STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175551	A. BUILDING _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET OLATHE, KS 66061

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00183409 and KS00183159. The 2567 was sent electronically on 10/31/23.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/31/2023

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 609	Continued From page 1	F 609		

by:
The facility identified a census of 69 residents. One resident was reviewed for abuse. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility failed to report a fracture of unknown origin as potential abuse or neglect to the State Agency (SA), within the mandated time frame. This deficient practice placed R1 at risk for unresolved and ongoing abuse, a decrease in psychosocial well-being, and further injuries.

Findings included:

- The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of encephalopathy (damage or disease that affects the brain), need for assistance with personal care, generalized muscle weakness, and dementia (progressive mental disorder characterized by failing memory, confusion) with other behavioral disturbance.

The "Admission Minimum Data Set (MDS)" dated 08/25/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R1 required extensive assistance with two staff for bed mobility, transfers, dressing, and toileting and extensive assistance with one staff for personal hygiene. R1 had no falls since admission.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" date 08/30/23, documented R1 had a BIMS score of 10 with cognitive communication deficits as the problem.

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F 609	Continued From page 2	F 609		

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 08/30/23, documented R1 needed help with ADLs and mobility.

R1's "Care Plan" dated 08/14/23, documented R1 was at risk for impaired cognitive function and impaired thought processes related to dementia. The care plan documented an intervention, dated 08/22/23, that directed staff kept routine consistent and tried to provide consistent caregivers as much as possible in order to decrease confusion.

R1's "Care Plan" dated 08/14/23, documented R1 was at risk for falls related to frequent falls, weakness, medication side effects, and impulsivity. The care plan documented interventions initiated 08/14/23 that directed staff made sure the call light was within reach and encouraged R1 to use it to call for assistance as needed, staff educated R1 about safety reminders and what to do if a fall occurred, staff ensured R1 wore appropriate footwear when ambulating or wheeling in wheelchair, staff maintained a clear pathway free of obstacles, and R1 needed a safe environment.

The "Notes" tab of R1's EMR revealed the following:

A "Nursing" note on 10/10/23 at 10:16 PM that documented the nurse was summoned to R1's room by the Certified Nurse Aide (CNA) and found R1 lying on the floor next to the bed. The CNA explained he left R1's room to get sheets for the bed and by the time he came back, R1 was on the floor. R1 could not explain what happened; he denied any pain or discomfort upon range of

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F 609	Continued From page 3	F 609		

motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) assessment, and there were no visible injuries noted. Staff assisted R1 back in his wheelchair and later into bed with bed in lowest position.

A "Nursing" note on 10/12/23 at 06:45 AM documented R1's left wrist was red and swollen but not edematous (swelling resulting from an excessive accumulation of fluid in the body tissues). Staff notified the on-call for the primary care provider and received orders for a STAT (urgent) x-ray of R1's left wrist. Staff notified R1's family of the swollen wrist and intended x-ray.

An "Encounter" note on 10/12/23 at 12:00 AM, electronically signed by Consultant GG on 10/13/23 at 03:30 PM, documented R1 had multiple falls with a new right hand fracture that was followed by the joint and bone clinic. The note documented R1 had a splint on his right hand. and also had some swelling and ecchymosis (redness) of the left hand. The note documented x-rays of the right ribs and left wrist were completed due to pain. Both were reviewed, and R1 did have a new hairline fracture with no displacement of the left ulna/radius (bones in the arm). The note documented Consultant GG offered R1's representative the choice between an orthopedic appointment or a visit to the emergency room but R1's representative could not decide so the facility would order a splint and with a consult to orthopedic clinic. She wrote the plan for R1 that included R1 had a new left wrist hairline fracture with no displacement, nursing to splint the wrist, and continue pain management; R1 to follow-up with orthopedics.

