

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

PRINTED: 11/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/16/2023
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF LEAWOOD - IRON HORSE HLTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5401 W 143RD STREET LEAWOOD, KS 66224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS0018317.	F 000			
F 550 SS=D	The 2567 was sent electronically on 11/27/23. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550			

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

TITLE

(X6) DATE

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 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to ensure that resident's rights and dignity were respected by staff when Resident (R) 16 and R1, both dependent residents, sat at the dining table as staff stood in between these residents to assist them with eating. This placed the residents at risk for decreased self-esteem and impaired dignity. Findings included: - On 11/13/23 at 12:48 PM R16 sat in his wheelchair at a dining room table and R1 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) on the other side of the same table. Certified Nurse Aide (CNA) O stood in between R16 and R1 while she assisted the two residents to eat. On 11/16/23 at 01:14 PM CNA N stated that staff should sit down beside a resident when assisting them to eat. CNA N stated staff should not ever stand to assist a resident to eat to respect their dignity.			F 550			

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F 550	Continued From page 2 On 11/16/23 at 01:27 PM Licensed Nurse G stated staff should be seated next to a resident while assisting with eating to respect their dignity. On 11/16/23 at 02:50 PM Administrative Nurse D stated she expected staff members to be seated beside a resident when assisting with eating and not standing in front of or beside them. The facility policy "Promoting/Maintaining Resident Dignity" revised 01/01/23 documented: It was the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members were involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The facility failed to ensure that resident's rights and dignity were respected by staff when staff stood in between R16 and R1 to feed them their meal. This placed the residents at risk for decreased self-esteem and impaired dignity.	F 550			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at	F 565			

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F 565	Continued From page 3 the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: The facility reported a census of 63. Based on observations, record review, and interviews, the facility failed to adequately address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial wellbeing and impaired quality of life. Findings Included- - A review of the facility's "Resident Council Minutes" from 11/2022 through 11/2023 indicated	F 565			

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F 565	Continued From page 4 the council had recurring concerns with staff not verifying meal tickets, offering choices, availability of snacks and fruits and vegetables, not taking orders before meal service, and posting the daily menus. Further recurring issues were call light response times. The "Resident Council Minutes" form instructed any old business that was unresolved be moved to new business. The 11/2022 "Resident Council Minutes" documented new business (concerns) that meal menus were not displayed, there were no snacks and fruit and/or vegetables were not always available. Further concerns included nursing staff were not asking the residents what they wanted or offering choices, staff were turning off call lights without providing services and lack of staff to attend to call lights during meals. The 12/2022 "Resident Council Minutes" listed new business concerns included lack of options at mealtimes, and no snacks were available. Further new business concerns included low availability of supplies and lack of restocking of towels and supplies. The minutes lacked actions taken or outcomes for the repeat concerns. The 01/2023 "Resident Council Minutes" listed new business concerns included lack of options at mealtimes, lack of vegetable variety, cold food and meal tickets. Further new business concerns included nursing staff were not asking the residents what they wanted or offering choices. The minutes lacked actions taken or outcomes for the repeat concerns. The 02/2023 "Resident Council Minutes" listed new business concerns included fresh fruits and vegetable availability, and small portion sizes.	F 565			

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F 565	Continued From page 5 Further new business concerns included nursing staff were not asking the residents what they wanted at meals. The minutes lacked actions taken or outcomes for the repeat concerns. The 04/2023 "Resident Council Minutes" lacked documentation of concerns on the form but included a handwritten page which listed topics under Dietary heading including "double portion not consistent" and under Nursing "call light times/issues." The minutes lacked actions taken or outcomes for the repeat concerns. The 05/2023 "Resident Council Minutes" listed new business concerns included meal tickets again. Further new business concerns included nursing staff were not asking the residents what they wanted at meals and call light times. The minutes lacked actions taken or outcomes for the repeat concerns. The 06/2023 "Resident Council Minutes" listed new business concerns the lack of fresh fruit and problems with snack availability again. Further new business concerns included call light times. Notes under appreciation listed the food was getting better. The minutes lacked actions taken or outcomes for the repeat concerns. The 07/2023 "Resident Council Minutes" listed new business concerns included snacks not available/stocked, no stocking of supplies such as napkins and utensils in kitchenette, and no fresh fruit again. Further new business concerns included nursing staff were not asking the residents what they wanted at meals, food trays were served late, and staff would say "be right back" and not return and poor call light times again. The minutes did record action taken was	F 565			

