

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

PRINTED: 10/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175187		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023	
NAME OF PROVIDER OR SUPPLIER ADVENTHEALTH CARE CENTER OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 75TH STREET 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 584 SS=E	The following citations represent the findings of Health Resurvey Aspen event 7I7N11 and complaint investigation KS00183006 and KS00183546. The 2567 was sent electronically on 10/30/23. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);			F 584			

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

TITLE

(X6) DATE

10/30/2023

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.

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, and interview the facility failed to maintain a clean, comfortable, home like environment when the lights in the dining room were nonfunctioning, the light fixtures contained dead insects, and the dining chairs were stained and had food particles. This placed the residents at risk for decreased comfort and impaired psychosocial wellbeing. Findings included: - On 10/16/23 at 11:59 AM, observation in the main dining room revealed the following: The fluorescent light, approximately three feet (ft) long by 18 inches wide, had nonfunctioning bulbs, on the ceiling above the dining room door where the STOP sign was posted. Two ceiling fluorescent light fixtures, close to the kitchen entrance. had nonfunctioning light bulbs. On 10/16/23 at 12:00PM, observation of the main dining room revealed the following: The sink countertop edge lacked a piece of laminate trim approximately two feet wide by 4	F 584			

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F 584	Continued From page 2 inches wide, showing the rough wood. The countertop had another piece of laminated trim missing in the right corner approximately four inches long by two inches wide. On 10/16/23 at 12:00 PM six fluorescent ceiling light fixtures throughout the main dining room had numerous dead bugs in them. On 10/16/23 at 12:24 PM, observation revealed five of the six dining chairs in the rehab dining room had dried food stains on the seat. On 10/18/23 at 01:00 PM, observation revealed three of the six dining room chairs had layered, dried food stains on the seats. On 10/18/23 at 10:15 AM, Maintenance Staff (MS) U verified the nonfunctional light bulbs and broken laminate and stated he was unaware the laminated trim was missing. MS U stated staff were to leave a work order for him on the facility maintenance program, if they had any environmental issues, or he tried to make rounds every day to see if there were any issues. On 10/18/23 at 01:00 PM, Administrative Nurse D verified the dining chairs needed cleaned and were not clean enough to sit on. The facility's "Cleaning of Common Areas" policy, dated 04/01/23, stated all staff are responsible to see the common areas are clean and neat. The facility failed to maintain a clean, comfortable, home like environment when the lights in the dining room were nonfunctioning, the light fixtures contained dead insects, and the dining chairs were stained and had food particles.	F 584			

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F 585	This placed the residents at risk for decreased comfort and impaired psychosocial wellbeing.				
SS=E	Grievances CFR(s): 483.10(j)(1)-(4)	F 585			
	§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information				

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F 585	Continued From page 4 of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a	F 585			

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F 585	Continued From page 5 summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to discuss with the resident council how to file a grievance regarding their care and treatment in the facility. This deficient practice placed the residents in the facility at risk for unresolved resident concerns and decreased quality of life. Findings included: - On 10/16/23 at 11:45AM, during observation in the main dining room, 34 residents sat in wheelchairs or dining chairs at the tables. Further observation revealed at 12:40PM, residents continued to sit in the dining room and no noon meal had been served yet.	F 585			

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F 585	Continued From page 6 On 10/16/23 at 11:57AM, observation at the rehab dining room revealed no hot meal cart had been delivered for the rehab dining room or room trays. At 12:00PM, dietary staff delivered the food cart to the hall beside the rehab dining room and left it. At 12:24 PM, observation revealed a Certified Nurse Aide (CNA) opened the meal cart and served meals in the rehab dining room. On 10/17/23 at 02:00PM, during private discussion with the residents of the resident council, residents verbalized an ongoing unpleasant experience with the noon meal always being delivered late. Residents verbalized there was new management in the facility and said they had no knowledge of who was in charge of the facility. Residents verbalized they were unsure of who to report to for a grievance or concern. Review of Resident Council meeting minutes for September and October 2023 revealed no discussion with the council members regarding grievances. The facility lacked any Resident Council minutes from October 2022 to September 2023. Review of the facility's grievance log lacked evidence of grievances verbalized by the council. On 10/18/23 at 01:30PM, Activity Z stated she only had resident council minutes for September and October 2023. Activity Z also verbalized she was not aware residents did not know how to file a grievance. On 10/19/23 at 08:30AM, Dietary Staff (DS) BB verified the noon meal had been consistently served late. DS BB further verified residents have been upset about late delivery of the meal.	F 585			

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F 585	Continued From page 7 On 10/19/23 at 09:00AM, Social Service X verified the facility has not had a meeting with the resident council to inform them of the new management of the facility and changes in the facility. Social Services X also verified she has spoken with the resident council members about how to file a grievance. On 10/19/23 at 09:15AM, Administrative Staff A verified no management staff had met with the resident council regarding new management changes in facility or discussed with the resident council members concerns regarding late noon meal delivery. The facility's "Grievance" policy dated 08/22/17, stated the facility has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints. The person filing a grievance is to receive a prompt response from the facility on the direction being taken to solve the grievance. The person who had filed the grievance will be continued to be updated on the ongoing resolution of the grievance. The facility's "Resident Council" policy dated 04/01/23, stated the purpose of the resident council is for residents to develop suggestions on improving services and quality of life and resolve differences in the facility. Keep residents informed of changes in the facility that affect their daily care. The facility failed to discuss the process of grievances with the resident council, placing the residents in the facility at risk for unresolved concerns and decreased quality of life.	F 585			

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F 623 F 623 SS=D	Continued From page 8 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623 F 623			

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F 623	Continued From page 9 required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623			

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F 623	Continued From page 10 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents with one reviewed for hospitalization. Based on observation, interview, and record review the facility failed to notify the State Long Term Care Ombudsman (resident advocate) of Resident (R)26's discharges to a hospital in July 2023 and in September 2023. This deficient practice placed R26 at risk for decreased oversight of transfers. Findings included: - R26's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), end stage renal disease requiring dialysis (ESRD-a terminal disease of the kidneys), and heart disease.	F 623			