Upon request of the investigation into R1's left

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fracture of unknown cause, the facility provided a timeline of the incident which included the following: R1 had a fall on 10/10/23 with no injury noted; increased complaints of pain on 10/12/23, change in condition noted, and x-ray orders obtained; x-rays from 10/12/23 noted severe osteopenia (loss of bone density which weakens the bone) and a hairline fracture to left wrist; appointment follow up on 10/13/23 where no fracture to left wrist was noted; facility awaited another follow-up appointment scheduled for 10/20/23 to confirm if the hairline fracture seen on facility x-ray was an acute fracture versus chronic osteopenia. The investigation included information on R1's fall on 10/10/23, the "Notes" related to R1's fall on 10/10/23, the "Progress Note" related to R1's left wrist redness and swelling on 10/12/23, Consultant GG's "Note" on 10/12/23, x-ray results for 10/12/23, and appointment date for orthopedic on 10/20/23 to confirm acute hairline left hand fracture vs chronic osteopenia. There was a lack of evidence of a thorough investigation to rule out abuse and neglect.

Upon request, the facility provided x-ray results for the x-rays performed in the facility on 10/12/23 for R1's left wrist. The x-ray documented acute fractures of the distal (away from the farthest point of origin or attachment) radius and ulna.

Upon request, the facility provided orthopedic "Progress Notes" from R1's visit on 10/13/23 that documented R1 returned to the clinic for urgent evaluation with concerns of an injury to his left hand and wrist. R1's family member stated that the staff at the facility noted that the resident's left hand was swollen and painful. Exam of the left wrist and hand demonstrated moderate swelling.

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F 609	Continued From page 5	F 609		

Imaging was ordered, performed, and interpreted in the office that day with evidence of an acute distal radius fracture. R1 was fitted with a wrist splint to wear on a full-time basis over the next week and he was recommended to return in one week for repeat evaluation and placement into a short arm cast.

On 10/17/23 at 12:24 PM, R1 sat in his wheelchair in the dining room. He attempted to stand up from his wheelchair and staff quickly attended to him. He stated he wanted to go to the restroom and staff assisted him to the shower room for toileting. He wore splints on both hands/wrists.

On 10/17/23 at 11:55 AM, R1's family member stated on 10/12/23, the day nurse noticed R1's left hand was red and swollen so the provider was contacted, and x-rays were ordered. The nurse called her and informed her his left hand was broken. R1's family member stated she was at the orthopedic appointment with R1 on 10/13/23 and they confirmed that his left wrist was broken and due to the swelling, the provider was going to wait a week to put the cast on.

On 10/17/23 at 03:28 PM, CNA N stated if there was an injury of unknown cause, she told the first nurse she saw and got Administrative Nurse D to look at it.

On 10/17/23 a 03:49 PM, Licensed Nurse (LN) G stated if there was an injury of unknown cause, she immediately checked it out and notified the doctor, Administrative Nurse D, and family. She stated the Assistant Director of Nursing (ADON) and Administrative Nurse D then completed an investigation. LN G stated from what she heard,

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R1's left wrist was broken.

On 10/17/23 at 04:15 PM, Administrative Nurse D stated R1's fall from 10/10/23 was reviewed and he had no issues or complaints at that time. He stated 48 hours later, the nurse noticed R1's left wrist was red, swollen, and had some pain. The facility got an x-ray and his wife was notified about an acute fracture. Administrative Nurse D stated R1 went to the orthopedic clinic and Consultant GG documented in her note that there was no acute fracture. R1 had another follow-up with orthopedics on 10/20/23. He stated the fracture was pathological because he had osteopenia (loss of bone density which weakens the bone) and had so many falls. He stated it was hard telling what caused the fracture, but he did not think it was related to the fall on 10/10/23. Administrative Nurse D stated the facility did not receive or request any progress notes or results from the orthopedic visit on 10/13/23. He stated there was some confusion on whether the left wrist was fractured or not fractured, and it was not reported to state. Generally, injuries of unknown origin were reported to the SA and the facility had four hours to report to the SA.

The facility's "Abuse: Prevention of and Prohibition Against" policy, last revised/reviewed October 2023, directed allegations of abuse, neglect, misappropriation of resident property, or exploitation were reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per the policy and applicable regulations.

The facility failed to ensure R1 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility

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F 609	Continued From page 7 failed to report a fracture of unknown origin as potential abuse or neglect to the SA, within the mandated time frame. This deficient practice placed R1 at risk for unresolved and ongoing abuse, a decrease in psychosocial well-being, and further injuries.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility identified a census of 69 residents. One resident was reviewed for abuse. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility failed to investigate a fracture of unknown origin as potential abuse or neglect and send the completed investigation to the State Agency (SA)	F 610		

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within the required timeframe. This deficient practice placed R1 at risk for unresolved and ongoing abuse, a decrease in psychosocial well-being, and further injuries.