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F 565	Continued From page 6 to stock the kitchenette with sandwiches and snacks. The issue was marked as resolved. Further actions included management staff would be dining rooms for lunch and dinner meals and staff were educated on mealtimes. Call light times were reviewed. The concerns were marked as resolved. The 08/2023 "Resident Council Minutes" listed new business concerns which included running out of food and nursing staff were still not asking residents regarding meal preferences. Further new business concerns included call light times again. The minutes listed actions taken were the facility made a large "back stock" order and provided staff education. No outcomes were indicated for the repeat concerns. The 09/2023 "Resident Council Minutes" listed new business concerns which included poor availability of utensils, fresh fruit items, The minutes listed actions taken were the facility would prep and order more options and would stock the kitchenettes for late night snacks. No outcomes were indicated for the repeat concerns. The 10/2023 "Resident Council Minutes" listed new business concerns which included inconsistent portion sizes, meal ticket issues, and poorly stocked kitchenettes. The minutes listed actions taken were the facility restocked the kitchenette and provided staff education on portion size. No outcomes were indicated for the repeat concerns. The 11/2023 "Resident Council Minutes" listed new business concerns which included cold food and meal ticket issues again. Further new business concerns included nursing staff were	F 565			

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F 565	Continued From page 7 not asking the residents what they wanted at meals. The minutes lacked actions taken or outcomes for the repeat concerns. On 11/15/22 at 11:43AM the Resident Council reported the facility continually struggled to ensure meal tickets were followed. The council reported the facility provided staff education, but the meal tickets were still not matching what was ordered or requested. The council reported staff were not verifying the meals choices with all the residents before meal service and the menu boards were not updated daily. The council reported concerns with only one hallway's meal preferences being checked but the other hallway being ignored. The council reported concerns with the timing of meals and portion sizes being inconsistent. On 11/16/23 at 08:05AM R26 sat in her room and stated she was waiting on breakfast to arrive. At 08:10AM Certified Nurse's Aide (CNA) N entered the room with R26's meal tray. CNA N brought R26's plate to her bedside table and stated it was biscuits and gravy. R26 immediately refused the plate. An inspection of the plate revealed the gravy had pepper sausage. CNA N stated all the resident received the same meals for breakfast. An inspection of the meal ticket revealed the sausage gravy was scratched out. CNA N confirmed the sausage-based gravy was on the plate. R26 stated staff did not asked her about her meals choices before serving her biscuits and gravy. On 11/16/23 at 01:12PM Dietary Staff BB stated the facility was still improving at ticket verification and the staff should be asking the residents their food choices before each meal service and			F 565			

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F 565	Continued From page 8 review the tickets for accuracy of the food served. He stated the daily menu were posted in both dining areas daily for the residents to review. On 11/16/23 at 02:26PM Activities Staff Z stated she helped the council arrange meeting each month and reported concerns to the responsible department. She stated each concern should have a prompt response from staff and be resolved as quickly as possible. A review of the facility's "Resident Rights" policy revised 01/2023 indicated the facility will make prompt efforts to address grievances or reported concerns by the residents. The policy indicated the residents have the rights to receive care and services based upon the needs and preferences of the residents. The facility failed to adequately address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial wellbeing and impaired quality of life.	F 565			
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585			

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F 585	Continued From page 9 §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 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	F 585			

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F 585	Continued From page 10 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 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	F 585			

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F 585	Continued From page 11 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included 17 residents with two reviewed for grievances. Based on observation, record review, and interviews, the facility failed to adequately resolve Resident (R)26's grievances related to her ongoing dietary concerns. This deficient practice placed R26 at risk for decreased psychosocial wellbeing. Findings Included: - The "Medical Diagnosis" section within R26s Electronic Medical Records (EMR) included diagnoses of quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), major depressive disorder (major mood disorder), muscle weakness, abnormal posture, and multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord). R26's "Quarterly Minimum Data Set (MDS)" dated 08/22/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted she required set-up assistance from meals. The MDS noted no weight loss or swallowing disorders. R26's "Nutritional Care Area Assessment (CAA)" completed 01/26/23 indicated she was at risk for weight loss due to her medical diagnoses. The CAA indicated she required staff assistance with most of her activities of daily living (ADLs) including meal set-up. The CAA encouraged staff to provide assistance with meals when needed.	F 585			

