Plan" directed staff anticipated R2's need for pain relief and responded immediately to any complaint of pain and followed pain scale to medicate as ordered. The "Orders" tab of R2's EMR documented an order with a start date of 12/03/19 for Tylenol (acetaminophen- pain reliever) 650 milligrams (mg) every six hours as needed for pain scale of one to four out of 10; an order with a start date of 10/27/20 and discontinued date of 04/25/23 for Percocet (Oxycodone-Acetaminophen) 5-325 mg one time a day for pain; an order with a start date of 10/27/20 and discontinued date of 04/25/23 for	F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023	
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 697	Continued From page 8 Percocet 5-325 mg every 12 hours as needed for pain scale of five to 10 out of 10; an order with a start date of 02/10/22 and discontinued date of 04/25/23 for Xtampza Extended Release (ER) 27 mg every 12 hours for pain; an order with a start date of 03/14/23 to monitor level of pain every shift; an order with a start date of 04/25/23 and discontinued date of 04/25/23 for Percocet 5-325 mg every four hours as needed for severe pain; an order with a start date of 04/25/23 and discontinued date of 04/26/23 for Percocet 5-325 mg every four hours as needed for severe pain; and an order with a start date of 04/25/23 and discontinued date of 04/26/23 for oxycodone hydrochloride (HCl) 30 mg every 12 hours for moderate to severe pain; an order with a start date of 04/26/23 for oxycodone HCl 30 mg every 12 hours for moderate to severe pain. Review of R2's "Medication Administration Record (MAR)" for April 2023 revealed the following: R2 received her last dose of Xtampza on the evening of 04/24/23. R2 did not receive her scheduled Xtampza on 04/25/23 morning or evening. R2 received her last dose of scheduled Percocet on 04/25/23 at 10:00 AM. R2 received a PRN Percocet on 04/25/23 at 07:42 PM for pain rated 10 out of 10 with documentation that it was ineffective. R2 received PRN Tylenol on 04/25/23 at 07:36 AM for pain rated eight out of 10 with documentation that it was effective.			F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 697	Continued From page 9 R2 received a PRN Percocet on 04/26/23 at 12:25 AM for pain rated seven out of 10 with documentation that it was effective. R2 received a PRN Percocet on 04/26/23 at 08:19 AM for pain rated 10 out of 10 with documentation that it was effective. R2 did not received scheduled oxycodone 30 mg on 04/26/23 morning. R2 received her first dose of oxycodone 30 mg on 04/26/23 evening. R2 received PRN Tylenol on 04/26/23 at 03:44 PM for pain rated nine out of 10 with documentation that it was effective. R2 had documented pain monitoring of seven out of 10 on 04/25/23 day shift, three out of 10 on 04/25/23 evening shift, 10 out of 10 on 04/26/23 day shift, nine out of 10 on 04/26/23 evening shift, six out of 10 on 04/28/23 day shift, five out of 10 on 05/01/23 day shift, seven out of 10 on 05/01/23 evening shift, and five out of 10 on 05/02/23 day shift. The "Notes" tab of R2's EMR documented the following: An "eMAR Note" on 04/25/23 at 08:40 AM documented Xtampza was ordered and the nurse practitioner (NP) was aware. An "eMAR Note" on 04/25/23 at 07:29 PM documented Xtampza was on reorder. An "eMAR Note" on 04/25/23 at 07:42 PM documented PRN Percocet was given per R2's request with follow up at 08:36 PM that documented PRN administration was ineffective with pain rated 10 out of 10.	F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 697	Continued From page 10 A "Nursing" note on 04/25/23 at 11:35 PM documented order confirmed for oxycodone HCl 30 mg every 12 hours for moderate to severe pain. An "eMAR Note" on 04/26/23 at 12:25 AM documented PRN Percocet was given for R2's complaint of generalized pain. A "Nursing" note on 04/26/23 at 07:00 AM documented R2 was at the nurses desk complaining of pain. Staff encouraged Tylenol and she refused. Staff offered R2 to lay in bed, meditation, and to read her bible. R2 refused. Staff went over new medications with her and she said she understood then went to her room. A "Nursing "note on 04/26/23 at 07:50 AM documented R2 was yelling very loudly and when staff entered her room, she continued to yell and say that she could not handle this. Staff encouraged PRN Tylenol and she refused. Staff encouraged repositioning in bed and reminded R2 she would get her medications soon. An "eMAR Note" on 04/26/23 at 08:18 AM documented oxycodone HCl 30 mg was ordered and the NP was aware. An "eMAR Note" on 04/26/23 at 08:19 AM documented PRN Percocet was given for pain all over as R2 requested and staff gave as R2 yelled out. Follow-up documentation at 08:53 AM documented PRN administration was effective but documented R2 rated her pain nine out of 10 and continued to be in pain. The NP was at the facility and was aware R2 needed Percocet and oxycodone.	