Findings included:

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08/22/23, that directed staff kept routine consistent and tried to provide consistent caregivers as much as possible in order to decrease confusion.

R1's "Care Plan" dated 08/14/23, documented R1 was at risk for falls related to frequent falls, weakness, medication side effects, and impulsivity. The care plan documented interventions initiated 08/14/23 that directed staff made sure the call light was within reach and encouraged R1 to use it to call for assistance as needed, staff educated R1 about safety reminders and what to do if a fall occurred, staff ensured R1 wore appropriate footwear when ambulating or wheeling in wheelchair, staff maintained a clear pathway free of obstacles, and R1 needed a safe environment.

The "Notes" tab of R1's EMR revealed the following:

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F 610	Continued From page 10	F 610		

excessive accumulation of fluid in the body tissues). Staff notified the on-call for the primary care provider and received orders for a STAT (urgent) x-ray of R1's left wrist. Staff notified R1's family of the swollen wrist and intended x-ray.

An "Encounter" note on 10/12/23 at 12:00 AM, electronically signed by Consultant GG on 10/13/23 at 03:30 PM, documented R1 had multiple falls with a new right hand fracture that was followed by the joint and bone clinic. The note documented R1 had a splint on his right hand. and also had some swelling and ecchymosis (redness) of the left hand. The note documented x-rays of the right ribs and left wrist were completed due to pain. Both were reviewed, and R1 did have a new hairline fracture with no displacement of the left ulna/radius (bones in the arm). The note documented Consultant GG offered R1's representative the choice between an orthopedic appointment or a visit to the emergency room but R1's representative could not decide so the facility would order a splint and with a consult to orthopedic clinic. She wrote the plan for R1 that included R1 had a new left wrist hairline fracture with no displacement, nursing to splint the wrist, and continue pain management; R1 to follow-up with orthopedics.

Upon request of the investigation into R1's left fracture of unknown cause, the facility provided a timeline of the incident which included the following: R1 had a fall on 10/10/23 with no injury noted; increased complaints of pain on 10/12/23, change in condition noted, and x-ray orders obtained; x-rays from 10/12/23 noted severe osteopenia (loss of bone density which weakens the bone) and a hairline fracture to left wrist; appointment follow up on 10/13/23 where no

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fracture to left wrist was noted; facility awaited another follow-up appointment scheduled for 10/20/23 to confirm if the hairline fracture seen on facility x-ray was an acute fracture versus chronic osteopenia. The investigation included information on R1's fall on 10/10/23, the "Notes" related to R1's fall on 10/10/23, the "Progress Note" related to R1's left wrist redness and swelling on 10/12/23, Consultant GG's "Note" on 10/12/23, x-ray results for 10/12/23, and appointment date for orthopedic on 10/20/23 to confirm acute hairline left hand fracture vs chronic osteopenia. There was a lack of evidence of a thorough investigation to rule out abuse and neglect.

Upon request, the facility provided x-ray results for the x-rays performed in the facility on 10/12/23 for R1's left wrist. The x-ray documented acute fractures of the distal (away from the farthest point of origin or attachment) radius and ulna.

Upon request, the facility provided orthopedic "Progress Notes" from R1's visit on 10/13/23 that documented R1 returned to the clinic for urgent evaluation with concerns of an injury to his left hand and wrist. R1's family member stated that the staff at the facility noted that the resident's left hand was swollen and painful. Exam of the left wrist and hand demonstrated moderate swelling. Imaging was ordered, performed, and interpreted in the office that day with evidence of an acute distal radius fracture. R1 was fitted with a wrist splint to wear on a full-time basis over the next week and he was recommended to return in one week for repeat evaluation and placement into a short arm cast.

On 10/17/23 at 12:24 PM, R1 sat in his

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wheelchair in the dining room. He attempted to stand up from his wheelchair and staff quickly attended to him. He stated he wanted to go to the restroom and staff assisted him to the shower room for toileting. He wore splints on both hands/wrists.

On 10/17/23 at 11:55 AM, R1's family member stated on 10/12/23, the day nurse noticed R1's left hand was red and swollen so the provider was contacted, and x-rays were ordered. The nurse called her and informed her his left hand was broken. R1's family member stated she was at the orthopedic appointment with R1 on 10/13/23 and they confirmed that his left wrist was broken and due to the swelling, the provider was going to wait a week to put the cast on.