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F 585	Continued From page 12 R26's "Care Plan" initiated 01/20/21 noted she was at risk for an alteration in nutrition related to her medical diagnoses. The plan instructed staff to encourage and reinforce the importance of maintaining her ordered diet. The plan indicated she was able to feed herself. The plan indicated she was on a regular diet but directed "no pork" (01/20/21). R26's "Physician's Orders" revealed a dietary order dated 02/02/21 R26 was served a regular textured diet with thin liquids. The order specified "no pork." A review of the facility's "Grievance Logs" indicated R26 had one grievance filed 07/06/23 related to her dietary concerns. The grievance log indicated Dietary Staff BB had resolved the grievance. The facility was unable to provide the grievance form related to the grievance for 07/06/23. On 11/15/23 at 11:05AM R26 stated she had complained to the facility and staff multiple times related to the facility serving her pork during mealtimes. She stated she voiced grievances month prior, but they continue to serve her pork. On 11/16/23 at 08:05AM R26 sat in her room and stated she was waiting on breakfast to arrive. At 08:10AM Certified Nurse's Aide (CNA) N entered the room with R26's meal tray. CNA N brought R26's plate to her bedside table and stated it was biscuits and gravy. R26 immediately refused the plate. An inspection of the plate revealed the gravy had pepper sausage. CNA N stated all the resident received the same meals for breakfast. An inspection of the meal ticket revealed the	F 585			

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F 585	Continued From page 13 sausage gravy was scratched out. CNA N confirmed the sausage-based gravy was on the plate. On 11/16/23 at 10:30AM R26's representative stated the facility was not checking the dietary tickets before serving the meals. He stated he also complained to the facility about her dietary preferences on multiple occasions, but the occurrences didn't stop after complaining. On 11/16/23 at 01:45PM Social Service X stated all grievance were turned over to the designated department head for review. She stated the facility would ensure the grievances were resolved in a timely manner and the issues would not return. On 11/16/23 at 12:13PM Dietary staff BB stated each resident's diet and preferences were recorded in a binder kept in the kitchen. He stated staff reeducation had been provided to ensure each resident was provide the correct diet. He stated staff should be verifying with the cook in the kitchenette before serving meals to the residents. He stated the dietician and himself meet with the quality assurance to address concerns or other dietary needs the occur. He stated staff was to verify R26's meals before serving her. A review of the facility's "Grievance" policy revised 01/2023 indicated any resident or family member had the right to voice a grievance with the facility. The policy indicated grievances may be filed in writing, verbally, or anonymously. The policy indicated the grievance will be documented and addressed by the appropriate department. The policy indicated the facility will take prompt	F 585			

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F 585	Continued From page 14 efforts to resolve he grievances and the record will be maintained for a period of no less than three years. The facility failed to adequately resolve R26's grievances related to her ongoing dietary concerns. This deficient practice placed R26 at risk for decreased psychosocial wellbeing.	F 585			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included 17 residents with five residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interviews, the facility failed to provide consistent bathing opportunities for Resident (R)26, R4, and R15. This deficient practice placed both residents at risk for infections, skin breakdown, and impaired dignity. Findings Included: - The "Medical Diagnosis" section within R26's Electronic Medical Records (EMR) included diagnoses of quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord)., major depressive disorder (major mood disorder), muscle weakness, abnormal posture, and multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord).	F 677			

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F 677	Continued From page 15 R26's "Quarterly Minimum Data Set (MDS)" dated 08/22/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated she was dependent on staff for bed mobility, transfers, bathing, personal hygiene, toileting, and dressing. R26's "Activities of Daily Livings (ADLs) Care Area Assessment (CAA)" completed 01/26/23 indicated she required staff assistance with most of her Activities of Daily Living (ADLs) including meal set-up. The CAA noted she was at risk for ADL decline. R26's "Care Plan" initiated 01/20/21 noted she was dependent on staff for toileting, personal hygiene, and bathing. The plan noted she preferred female staff for bathing and personal cares. The plan indicated she was schedule for bathing twice weekly and as needed. R26's "Documentation Survey Report" from 09/01/23 through 11/16/23 (76 days reviewed) indicated she received bathing on eight occasions (9/2, 9/9, 9/12, 9/23, 10/3, 10/10, 11/4, 11/13). The report indicated she refused bathing on two occasions (9/26 and 10/14). On 11/14/23 at 03:30PM R26 sat in her wheelchair in the activities room. She stated she has had issues with the facility not consistently giving her baths. She reported she had one the previous evening but was supposed to have two baths a week. On 11/16/23 at 10:30AM R26's representative indicated recently the facility had consistently failed to provide the resident with bathing. He	F 677			

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F 677	Continued From page 16 stated there were weeks when R26 would only have one bath and he would have to remind the facility. He stated he comes in to help R26 out with her personal hygiene and bathing whenever it did not get completed by the facility. On 11/16/23 at 01:23PM Certified Nurse's Aide (CNA) N stated R26 received shower and bed baths depending on what she preferred at the time. She stated R26 required two staff for transfer and her shower chair. CNA N stated direct care staff would follow the bathing scheduled in the EMR and documented the type of bathing given or if refused. CNA N stated the nurse would be notified if refusals occurred. On 11/16/23 at 02:30PM Administrative Nurse D reported staff were to follow the bathing schedule for each resident. She stated staff were expected to document refusals in the EMR and notify nursing of missed occurrences or documentation. She stated the nurse was expected report frequent occurrences for review. The facility's "Activities of Daily Living" (ADLs) policy dated 01/01/23 documented the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Refusal of care and treatment by the resident or his/her representative to maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative. The facility would develop a comprehensive care plan to assist the resident in achieving and maintaining the highest practicable outcome	F 677			