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F 623	Continued From page 11 R26's "Annual Minimum Data Set" (MDS), dated 05/02/23, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R26 required supervision for hygiene, limited staff assistance for eating, and extensive staff assistance for bed mobility, toileting, mobility. The MDS documented R26 had recent surgery. R26's EMR documented the resident was hospitalized 07/17/23 to 07/21/23 and again 09/25/23 to 09/29/23. The facility's email to the LTCO for discharges during July 2023 and September 2023 lacked R26's name. On 10/17/23 at 07:59 AM, observation revealed R26 sat in a wheelchair in her room waiting for medications with five drink cups on her bedside table. On 10/18/23 at 01:45 PM, Social Services X verified she had not sent a notice of R26's discharges in July and September. She stated the facility's system only selected the residents who were discharged home or to another facility, not when a resident was admitted to the hospital and then re-admitted here. The facility's "Transfer and Discharge, Voluntary-Notification of State Long Term Care Ombudsman" policy, dated 04/01/23, stated written notice to the state ombudsman would be sent monthly for residents discharged from the facility or transferred to a hospital. The facility failed to notify the State LTCO of	F 623			

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F 623	Continued From page 12	F 623			
F 625 SS=D	R26's discharge to a hospital in July 2023 and in September 2023. This deficient practice placed R26 at risk for decreased oversight of transfers. Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents with one reviewed	F 625			

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F 625	Continued From page 13 for hospitalization. Based on observation, interview, and record review the facility failed to provide a "Bed Hold Notice" to Resident (R) 26 upon discharge to a hospital in July 2023 and in September 2023. This deficient practice placed R26 at risk of making uninformed decisions regarding her care. Findings included: - R26's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), end stage renal disease requiring dialysis (ESRD-a terminal disease of the kidneys), and heart disease. R26's "Annual Minimum Data Set" (MDS), dated 05/02/23, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R26 required supervision for hygiene, limited staff assistance for eating, and extensive staff assistance for bed mobility, toileting, mobility. The MDS documented R26 had a recent surgery. R26's EMR documented the resident was hospitalized from 07/17/23 to 07/21/23 and again 09/25/23 to 09/29/23. The facility lacked evidence a "Bed Hold Notice" was provided to R26 or her representative each time R26 was hospitalized. On 10/17/23 at 07:59 AM, observation revealed R26 sat in a wheelchair in her room waiting for medications with five drink cups on her bedside table.	F 625			

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F 625	Continued From page 14 On 10/18/23 at 12:37 PM, Administrative Staff B verified the facility did not provide residents a "Bed Hold Notice" with each discharge. The facility's "Bed-Hold" policy, dated 04/01/23, stated the facility would notify the resident at the time of admission and again prior to hospital transfer. The facility failed to provide R26 a "Bed Hold Notice" upon discharge to the hospital, placing R26 at risk to make uninformed decisions regarding her care.	F 625			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655			

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F 655	Continued From page 15 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents with one reviewed for smoking safety. Based on observation, interview, and record review the facility failed to develop a baseline care plan to include Resident (R) 127's smoking. This deficient practice placed R127 at risk for impaired safety due to uncommunicated care needs. Findings included: - R127's Electronic Medical Record (EMR) documented diagnoses of a fracture of left lower leg, schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation	F 655			

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F 655	Continued From page 16 of thought), and orthostatic hypotension (blood pressure dropping with change of position). The "Minimum Data Set" (MDS), dated 10/09/23, was in progress. R127's baseline "Care Plan" dated 10/06/23 lacked information regarding R127's smoking. R127's EMR lacked evidence the facility assessed the resident's ability to safely smoke and lacked determination if the resident required supervision while smoking. On 10/17/23 at 10:30 AM, observation revealed R127 outside on the west patio, smoking a cigarette by herself. On 10/19/23 at 08:52 AM, observation revealed R127 rang the doorbell on the smoking patio to come back into the facility. Licensed Nurse (LN) H answered and assisted R127 back into the facility. 10/16/23 at 03:30 PM, R127 stated she went outside on her own to smoke without staff, whenever she wanted. On 10/18/23 at 09:34 AM, Administrative Staff D stated R127 could go out outside to smoke as often as she liked by herself. Administrative Staff D verified the facility had not developed a baseline care plan related to R127's smoking. The facility's "Smoking policy" stated any smoking related privileges, restrictions, and concerns would be noted on the care plan and all personnel caring for the resident alerted.	F 655			

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F 655	Continued From page 17 The facility's "Baseline Care Plans," dated 03/2022, stated a baseline care plan to meet the resident's immediate health and safety needs would be developed within forty-eight hours of admission. The facility failed to include smoking on the baseline care plan for R127 placing the resident at risk for impaired safety due to uncommunicated care needs.	F 655			
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 75 residents. The sample included 18 residents with one reviewed for smoking safety. Based on observation, interview, and record review the facility failed to assess Resident (R) 127 for safety while smoking. This deficient practice placed R127 at risk for accidents while smoking. Findings included: - R127's Electronic Medical Record (EMR) documented diagnoses of a fracture of left lower leg, schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation	F 689			

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F 689	Continued From page 18 of thought), and orthostatic hypotension (blood pressure dropping with change of position). The "Minimum Data Set" (MDS), dated 10/09/23, was in progress. R127's baseline "Care Plan" dated 10/06/23 lacked information regarding R127 smoking. R127's EMR lacked evidence the facility assessed the resident's ability to safely smoke and lacked determination if the resident required supervision while smoking. On 10/17/23 at 10:30 AM, observation revealed R127 outside on the west patio, smoking a cigarette by herself. On 10/19/23 at 08:52 AM, observation revealed R127 rang the doorbell on the smoking patio to come back into the facility. Licensed Nurse (LN)H answered and assisted R127 back into the facility. 10/16/23 at 03:30 PM, R127 stated she went outside on her own to smoke without staff, whenever she wanted. On 10/18/23 at 09:34 AM, Administrative Staff D stated R127 could go out outside to smoke as often as she liked by herself. Administrative Staff D verified the facility had not assessed R127 for safety while smoking. The facility's "Smoking policy" stated the resident's smoking status would be evaluated upon admission, including the ability to smoke safely with or without supervision. The resident's ability to smoke safely would be re-evaluated	F 689			