On 10/17/23 at 03:28 PM, CNA N stated if there was an injury of unknown cause, she told the first nurse she saw and got Administrative Nurse D to look at it.

On 10/17/23 a 03:49 PM, Licensed Nurse (LN) G stated if there was an injury of unknown cause, she immediately checked it out and notified the doctor, Administrative Nurse D, and family. She stated the Assistant Director of Nursing (ADON) and Administrative Nurse D then completed an investigation. LN G stated from what she heard, R1's left wrist was broken.

On 10/17/23 at 04:15 PM, Administrative Nurse D stated R1's fall from 10/10/23 was reviewed and he had no issues or complaints at that time. He stated 48 hours later, the nurse noticed R1's left wrist was red, swollen, and had some pain. The facility got an x-ray and his wife was notified about an acute fracture. Administrative Nurse D

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stated R1 went to the orthopedic clinic and Consultant GG documented in her note that there was no acute fracture. R1 had another follow-up with orthopedics on 10/20/23. He stated the fracture was pathological because he had osteopenia (loss of bone density which weakens the bone) and had so many falls. He stated it was hard telling what caused the fracture, but he did not think it was related to the fall on 10/10/23. Administrative Nurse D stated the facility did not receive or request any progress notes or results from the orthopedic visit on 10/13/23. He stated there was some confusion on whether the left wrist was fractured or not fractured, and it was not reported to state. Generally, injuries of unknown origin were reported to the SA and the facility had four hours to report to the SA then five days to send in the completed investigation.

The facility's "Abuse: Prevention of and Prohibition Against" policy, last revised/reviewed October 2023, directed all identified events were reported to the Administrator immediately. All allegations of abuse, neglect, misappropriation of resident property, and exploitation were promptly and thoroughly investigated by the Administrator or his/her designee. The investigation and the results of the investigation were documented. The "policy" did not direct the timeframe for when the completed investigation was sent to the SA.

The facility failed to ensure R1 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility failed to investigate a fracture of unknown origin as potential abuse or neglect and send the completed investigation to the SA within the required timeframe. This deficient practice placed R1 at risk for unresolved and ongoing abuse, a

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F 610	Continued From page 14 decrease in psychosocial well-being, and further injuries.	F 610		
F 689 SS=G	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 identified a census of 69 residents. The sample included three residents reviewed for falls. Based on observations, record review, and interviews, the facility failed to follow fall interventions to prevent a fall with major injury for Resident (R) 1. On 09/16/23, Certified Nurse Aide (CNA) M forgot to place the fall mat on the floor, next to R1's bed. R1 was subsequently found on the floor with a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma), skin tear, and a right thumb fracture. The injuries resulting from the deficient practice also placed R1 at increased risk for pain. Findings included: - The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of encephalopathy (damage or disease that affects the brain), need for assistance with personal care, generalized muscle weakness, and dementia (progressive mental disorder	F 689	Past noncompliance: no plan of correction required.	

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characterized by failing memory, confusion) with other behavioral disturbance.

The "Admission Minimum Data Set (MDS)" dated 08/25/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. R1 required extensive assistance with two staff for bed mobility, transfers, dressing, and toileting and extensive assistance with one staff for personal hygiene. R1 had no falls since admission.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" date 08/30/23, documented R1 had a BIMS score of 10, with cognitive communication deficits as the problem.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 08/30/23, documented R1 needed help with ADLs and mobility.

R1's "Care Plan" dated 08/14/23, documented R1 was at risk for falls related to frequent falls, weakness, medication side effects, and impulsivity. The "Care Plan" documented an intervention, dated 08/27/23, that directed R1 had a minor injury fall and a fall mat was placed next to the bed.

The "Notes" tab of R1's EMR revealed the following:

A "Nursing Note" on 09/17/23 at 04:10 AM documented R1 left on a stretcher to the hospital due to the development of a hematoma on the back of his head and swelling, bruising, and pain on his right thumb related to falls.