F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 697	Continued From page 11 A "Nursing" note on 04/26/23 at 11:01 AM documented new order by Consultant GG to discontinue R2's PRN Percocet. Staff called Consultant GG to clarify with no answer. An "eMAR Note" on 04/26/23 at 12:33 PM documented agitation was noted, R2 paced the halls throughout the day and yelled out at time due to pain. A "Nursing" note on 04/26/23 at 01:06 PM documented staff placed another call to Consultant GG to clarify Percocet order that was discontinued with no answer again. A "Nursing" note on 04/26/23 at 01:21 PM documented staff spoke with the pharmacy and ordered oxycodone 30 mg STAT (urgent/immediately). A "Nursing" note on 04/26/23 at 01:46 PM documented staff asked R2 if she wanted to go to the hospital and she said not yet. R2 was aware that medication was ordered STAT. An "eMAR Note" on 05/01/23 at 03:37 PM documented R2 received PRN Tylenol and follow-up documentation at 06:54 PM that documented PRN administration was ineffective with a pain rating of seven out of 10. An "eMAR Note" on 03:14 PM documented R2 received PRN Tylenol for complaints of pain all over with follow-up documentation at 04:31 that documented PRN administration was ineffective with a rating of nine out of 10. Upon request, the facility provided Consultant	F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 697	Continued From page 12 GG's "Progress Note" from 04/26/23. The "Progress Note" documented R2 was seen to follow up on pain management and had been taking Xtampza ER to help her symptoms. R2's insurance was not covering the medication for her any longer. Consultant GG documented he discussed with R2 the recent changes to her medications to an equivalent dose of OxyContin (oxycodone) and she expressed disappointment stating that she needed more pain medication. Consultant GG stated he explained to R2 that he wanted to assess how she did on the new medication before switching to anything else since she had not been getting her usual pain medication. The "Progress Note" documented the plan was Xtampza ER was discontinued with OxyContin put in its place. On 05/02/23 at 02:56 PM, R2 stated she was in pain and did not have a PRN order anymore. She stated she received pain medication at 08:00 AM and 08:00 PM but did not have a PRN order for during the day. She rated her pain nine out of 10 at that time and stated her pain over the weekend was moderate. She stated she could not take the pain any longer and it was not right that she was hurting so bad. R2 stood in her room, appeared distress, and uncomfortable with grimacing and moaning observed. On 05/02/23 at 03:06 PM, Licensed Nurse (LN) G stated R2 was on Xtampza for pain but her insurance was not covering it so it was changed to oxycodone 30 mg twice a day. R2 was in so much pain that staff called on-call provider during the night and got an order for Percocet every four hours as needed. She stated Consultant GG came in the next day and had ordered the oxycodone 30 mg and discontinued R2's PRN	F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 697	Continued From page 13 and scheduled Percocet. LN G said she had reached out to the on-call NP today and was told to offer Tylenol to R2. LN G stated she told the NP that R2 did not want Tylenol and the NP said she would see R2 tomorrow. On 05/02/23 at 04:21 PM, Administrative Nurse D stated R2's insurance stopped covering Xtampza and the facility had reached out to their medical director to get a replacement pain medication. She stated the nurses had reached out to the pharmacy who said they did not have the script for oxycodone, and she reached out to the pharmacy who sent it out STAT. Administrative Nurse D stated R2 still had extensive pain and she notified the medical director today to see R2 because her pain was uncontrolled. She stated the delay in receiving the scheduled oxycodone caused increased pain. Administrative Nurse D stated staff were to notify the on-call provider if they needed additional pain medication and the medical director would not have approved of the nurses reaching out to him directly without using the on-call service. The facility's "Recognition and Management of Pain" policy, last revised July 2017, directed the facility assisted each resident with pain management to maintain or achieve the highest practicable level of well-being and functioning by interviewing or observing the resident to determine if pain was present, identifying circumstances when pain can be anticipated, evaluating pain and working with the resident to develop a plan of care that considered their needs and goals, and developed and implemented a plan using nonpharmacologic and/or pharmacologic interventions to manage and/or prevent pain. The "policy" directed if the	F 697			

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

PRINTED: 05/05/2023
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 C 05/02/2023
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 697	Continued From page 14 pain management program was not effective, the LN contacted the resident's physician and consulted the physician for additional interventions if pain was not relieved by current orders. The facility failed to provide effective pain management for R2. This deficient practice had the risk for increased and unnecessary pain and decreased psychosocial well-being for R2.	F 697			