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F 689	Continued From page 19 quarterly, with significant change, and as determined by staff. Any smoking related privileges, restrictions, and concerns would be noted on the care plan and all personnel caring for the resident alerted.	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents with one reviewed for hydration. Based on observation, interview,	F 692			

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F 692	Continued From page 20 and record review the facility failed to monitor fluid intake for Resident (R) 41, as ordered by the physician. This deficient practice placed R41 at risk for fluid overload. Findings included: - R41's Electronic Medical Record documented diagnoses of chronic congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), fluid overload, heart transplant status, end stage renal disease (ESRD-a terminal disease of the kidneys) with dependence on renal dialysis (procedure where impurities or wastes were removed from the blood) and cognitive communication deficit. The "Admission Minimum Data Set" (MDS), dated 08/13/23, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R41 required supervision for eating, hygiene, limited staff assistance for bed mobility, and extensive staff assistance for transfers, dressing, and toileting. The MDS documented R41 weighed 214 pounds and had difficulty with swallowing. The "Nutrition Care Area Assessment" (CAA), dated 08/13/23, stated R41 ate a regular diet with regular fluids, and the Registered Dietician (RD) would evaluate. The plan directed staff to see orders 08/2023. The "Dehydration/Fluid Maintenance CAA" directed to see discharge orders 08/10/23. R41's "Care Plan," dated 08/11/23, stated R41 had nutritional concerns related to potential weight loss/gain, was dependent on renal	F 692			

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F 692	Continued From page 21 dialysis, had a heart transplant, and cardiac issues. The care plan documented R41 stated it was hard to follow a fluid restriction. The care plan directed staff to provide a diet as ordered which was a liberalized renal diet with thin liquids. The care plan directed staff to observe for signs of dehydration, discomfort, or condition changes initiated 08/28/23, and monitor intake of food and fluids initiated on 08/11/23. The "Nutrition Assessment," dated 08/11/23, documented a 2000 milliliter (ml) fluid restriction and stated R41 was encouraged to follow the 2000 ml fluid restriction. R41 said he was trying to watch what he drank. The "Physician Order," dated 08/19/23, directed staff to monitor R41's daily weight on non-dialysis days every Tuesday, Thursday, Saturday, and Sunday for heart failure and fluid overload; notify the provider of weight gain more than three pounds (lbs.) in three days or more than five lbs. in one week. The "Physician Order," dated 08/24/23, directed staff to follow fluid restriction of 2000 ml per 24 hours. The order lacked fluid amounts per shift and stated encourage the resident to maintain fluid restriction 2000 ml in 24 hours every shift reading exactly as follows: "Nursing to provide fluid with medications per shift: ___ml 11pm to 7am: ___ml 7am to 3pm: ___ml 3pm to 11pm and the remainder to be supplied by dietary." The "Dietary Note," dated 09/17/23, stated the fluid restriction was not monitored. R41's EMR lacked specific fluid amounts to be provided each shift by dietary and nursing and	F 692			

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F 692	Continued From page 22 lacked evidence staff monitored R41's intake of fluids. On 10/17/23 at 07:48 AM, observation revealed R41 sat in a wheelchair in his room. He wore a long-sleeved shirt and stated his dialysis access was in his left arm. On 10/17/23 at 07:45 AM, Licensed Nurse (LN) G stated R41 was leaving soon to go for an extra dialysis treatment that morning, due to fluid overload. She stated R41 had a fluid restriction of 2000 ml per day but did not follow it. LN G said R41's family brought him soda pop and other drinks. On 10/17/23 at 07:48 AM, R41 stated he thought his fluid restriction was 48 ounces (oz) a day. R41 stated he sometimes felt dehydrated and had hand cramps, so he drank more fluids. He stated he drank the soda pop in his room when his stomach felt "off." Observation revealed several bottles of soda on R41's dresser at that time. On 10/18/23 at 12:53 PM, Administrative Nurse E stated the resident was admitted with fluid restriction orders and verified the physician and registered dietician had not specified fluid amounts to be provided each shift; staff had not care planned to monitor R41's intake of food and fluids. She stated staff encouraged and educated the resident and further verified staff did not monitor R41's intake of fluids. On 10/18/23 at 12:45 PM, Administrative Nurse D stated staff should have assessed R41 for amounts of fluid per shift to be provided and should have monitored R41's intake.	F 692			

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F 692	Continued From page 23 The facility's "Encouraging and Restricting Fluids" policy, dated 04/01/21, directed staff to verify the physician's order, review the care plan, and follow specific instructions concerning fluid restrictions. The policy directed staff to record the fluid intake each shift, encourage the resident to stay within the limits of his intake, and remove the water pitcher and cup from the room. The facility failed to monitor fluid intake for R41 as physician ordered, placing R41 at risk for fluid overload.	F 692			
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on record review and interview the facility failed to ensure five of five nurse aides, reviewed for regular in-service education, completed an annual performance review. This placed the residents at risk for unskilled care. Findings included: - Review of Certified Nurse Aide (CNA) M, CNA N, CNA P, CNA Q, and Certified Medication Aide (CMA) R's in-service records lacked evidence of an annual performance review.	F 730			