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A "Nursing Note" on 09/17/23 at 06:17 AM documented R1 was found sitting on the floor next to his bed. He had a skin tear on his forehead above the left eye and no other injuries were noted at that time. Staff assisted R1 off the floor. Staff cleaned the skin tear and applied a band-aid. The note documented the unidentified CNA that assisted R1 to bed forgot to place the floor mat next to R1's bed. The CNA was reminded to always place mat next to R1's bed in order to prevent falls and the CNA voiced understanding. During a follow-up skin assessment, a quarter-sized hematoma was noticed at the back of R1's head and some bruising and swelling were noticed to his right hand and thumb area. R1 voiced pain and tenderness with touch. Staff notified the physician of the changes and received an order to send R1 to hospital for x-ray of the right hand and a computed tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) of the head.

A "Nursing Note" on 09/17/23 at 04:06 PM documented R1 returned from hospital on 09/17/23 at 06:30 AM. He came back with a contusion (bruise), a fracture to his right hand, and a head injury. R1 was to follow-up with orthopedics and had a splint in place. The note documented an intervention, staff were to get R1 in bed between 08:00 PM and 09:00 PM with a fall mat in place by the bed. R1 sat comfortably in wheelchair in sight of nurse and the CNAs were aware of updated interventions.

A "Nursing Note" on 09/18/23 at 12:15 PM documented the Interdisciplinary Team (IDT) met to review R1 related to second fall from 09/16/23.

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The note documented R1 was found lying on the floor next to his bed with a small skin tear above the left eye and he had been checked on approximately 15 to 20 minutes prior to the fall and was resting in bed comfortably. The note documented an intervention for R1 to have a parameter overlay applied to his bed to help him establish the edge of the bed during bed mobility.

A "Nursing Note" on 09/18/23 at 12:18 PM documented IDT met to review R1 related to his incidents from 09/16/23 and 09/17/23. The note documented R1 had two falls and sustained small skin tears to the forehead at his hairline and above his eye. The note documented R1 started exhibiting pain to his right hand, had bruising to his right hand, and was sent to the hospital for evaluation and treatment. R1 returned on 09/17/23 with a right hand/thumb fracture. The note documented R1 had a splint in place to his right hand but continued to remove it despite redirection.

Upon request, the facility provided the x-ray report from 09/17/23. The x-ray report documented R1 had an acute traumatic fracture at the base of the first metacarpal (thumb).

The facility's investigative report, dated 09/25/23, documented on 09/16/23 at approximately 11:03 PM, R1 fell and was noted to have a small hematoma and pain to his right hand. The facility sent R1 to the hospital for evaluation and treatment and family and medical doctor were notified at the time of the fall. Staff checked on R1 approximately 15 to 30 minutes prior to the fall due to R1 was being on increased monitoring related to fall precautions. R1 had a fracture to his right hand and a laceration (cut) to the left

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side of his forehead. R1 returned to the facility on 09/17/23 at approximately 06:30 AM with a splint in place and a follow-up appointment scheduled with orthopedics. Certified Nurse Aide (CNA) M from the shift was educated on the importance of completing fall interventions and ensuring the fall mat was in place.

On 10/17/23 at 12:24 PM, R1 sat in his wheelchair in the dining room. He attempted to stand up from his wheelchair and staff quickly attended to him. He stated he wanted to go to the restroom and staff assisted him to the shower room for toileting. He wore splints on both hands/wrists.

On 10/17/23 at 03:28 PM, CNA N stated the Kardex (nursing tool that gives a brief overview of the care needs of each resident) told staff how to care for residents including how to transfer and how many staff were needed for assistance. She stated R1's fall preventions included a fall mat on the floor when the resident was in bed and a perimeter mattress. CNA N stated she did not open the Kardex unless she was not 100 percent sure about how to take care of someone. CNA N said if there was a new intervention, then the nurse or therapy staff told the CNA.

On 10/17/23 at 03:49 PM, Licensed Nurse (LN) G stated staff knew how to care for residents by looking at the care plan which was updated between nursing and therapy staff. She stated the CNAs had access to the Kardex which told them how a resident transferred, what staff assistance with ADLs were required, and any fall interventions such as a fall mat. LN G stated falls were prevented with R1 by keeping him entertained including giving him a snack, giving

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him coffee, having him do the fidget board or activities, and bringing him to the dining room; if R1 was in his bed, he had a fall mat placed beside the bed and was on frequent checks.

On 10/17/23 at 04:15 PM, Administrative Nurse D stated the Kardex told staff how to care for a resident as well as the "Tasks" tab of the EMR. The Kardex told staff transfer status, diet type, fall interventions, and any assistance needed with meals. Administrative Nurse D stated fall interventions for R1 included the bed in low position, toileting schedule, fall mat, and bolsters on the mattress to show R1 the edge of the bed.

CNA M was unavailable for interview on 10/23/23 at 07:17 PM.

The facility's "Fall Management System" policy, last revised June 2023, directed residents with high risk factors identified on the Fall Risk Evaluation had an individualized care plan developed that included measurable objectives and timeframes. The care plan interventions were developed to prevent falls by addressing the risk factors and considered the particular elements of the evaluation that put the resident at risk.

The facility failed to follow fall interventions to prevent a fall with major injury for R1. This deficient practice resulted in R1 suffered a right thumb fracture.

The facility implemented the following corrections by 09/29/23:
R1's care plan was updated on 09/16/23.
CNA M received education on fall precautions and interventions on 09/18/23.
CNA M received counseling on inadequate

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F 689	Continued From page 20 implementation of fall interventions on 09/18/23. Staff were educated on falls during monthly in-service on 09/29/23. This deficient practice was cited at past noncompliance. The scope and severity remained at a "G".	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 identified a census of 69 residents. Three residents were reviewed for weight loss. Based on observations, record review, and interviews, the facility failed to follow recommendations from the dietitian and failed to	F 692		

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provide consistent weight loss interventions for Resident (R) 1 who had a significant weight loss of 16.3% from 08/14/23 to 10/09/23. This deficient practice placed R1 at risk for further weight loss and physical complications.

Findings included:

- The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of encephalopathy (damage or disease that affects the brain), need for assistance with personal care, generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with other behavioral disturbance, mild protein-calorie malnutrition (condition that results from lack of sufficient nutrients in the body), type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dysphagia (swallowing difficulty).

The "Admission Minimum Data Set (MDS)" dated 08/25/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R1 required extensive assistance with two staff for bed mobility, transfers, dressing, and toileting and extensive assistance with one staff for personal hygiene. R1 had no falls since admission.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" date 08/30/23, documented R1 had a BIMS score of 10 with cognitive communication deficits as the problem.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated

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08/30/23, documented R1 needed help with ADLs and mobility.

The "Nutritional Status CAA" dated 08/30/23, documented R1 ate 50 to 75 percent of his meals, ate in the dining room, was able to make food preferences known, stated the food was good, and was eating well. R1's Mini Nutritional Assessment (MNA- a screening tool used to help identify elderly people who were malnourished or at risk of malnutrition) score was nine which indicated he was at risk of malnutrition.

R1's "Care Plan" dated 08/14/23, documented R1 was at risk for impaired cognitive function and impaired thought processes related to dementia. The care plan documented an intervention, dated 08/22/23, that directed staff kept routine consistent and tried to provide consistent caregivers as much as possible in order to decrease confusion.

R1's "Care Plan" dated 08/14/23, documented R1 had a nutritional problem related to DM and protein calorie-malnutrition. The care plan documented interventions dated 08/14/23 that directed staff honored resident rights to make personal dietary choices and provided dietary education as needed; staff invited R1 to activities that promoted additional intake; R1 ate meals in dining room when he agreed; staff monitored/recorded/reported to medical doctor as needed (PRN) signs and symptoms of decreased appetite, nausea and vomiting, unexpected weight loss, and complaints of stomach pain; and staff monitored/recorded/reported to medical doctor PRN signs and symptoms of malnutrition including emaciation (the state of being abnormally thin or weak), muscle wasting, and

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significant weight loss. The care plan documented an intervention dated 08/25/23 that directed staff provided and served supplements as ordered.

The "Assessments" tab of R1's EMR revealed a "Nutrition- Admission Evaluation" on 08/24/23 that documented R1's most recent weight was 181.6 pounds (lbs), his usual weight was 182 lbs, and his desirable weight was 160 lbs.

The "Orders" tab of R1's EMR documented an order with a start date of 08/14/23 and discontinued date of 08/21/23 for daily weights for three days then weekly weight every Monday; an order with a start date of 08/22/23 for daily weights for three days then weekly weight every Monday; an order with a start date of 08/23/23 to offer and provide protein snacks per resident choice three times a day; an order with a start date of 09/14/23 to weigh daily in the morning for weight monitoring for seven days, and an order with a start date of 10/05/23 for megestrol acetate (Megace- appetite stimulant medication) 400 milligrams/10 milliliters (mL) give 10 mL one time a day for appetite stimulant.