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F 730	Continued From page 24 On 10/19/23 at 09:19 AM, Administrative Nurse D verified the lack of documentation indicating the above staff received an annual performance review. Upon request the facility did not provide a policy regarding CNA/CMA annual performance review. The facility failed to ensure CNA M, CNA N, CNA P, CNA Q, and CMA R completed an annual performance review. This placed the residents at risk for unskilled care.	F 730			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732			

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F 732	Continued From page 25 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure the daily staff nursing hours were posted for three of four of the survey onsite days. Findings included: - On 10/16-18/23 observation revealed the daily nurse staffing hours were not posted in the facility. 10/18/23 at 09:34 AM, Administrative Nurse D verified the daily nurse staffing hours were not posted. Administrative Nurse D stated it should be posted in a highly visible area. The facility's "Nurse Staffing Information Policy," revised 04/01/23, documented the facility must post the following information daily: facility name, the current date, the total number and the actual hours worked by the following categories of	F 732			

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F 732	Continued From page 26 licensed and unlicensed nursing staff directly responsible for resident care per shift, which included registered nurses, licensed practical nurses or licensed vocational nurses (as defined under State law), number of certified nurse aides, and the resident census. The policy documented the facility must post the nurse staffing data as specified above daily at the beginning of each shift in a clear and readable format and in a prominent place readily accessible to residents and visitors.	F 732			
F 756 SS=D	The facility failed to post the daily nurse staffing hours for three days of the onsite survey. Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756			

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F 756	Continued From page 27 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to follow the consultant pharmacist's recommendation and obtain a specific approved indication for the use of Seroquel (antipsychotic medication used to treat psychosis and other mental emotional conditions). This deficient practice placed Resident (R)60 at risk for inappropriate use of antipsychotic medication. Findings included: - R60's Electronic Medical Record documented diagnoses of encephalopathy (disease in which the functioning of the brain is affected by some agent or condition), pervasive developmental disorder (condition resulting from delayed mental or physical development), cerebral palsy (progressive disorder of movement, muscle tone			F 756			

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F 756	Continued From page 28 or posture caused by injury or abnormal development in the immature brain, most often before birth), and dementia (progressive mental disorder characterized by failing memory, confusion). The "Significant Change Minimum Data Set" (MDS), dated 09/14/23, documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired decision-making skills. The MDS documented R60 had physical, verbal, and other behaviors, which interfered with care and social interactions, and disrupted the environment and/or intruded on the privacy of others. The MDS documented R60 required supervision for eating, limited staff assistance for walking, and extensive staff assistance for all other activities of daily living. The MDS documented R60 received antipsychotic drugs routinely. The "Antipsychotic Drug Use Care Area Assessment" (CAA), dated 09/14/23, stated the CAA triggered for use of antipsychotic medication use. The facility monitored the resident for antianxiety and antipsychotic medications due to the resident's history and potential need for interventions. The "Physician Order," dated 07/10/23, directed staff to administer Seroquel 100 milligrams (mg), three times per day, for psychosis (any major mental disorder characterized by a gross impairment in reality perception). The "Medication Administration Record" (MAR) for antipsychotic medication observations documented no behaviors of agitation or restlessness from 10/01/23 through 10/16/23.	F 756			

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F 756	Continued From page 29 The "Consultant Pharmacist Monthly Reviews" documented the following: 02/22/23 Seroquel needed a specific diagnosis for use. 03/22/23 Seroquel required an update in the medical record to include specific diagnosis based on assessment and goals. The resident further required a list of targeted behaviors, documentation that other causes and medications were considered, a note that individualized non-pharmacological interventions were in place, and that ongoing monitoring was ordered. The pharmacist wrote the February 2023 recommendations regarding Seroquel diagnosis were not acted upon. On 10/17/23 at 07:39 AM, observation revealed R60 in bed and hollered out. A nurse responded within a few minutes, and he calmed after the nurse went in. On 10/17/23 at 01:40 PM, Administrative Nurse E stated R60's Seroquel order was adjusted numerous times since 02/03/23. She verified the current diagnosis for Seroquel (psychosis) was not approved by the Center for Medicaid/Medicare (CMS). The facility's "Drug Regimen Review" policy, dated 04/01/23, stated the pharmacist would review the drug regimen of each resident at least monthly and identify any irregularities or concerns and communicate them in writing to the director of nursing and the attending physician. The attending physician would respond in writing of any action taken to address the concern. If the physician chose not to act on the pharmacist recommendation the physician must document	F 756			

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F 756	Continued From page 30 his/her rationale as to why a change was not indicated. The facility failed to act upon the consultant pharmacist recommendation to obtain an appropriate indication for the use of Seroquel, placing R60 at risk for inappropriate use of antipsychotic medication.	F 756			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758			

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F 758	Continued From page 31 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents with one reviewed for psychotropic drug use. Based on observation, interview, and record review the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R)60, who had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications.	F 758			

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F 758	Continued From page 32 Findings included: - R60's Electronic Medical Record documented diagnoses of encephalopathy (disease in which the functioning of the brain is affected by some agent or condition), pervasive developmental disorder (condition resulting from delayed mental or physical development), cerebral palsy ((progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), and dementia. The "Significant Change Minimum Data Set" (MDS), dated 09/14/23, documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired decision-making skills. The MDS documented R60 had physical, verbal, and other behaviors, which interfered with care, social interactions, disrupted the environment, and intruded on the privacy of others. The MDS documented R60 required supervision for eating, limited staff assistance for walking, and extensive staff assistance for all other activities of daily living. The MDS documented R60 received antipsychotic drugs routinely. The "Antipsychotic Drug Use Care Area Assessment" (CAA), dated 09/14/23, stated the CAA triggered for use of antipsychotic medication use, the facility monitored the resident for antianxiety and antipsychotic medications due to the resident's history and potential need for interventions. The "Behavioral Symptoms CAA," dated 09/14/23, stated R60 had multiple behaviors,	F 758			