The "Weights/Vitals" tab of R1's EMR documented the following weights: 181.3 lbs on 08/14/23, 181.6 lbs on 08/23/23, 182.0 lbs on 08/24/23, 181.0 lbs on 09/03/23, 160.0 lbs on 09/14/23, 164.2 lbs on 09/15/23, 167.0 lbs on 09/16/23, 167.0 lbs on 09/17/23, 164.8 lbs on 09/18/23, 163.2 lbs on 09/25/23, 158.0 lbs on 10/02/23, and 151.8 lbs on 10/09/23. There was an 11.7% significant weight loss from 08/14/23 to 09/14/23 and a 16.3% significant weight loss from 08/14/23 to 10/09/23.

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Review of R1's "Medication Administration Record (MAR)" for 08/14/23 to 10/16/23 revealed the following: a lack of documentation that weights were obtained as ordered on 08/16/23, 08/25/23, 08/28/23, 09/04/23, 09/11/23, 09/20/23, and 10/16/23; a lack of documentation that snacks were offered and provided on 08/24/23 at 03:00 PM and 08/28/23 at 03:00 PM, no snack was offered and provided on 09/03/23 at 03:00 PM and 09/15/23 at 09:00 PM; R1 was sleeping and did not receive snack on 09/22/23 at 03:00 PM and 09:00 PM; and R1 refused snack on 08/26/23 at 09:00 PM, 08/31/23 at 09:00 PM, 09/08/23 at 09:00 PM, 09/09/23 at 10:00 AM, 09/10/23 at 09:00 PM, 09/24/23 at 10:00 AM and at 09:00 PM, 10/03/23 at 09:00 PM, 10/07/23 at 03:00 PM, and 10/16/23 at 09:00 PM.

The "Notes" tab of R1's EMR revealed the following:

A "Weight Change Note" on 09/14/23 at 10:17 AM documented R1 was discussed with Interdisciplinary Team (IDT) that day for risk related to significant weight change. The note documented the registered dietitian (RD) added Glucerna (supplemental shake) twice a day (BID) for supplement and daily weights for one week to monitor for accuracy. The note documented the Medical Doctor (MD) and family were aware.

A "Weekly Clinical/IDT Review" note on 09/21/23 at 09:35 AM documented IDT and RD met ro review R1. The note documented R1 weighed 164.8 lbs which was down 9.1% from 08/14/23. The note documented weight monitoring was to increase to three times a week and the RD was to update Glucerna order to half a carton four times a day. The note documented the MD and family

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	175551	A. BUILDING _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET OLATHE, KS 66061

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were aware.

A "Weight Change Note" on 09/21/23 at 11:28 AM documented R1 was discussed with IDT that day for risk related to significant weight change. The note documented R1 was on Glucerna BID with 50% intake at best with a recommendation to change supplement to 120 mL or half a bottle four times a day for better intake.

A "Nursing" note on 09/28/23 at 10:36 AM documented R1's weight was 163.2 lbs which was down 10.1% from 08/23/23 and R1 had an average intake of 25 to 75% of meals. The note documented weight monitoring was to increase to three times a week. The note documented the MD and family were aware.

An "Encounter" note on 10/05/23 at 12:00 AM documented R1 had protein calorie malnutrition with poor appetite and weight loss. The note documented weights and labs were followed, the RD was consulted, supplements were continued, and R1 would start on Megace 400 mg daily for an appetite stimulant.

A "Weekly Clinical/IDT Review" on 10/05/23 at 11:47 AM documented IDT and RD met to review R1. The note documented R1's weight was 158 lbs which was down 12.9% from 08/14/23 and R1 had an average intake of 25 to 75% of meals. The note documented weight monitoring was to increase to three times a week. The note documented a referral was made to the MD to assess.

A "Weight Change Note" on 10/05/23 at 03:33 PM documented R1 was discussed with IDT that day for risk related to significant weight change.

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The note documented a referral was made to the MD to consider an appetite stimulant.

An "Encounter" note on 10/12/23 at 12:00 AM documented R1 had protein calorie malnutrition with poor appetite and weight loss. The note documented weights and labs were followed, the RD was consulted, supplements were continued, and R1 started on Megace 400 mg daily for an appetite supplement.

A "Weekly Clinical/IDT Review" on 10/12/23 at 09:50 AM documented IDT and RD met to review R1. The note documented R1's weight was 151.8 lbs and R1 had an average intake of 25 to 75% of meals. The note documented R1 started on Megace on 10/06/23. The note documented weight monitoring was to increase to three times a week and a referral was made to the MD to assess.

A "Weight Change Note" on 10/12/23 at 01:01 PM documented R1 was discussed with IDT that day for risk related to significant weight change. The note documented it was discussed to consider offering sandwiches to help redirect R1 when he was more alert/awake since he fell asleep during meals.

An "Encounter" note on 10/14/23 at 12:00 AM documented R1 had protein calorie malnutrition with poor appetite and weight loss. The note documented weight monitoring continued, supplements were continued as directed by RD, and R1 was on Megace 400 mg for appetite supplement.

R1's EMR lacked evidence weight monitoring was increased to three times a week as

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recommended by RD.

On 10/17/23 at 12:24 PM, R1 sat in his wheelchair in the dining room and ate lunch. He attempted to stand up from his wheelchair and staff quickly attended to him. He stated he wanted to go to the restroom and staff assisted him to the shower room for toileting.

On 10/17/23 at 12:34 PM, R1 exited the shower room with staff and returned to the dining room table. Staff asked R1 if he was done eating lunch and he stated he was. R1 ate about 90% of his lunch and was offered coffee to which he accepted.

On 10/17/23 at 03:28 PM, Certified Nurse Aide (CNA) N stated she helped prevent weight loss by encouraging residents to eat in the dining room with other residents because sometimes when they see others eating, they eat. She stated she was not sure if R1 had any interventions for weight loss, but he did good at eating his meals and staff gave him snacks when he asked.

On 10/17/23 at 03:49 PM, Licensed Nurse (LN) G stated R1 had a weight loss, weighed 181 lbs on admission and his most recent weight was 151 lbs. She stated R1 received Megace for appetite stimulant which started on 10/06/23, the nurses gave Glucerna half a bottle four times a day, and he ate his snacks. LN G stated weights were mainly obtained by the CNAs every Monday for weekly weights, but everyone helped get the weights and the nurses documented them. She stated blank documentation in the MAR probably meant the order did not get signed out or was not done. LN G stated the RD sometimes asked the nurses questions about weight losses in the

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residents and talked about what interventions they might add.

On 10/17/23 at 04:15 PM, Administrative Nurse D stated R1 had weight loss interventions of Glucerna, assistance with meals, and snacks provided by nursing. He stated R1 did not want to initiate eating or wanting to eat and his family member did not want him to have any snacks that were not diabetic snacks. Administrative Nurse D stated the nurses provided snacks and Glucerna and documented the consumption percentage in the MAR. He stated blank documentation in the MAR meant nothing was documented, did not mean that it did not get done but he would have liked nurses to document. Administrative Nurse D stated the RD visited the facility on Mondays and Thursdays. He stated in Risk meetings on Thursdays, the RD or nursing managers put interventions in place or communicated with the doctor for an appetite stimulant or lab orders. The nurse managers or RD changed the weight frequency on the orders and weights were obtained by the CNAs or nurses. Administrative Nurse D stated the facility reviewed weights weekly in the Risk meeting and if there were any missing, they tried to catch them up.

The facility's "Nutrition Status Management" policy, last revised/reviewed August 2023, directed the nurse, CNA, or designee obtained the weight as ordered by the MD and record weight in the designated weight binder or directly in Point Click Care (PCC- EMR system). Weights were reconciled by IDT during risk review and added to PCC as needed. The policy directed once the resident was evaluated for nutrition status, the nurse supervisor/designee and dietary supervisor/designee determined if there was a

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F 692	Continued From page 29 significant change in the resident's condition and initiate resident at risk (RAI) process. If so, additional nutrition was offered to those residents including all high-risk residents. The facility failed to follow recommendations from the dietitian and failed to provide consistent weight loss interventions for R1 who had a significant weight loss of 16.3% from 08/14/23 to 10/09/23. This deficient practice placed R1 at risk for further weight loss and physical complications.	F 692		