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F 758	Continued From page 33 including yelling, hitting staff, placing himself in unsafe situations by crawling on the floor, entering other residents' rooms, refusing cares, walking unsteadily, and refusing assistance. The CAA stated staff and family used multiple approaches to address his behaviors, with mixed success. Medication approaches were used, but R60's family preferred not to use them. R60's "Medication Management Care Plan," dated 07/30/23, stated R60 received medications that had black box warnings (high risk warning). He was at risk for side effects and complications. The care plan directed staff to approach R60 and speak in a calm manner, divert attention, and remove from the situation and take to alternate location as needed. Minimize potential for R60's disruptive behaviors by offering tasks which divert attention such as coloring in his Paw Patrol coloring book or sitting by the nursing station. The care plan stated R60 used antipsychotic medications related to behavior management and directed staff to review behaviors and interventions and alternate therapies attempted and their effectiveness as per facility policy. The "Physician Order," dated 07/10/23, directed staff to administer Seroquel (antipsychotic) 100 milligrams (mg), three times per day, for psychosis (any major mental disorder characterized by a gross impairment in reality perception). The "Medication Administration Record" (MAR) for antipsychotic medication observations documented no behaviors of agitation or restlessness from 10/01/23 through 10/16/23. The "Psychiatric Visit Note," dated 07/03/23, for	F 758			

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F 758	Continued From page 34 an initial visit, document nursing reported some episodes of restlessness, the resident was easily redirected, and stated the resident would continue current psychotropic medications, including Xanax (antianxiety medication), Seroquel, and as needed Haldol (antipsychotic). The note stated the patient benefited psychiatrically and behaviorally at the current doses and dose reduction at that time would risk decompensation of patient. Diagnoses included agitation, dementia, and insomnia (inability to sleep). The "Psychiatric Visit Note," dated 08/28/23, stated the patient appeared to be doing well on the current drug regimen. The note identified the resident was pleasantly confused secondary to dementia and noted he did not have any episodes of high anxiety, agitation, aggressive behaviors, or exit seeking. He had restlessness but was easily redirected. Staff were to continue Seroquel 100 mg, three times daily, for behavioral disturbance. R60 could benefit from an intervention of psychological services to enhance coping skills. The "Consultant Pharmacist Monthly Reviews" documented the following: 02/22/23 Seroquel needed a specific diagnosis for the use. 03/22/23 Seroquel required an update the medical record to include specific diagnosis based on assessment and goals. The resident further required a list of targeted behaviors, documentation that other causes and medications were considered, a note that individualized non-pharmacological interventions were in place, and that ongoing monitoring was ordered. The pharmacist wrote the February 2023	F 758			

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F 758	Continued From page 35 recommendations regarding Seroquel diagnosis were not acted upon. R60's clinical record lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic. On 10/17/23 at 07:39 AM, observation revealed R60 in bed and he hollered out. A nurse responded within a few minutes, and he calmed after the nurse went in. On 10/17/23 at 01:40 PM, Administrative Nurse E stated R60's Seroquel order was adjusted numerous times since 02/03/23. She verified the current diagnosis for Seroquel (psychosis) was not approved by the Center for Medicaid/Medicare (CMS). The facility's "Psychotropic Medication Use" policy, dated 07/2022, stated residents would not receive medications not clinically indicated to treat a specific condition. The use of psychotropic medication may be appropriate in specific circumstances as specified by CMS. The facility failed to obtain an appropriate indication, or the required documentation, for the continued use of Seroquel, placing R60 at risk for unnecessary antipsychotic medication and related side effects.	F 758			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761			

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F 761	Continued From page 36 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. Based on observation, interview, and record review the facility failed to label insulin (hormone that lowers the level of glucose in the blood) when opened and dispose of expired medications in a timely manner. This deficient practice placed residents of the facility at risk to receive expired or ineffective medications. Findings included: - On 10/16/23 at 11:40 AM, observation revealed the southwest nurse's medication cart contained	F 761			

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F 761	Continued From page 37 the following medications: Naproxen (pain reliever), 220 milligram (mg) a partial bottle, with an expiration date of 09/23. Insulin glargine (long acting insulin) opened 09/12/23 (33 days ago). Insulin glargine not dated when opened. Nicotine gum, 2 mg, expired 07/23/20. On 10/16/23 at 11:45 AM, Licensed Nurse (LN) E verified the expired medications should have been disposed of and staff were to date insulins when opened. The facility's "Storage of Medications" policy, dated 04/01/23, stated discontinued, outdated, or deteriorated medications will be destroyed according to the facility policy. Multi dose vials that have been opened or accessed should be dated and discarded within 28 days of opening unless the manufacturer specified a shorter or longer date. The facility failed to label insulin when opened, and dispose of expired medications in a timely manner, placing residents of the facility at risk to receive expired or ineffective medications.	F 761			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER ADVENTHEALTH CARE CENTER OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 75TH STREET OVERLAND PARK, KS 66204		
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F 812	Continued From page 38 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. Based on observation, interview, and record review the facility failed to store foods and monitor refrigeration temperatures for the resident food storage in the nourishment rooms in accord with professional standards for food safety. This deficient practice placed the residents who received food from or stored their food in the nourishment refrigerators on two of two resident halls at risk for food borne illness. Findings included: - On 10/18/23 at 02:58 PM, observation revealed the nourishment room on the west hall had a refrigerator with a temperature of 39 degrees Fahrenheit (F). Inside the refrigerator was one bag of frozen food, unlabeled or dated; one partially eaten, unlabeled, pint of ice cream; one pizza box, not dated; two 32-ounce undated bottles of prune juice; one-half bottle of cherry soda, unlabeled or dated; one McDonalds bag with food dated 10/15, and one container of chicken rice soup, undated. On 10/18/23 at 03:35 PM, observation of the nourishment refrigerator on the east hall revealed	F 812			

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F 812	Continued From page 39 the refrigerator temperature of 45 degrees F. and no temperature log. The refrigerator held four water bottles, partially empty, unlabeled. The facility lacked evidence of temperature monitoring for both nourishment refrigerators. On 10/18/23 at 03:23 PM, Administrative Nurse E stated monitoring and upkeep of the nourishment room refrigerators was a group effort between housekeeping, nursing, and the registered dietitian. She stated the temperature logs were supposed to be taped to the refrigerator and temperatures assessed and documented daily. On 10/18/23 at 03:35 PM, Licensed Nurse (LN) I verified the lack of temperature monitoring for the east hall nourishment refrigerator. On 10/19/23 at 08:45 AM, Dietary Staff BB stated nursing staff was responsible for the nourishment refrigerators on the nursing units. The facility's "Storage of Food in Refrigeration" policy, dated 04/01/23, stated perishable food will be stored in refrigeration at 41 degrees F or below, all containers must be labeled with date the item was placed in storage, and previously cooked foods must be discarded after 3 days. The facility failed to label, date food items stored in the nourishment refrigerators and to monitor the temperatures daily, placing the residents at risk for food borne illness.	F 812			
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing	F 851			

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F 851	Continued From page 40 information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).	F 851			

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F 851	Continued From page 41 §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services PBJ Staffing Data Report CASPER Report 1705D FY Quarter 3 2023 (April 1 - June 30) documented the facility failed to report their PBJ data for Quarter 3 2023. On 10/17/23 at 02:42 PM, Administrative Staff A verified the facility had not reported the PBJ for	F 851			

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F 851	Continued From page 42 Quarter 3 2023 and stated they had a payroll company who was suppose to send PBJ, but they failed to report it. Administrative Staff A stated PBJ should be sent to CMS quarterly and he would be reporting it from now on. The facility's "Electronic Staffing Data Submission-Payroll-Based Journal (PBJ) policy," revised 04/01/23, documented staffing and census data would be collected quarterly and was required to be timely and accurate. Staffing data included the number of hours worked by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. Submissions would be received by the end of the 45th calendar day (11:50 PM Eastern Standard Time) after the last day in each fiscal quarter to be considered timely. The facility failed to submit PBJ data for Quarter 3 2023, which placed the residents at risk for unidentified and ongoing inadequate staffing.	F 851			
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.	F 868			

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F 868	Continued From page 43 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on record review and interview, the facility failed to ensure the required committee members attended the Quality Assurance Performance Improvement (QAPI) Committee quarterly meetings. This failure placed the residents who resided in the facility at risk for decreased quality of care. Findings included: - On 10/19/23 at 09:40 AM, the facility's Quality Assurance Performance Improvement (QAPI) meeting attendance sheets lacked signature the	F 868			

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F 868	Continued From page 44 infection preventionist (IP) attended the meetings. On 10/19/23 at 09:50 AM, Administrative Staff A verified the quarterly sign in sheets lacked an infection preventionist signature and stated the facility did not have a designated IP. The facility's "QAPI Plan," revised 5/31/23, documented the QAPI committee provides the backbone and structure for QAPI. This group includes the executive leadership team including Administrator, Director of Nursing Services, Medical Director, consulting pharmacist, infection control preventionist, plus 3 additional staff members. The facility failed to ensure the required member, including the IP, attended QAPI meetings at least quarterly, which placed residents at risk of unidentified quality of care issues.	F 868			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880			

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F 880	Continued From page 45 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880			

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F 880	Continued From page 46 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review and interview the facility failed to maintain an infection control program to recognize the occurrence of infections, recording their number and frequency, detect outbreaks and unusual pathogens with infection control implications in the facility from October 2022 to April 2023. The facility failed to provide appropriate infection control practices when performing wound care for Resident (R) 5, R130, R21 and R44. This placed the residents at risk for infection. Findings Included: - On 10/18/23 at 09:09AM, Administrative Nurse E verified the facility lacked infection control tracking from October 2022 until April 2023. On 10/18/23 at 10:00AM, Administrative Staff A verified the facility lacked an effective infection control program from October 2022 until April 2023. The "Infection Control Program" policy dated 10/2018, states the facility will provide	F 880			

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F 880	Continued From page 47 surveillance data and reporting information to be used to inform the facility of potential issues and trends of infections. The standard criteria is used to distinguish community-acquired from facility acquired infections. The facility failed to have an effective infection control program placing the residents residing in the facility at risk for infection. - On 10/17/23 at 08:35 AM, observation revealed Licensed Nurse (LN) H performed wound care for Resident (R) 5. He placed wound care items on a clean field on the bedside table. LN H provided urine incontinence care for R5 and after placing a new brief on R5, he changed his gloves without washing his hands. The pressure wound to R5's coccyx (triangular area at the base of the spine) was without a dressing; LN H cleansed the wound and, without washing hands or changing gloves, applied Skin-prep (liquid skin protectant), Santyl (a prescription enzyme used to help break up and remove dead skin and tissue of a wound), a collagen (protein derived wound treatment used to promote wound healing) patch, then applied a bordered foam dressing. On 10/18/23 at 09:24 AM, LN H verified he should have washed his hands between removing the soiled dressing and before applying the clean wound dressings. On 10/18/23 at 09:30 AM, Administrative Nurse D verified she expected staff to wash their hands after handling soiled items. The facility's "Dressings, Dry/Clean" policy, dated 2013, directed staff to wash and dry hands thoroughly, don clean gloves, and remove soiled dressing. Staff were to wash and dry hands	F 880			

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F 880	Continued From page 48 thoroughly before donning clean gloves and cleaning the wound/skin. Staff were to cleanse the wound, pat dry and apply the dressing per physician order. The facility failed to ensure thorough infection control during wound care dressing changes, placing the residents at risk for infection. - On 10/18/23 at 09:08 AM, observation during wound care for Resident (R) 130 revealed Licensed Nurse (LN) H removed the soiled leg dressings dated 10/17/23. LN H changed gloves without washing his hands, opened wound care products, and sprayed hypochloric acid (antibacterial agent) on the areas of cellulitis (skin infection caused by bacteria) areas. LN H then changed gloves without washing his hands and sprinkled collagen powder (protein derived wound treatment used to promote wound healing) on the leg wounds and spread Santyl ointment (a prescription enzyme used to help break up and remove dead skin and tissue of a wound), then Gentamycin ointment (antibacterial) over the Santyl on the leg wounds. LN H applied a dry dressing over the open areas, then wrapped the lower leg with gauze. After completing care LN H used hand cleanser. On 10/18/23 at 09:24 AM, LN H verified he should have washed his hands between removing the soiled dressing and before applying the clean wound dressings. On 10/18/23 at 09:30 AM, Administrative Nurse D verified she expected staff to wash their hands after handling soiled items. The facility's "Dressings, Dry/Clean" policy, dated	F 880			

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F 880	Continued From page 49 2013, directed staff to wash and dry hands thoroughly, don clean gloves, and remove soiled dressing. Staff were to wash and dry hands thoroughly before donning clean gloves and cleaning the wound/skin. Staff were to cleanse the wound, pat dry and apply the dressing per physician order. The facility failed to ensure thorough infection control during wound care dressing changes, placing the residents at risk for infection. - On 10/17/23 at 09:00AM, observation revealed Licensed Nurse (LN) H asked R21 if she was ready for her wound dressing, and R21 replied ok. LN H gathered supplies from a treatment cart outside R21's room and sat them on a barrier. LN H picked the supplies up along with the barrier sheet and entered R21's room. Without washing his hands, LN H applied gloves, removed the old dressing underneath R21's right breast to reveal a small amount of red drainage on the dressing. LN H removed and discarded the soiled gloves with the dressing inside them and tossed it on R21's top bedcover. Further observation revealed LN H did not wash his hands or apply hand sanitizer, applied new gloves, placed normal saline on a gauze pad, cleansed the wound area, then removed and discarded his gloves. LN H did not wash his hands but applied new gloves and placed Silvadene (a topical antibiotic used to treat an infection on areas of burned skin) cream on the wound with his gloved finger. LN H then removed and discarded his gloves, but did not wash hands, then donned clean gloves. LN H applied an abdominal dressing (ABD) and secured it with paper tape, removed and discarded his gloves. LN H then placed the contaminated gloves sitting on R21's top	F 880			

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F 880	Continued From page 50 bedcover, and other items used for wound dressing change into the trash. He tied up the bag, took it to the dirty utility and came back to room, then washed his hands. On 10/17/23 at 09:15AM, LN H verified he had placed his contaminated gloves on R21's bed cover and stated he should have discarded it in a trash can. On 10/18/23 at 02:00 PM, LN H verified he had not washed his hands during wound care on 10/17/23 and stated he should have washed hands after removing the dressing, after cleansing the wound and after placing the Silvadene cream on the wound area. He further verified he should have completed hand hygiene when he completed the procedure prior to leaving R21's room. On 10/19/23 at 09:27 AM, Administrative Nurse D stated she expected staff providing wound care to wash their hands before starting care, any time they took gloves off, and after they had completed the procedure. The facility's "Dressings, Dry/Clean Policy," revised September 2013, instructed staff to wash and dry hand thoroughly. The facility staff failed follow standard infection control procedures when staff failed to perform hand hygiene in between glove changes and failed to ensure sanitary practices when providing wound care for R21. This placed R21 at risk for infection. - On 10/17/23 at 08:45 AM, observation revealed Licensed Nurse (LN) H gathered supplies from a	F 880			

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F 880	Continued From page 51 cart outside R44's room door, placed them on a barrier on the cart, applied gloves, picked up the barrier sheet on the cart with supplies and carried it into R44's room. LN H removed and discarded his gloves, did not wash his hands, then applied new gloves. LN H closed the door using his elbow, and instructed R44 to turn on his left side. Observation revealed serosanguineous (semi-thick blood-tinged drainage) drainage on the cloth bed pad. Further observation revealed LN H removed the dressing, which had small amount of serosanguinous drainage as well and placed it in a trash can lined with a plastic bag. LN H then removed and discarded gloves. Further observation revealed LN H did not wash his hands, but donned a new pair of gloves, sprayed wound wash solution on gauze pads, cleansed the wound area, then removed and discarded the gloves. Further observation revealed LN H did not wash his hands, but donned new gloves, applied cream on his right gloved hand and wiped R44's buttocks around the wound area, then removed and discarded gloves. Further observation revealed LN H still did not wash his hands, but applied new gloves and cut Hydro-blue (a type of moist wound dressing which provides wound protection and addresses bacteria and yeast) foam dressing to size and shape of wound, squeezed Santyl (a prescription enzyme used to help break up and remove dead skin and tissue of a wound) ointment from the tube onto the foam dressing, then removed and discarded his gloves. LN H applied new gloves without performing hand hygiene and placed a border foam dressing on the wound, dated the dressing.. LN H placed all items used for wound care on the barrier sheet, discarded them into a trash can, removed and discarded his gloves, tied up the trash bag, took to the dirty utility room,	F 880			

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F 880	Continued From page 52 and returned to R44's room without performing hand hygiene. LN H at that time washed his hands in the resident's room. On 10/17/23 at 9:30 AM, LN H verified he had not washed his hands before providing wound care and when changing tasks during R44's wound care. LN H stated he should have performed hand hygiene. On 10/19/23 at 09:27 AM, Administrative Nurse D stated she expected staff providing wound care to wash their hands before starting care, any time they took gloves off, and after they had completed the procedure. The facility's "Dressings, Dry/Clean Policy," revised September 2013, instructed staff to wash and dry hands thoroughly. The facility staff failed to follow appropriate infection control technique when providing wound care for R44. This placed R44 at risk for infection.	F 880			
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F 882			

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F 882	Continued From page 53 §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, interview and record review, the facility failed to employ a designated Infection Preventionist (IP) as required. This placed the residents in the facility at increased risk for infection and related complications. Findings included: - On 10/17/23 at 03:07PM, Administrative Staff A verified the facility did not employ an IP. The facility's "Infection Preventionist" policy, dated 09/2023, stated the infection preventionist is responsible for coordinating, implementing and updating of the infection prevention and control program. Monitors changes in infection prevention and control guidelines and regulations to ensure that policies, practices, and protocols remain current and aid in preventing and controlling the spread of infections. A nurse must of earned a certificate for specialized training in infection control, and work at least part time in the facility. The facility failed to employ an IP as required placing the residents who reside in the facility at increased risk for infection and related complications.	F 882			

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F 920 F 920 SS=E	Continued From page 54 Requirements for Dining and Activity Rooms CFR(s): 483.90(h)(1)-(4) §483.90(h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- §483.90(h)(1) Be well lighted; §483.90(h)(2) Be well ventilated; §483.90(h)(3) Be adequately furnished; and §483.90(h)(4) Have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to provide adequate lighting in the main dining room. This placed the residents at risk for impaired quality of life. Findings Included: - On 10/16/23 at 11:59 AM, observation in the main dining room revealed the following: The fluorescent light, approximately three feet (ft) long by 18 inches wide, had nonfunctioning bulbs, on the ceiling above the dining room door where the STOP sign was posted. Two ceiling fluorescent light fixtures, close to the kitchen entrance. had nonfunctioning light bulbs. On 10/18/23 at 10:15 AM, Maintenance Staff (MS) U verified the above findings and stated he	F 920 F 920			

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F 920	Continued From page 55 became employed with the facility in August 2023 and he was trying to catch up with work orders but was unaware of the light fixture bulbs being burned out or needing cleaned. MS U stated staff were to leave a work order for him on the facility maintenance computer program if they had any environmental issues, and he tried to make rounds every day to see if there were any issues. On 10/19/23 at 09:28 AM, Administrative Nurse D stated staff were to enter any environmental issues on the facility maintenance computer program and the maintenance staff should make a log of issues needed repaired and mark each task when completed. The facility's "Preventive Maintenance Policy," revised 04/01/23, documented a preventive maintenance plan would be established and maintained by the facility to ensure that all equipment, facilities, and systems within the skilled nursing facility, including but not limited to heating, ventilation, and air conditioning (HVAC) electrical, plumbing, medical equipment, elevators, generators, and emergency systems. The facility failed to provide an adequate lighting in the main dining room for the residents who ate their meals there. This placed the residents at risk for impaired quality of life.	F 920			
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 921			

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F 921	Continued From page 56 by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation and record review the facility failed to provide a safe and sanitary environment, when six fluorescent ceiling light fixtures had numerous bugs, the sink counter top edge had missing pieces of laminate in the main dining room, and chairs in the rehabilitation dining room had stains and food particles three days of the onsite survey. This placed the residents at risk for decreased quality of care and life. Findings included: - On 10/16/23 at 12:00PM, observation of the main dining room revealed the following: The sink countertop edge lacked a piece of laminate trim approximately two feet wide by 4 inches wide, showing the rough wood. The countertop had another piece of laminated trim missing in the right corner approximately four inches long by two inches wide. - On 10/016/23 at 12:00 PM six fluorescent ceiling light fixtures throughout the dining room had numerous dead bugs in them. - On 10/16/23 at 12:24 PM, observation revealed five of the six dining chairs in the rehab dining room had dried food stains on the seat. - On 10/18/23 at 01:00 PM, observation revealed three of the six dining room chairs had layered, dried food stains on the seats. - On 10/18/23 at 10:15 AM, Maintenance Staff (MS) U verified the above findings and stated he was unaware the laminated trim was missing. MS	F 921			

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F 921	Continued From page 57 U stated staff were to leave a work order for him on the facility maintenance program, if they had any environmental issues, or he tried to make rounds every day to see if there were any issues. On 10/18/23 at 01:00 PM, Administrative Nurse D verified the dining chairs needed cleaned and were not clean enough to sit on. The facility's "Cleaning of Common Areas" policy, dated 04/01/23, stated all staff are responsible to see the common areas are clean and neat. The facility's "Preventive Maintenance Policy," revised 04/01/23, documented a preventive maintenance plan would be established and maintained by the facility to ensure that all equipment, facilities, and systems within the skilled nursing facility, including but not limited to HVAC, electrical, plumbing, medical equipment, elevators, generators, and emergency systems. The facility failed to provide a safe and sanitary environment, when six fluorescent ceiling light fixtures had numerous bugs, the sink counter top edge had missing pieces of laminate in the main dining room, and chairs in the rehabilitation dining room had stains and food particles three days of the onsite survey. This placed the residents at risk for decreased quality of care and life.	F 921			
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the	F 947			

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F 947	Continued From page 58 continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. Based on record review and interview, the facility failed to ensure three of five Certified Nurse Aides (CNAs) completed their required 12-hour annual in-services. This placed the residents at risk for receiving unskilled care. Findings included: - On 10/22/23 at 8:00 AM, review of CNA M, CNA N, and Certified Medication Aide (CMA) R annual in-service hours lacked evidence the staff had the required 12 hours of in-service training. On 10/19/23 at 09:19, Administrative Nurse D verified the facility lacked documentation the above staff completed their required 12-hour in-services. The "Facility Assessment Tool," revised 09/15/23," documented staff would be provided education and training by multiple means which	F 947			

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F 947	Continued From page 59 included online education monthly and as needed staff in-services. The tool documented staff would receive education upon hire and reviewed at least annually. The facility's "In-Service Training, Nurse Aide Policy," revised August 2022, documented the facility would complete a performance review of nurse aides every 12 months. Annual in-services would ensure the continuing competencies of nurse aides and are no less than 12 hours per employment year. The facility failed to ensure CNAs received their annual required 12 hour in-services. This placed the residents at risk for receiving unskilled care.	F 947			