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F 677	Continued From page 17 based on the comprehensive assessment. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility would identify resident triggers through the Care Area Assessment (CAA) process to assess causal factors for decline, potential decline, or lack of improvement. The facility failed to provide consistent bathing opportunities for R26. This deficient practice placed the resident at risk for infections, skin breakdown and impaired dignity. - R4's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Annual Minimum Data Set" (MDS) dated 11/02/232 documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented that R4 required partial/moderate assistance with shower/bathe herself for the observation period. The "Quarterly MDS" dated 08/05/23 lacked an assessment of R4's BIMS. The MDS documented that R4 required partial/moderate assistance with shower/bathe herself for the observation period. R4's "Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 11/04/22 documented R4 required assistance with her ADLs.	F 677			

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F 677	Continued From page 18 R4's "Care Plan" revised 09/30/23 documented she was able to perform showering/bathing with partial/moderate assistance. Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed for the following dates for R4 from 08/01/23 to 11/12/23 (104 days) documented one "Shower" (SH) on 10/02/23, one "Resident Refused" (RR) 08/28/23, and "Not Applicable" (NA) was documented 24 days on the following dates 08/03/23, 08/07/23, 08/10/23, 08/14/23, 08/17/23, 8/21/23, 08/31/23, 09/04/23, 09/07/23, 09/18/23, 09/21/23, 09/25/23, 09/28/23, 10/05/23, 10/09/23, 10/12/23, 10/16/23, 10/19/23, 10/23/23, 10/26/23, 10/30/23, 11/02/23, 11/06/23, and 11/09/23. R4's clinical record revealed one refusal documented. Observation on 11/13/23 at 01:04 PM R4 sat in her room in a wheelchair. Her hair was combed back and appeared oily and stringy. On 11/16/23 at 08:14 AM Certified Medication Aide (CMA) R stated the shower/bath list shows on the Kardex (nursing tool that gives a brief overview of the care needs of each resident). CMA R stated the nursing staff would approach the resident several times during the day and offer a bath. CMA R stated if the resident continued to refuse, the staff would report the refusal to the nurse and document the refusal in the resident's clinical record under the bathing task. On 11/16/23 at 02:05 PM Certified Nurse Aide (CNA) N stated R4 refused most everything. CNA N stated the staff would offer alternative bathing for any resident that refused a bath.	F 677			

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F 677	Continued From page 19 On 11/16/23 at 02:54 PM Administrative Nurse D stated the shower/bath list was found on the Kardex. Administrative Nurse D stated if the resident was to refuse their bath the CNAs would report the refusal to the nurse and the nurse would talk with the resident and document the reason in EMR under the nurse's notes. The facility's "Activities of Daily Living" (ADLs) policy dated 01/01/23 documented the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Refusal of care and treatment by the resident or his/her representative to maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative. The facility would develop a comprehensive care plan to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility would identify resident triggers through the Care Area Assessment (CAA) process to assess causal factors for decline, potential decline, or lack of improvement. The facility failed to provide consistent bathing for R4. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. - R15's Electronic Medical Record (EMR) from			F 677			

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F 677	Continued From page 20 the "Diagnoses" tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), and neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The "Significant Change Minimum Data Set" (MDS) dated 10/20/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R15 required substantial/maximal assistance for shower/bathe self and transfer during bathing activities. R15's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 10/24/23 documented she was at risk for alterations in her cognition, but she was able to make her needs known. R15's "Care Plan" revised 10/02/23 documented R15 was able to perform showering/bathing task with staff supervision. Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed for the dates R15 was in the facility, from 08/01/23 to 08/30/23 (30 days was discharged to hospital), documented "Sponge Bath" (SB) was provided one day on 08/04/23, "Shower" (SH) was provided three days on 08/08/23, 08/11/23, and 08/29/23, "Resident Refused" (RR) one day on 08/15/23 and "Not Applicable" (NA) was documented 12 days on 08/05/23, 08/09/23, 08/12/23, 08/13/23, 08/17/23, 8/18/23, 08/19/23, 08/22/23, 08/23/23, 08/24/23, 08/26/23, and	F 677			

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F 677	Continued From page 21 08/27/23. Reviewed from 09/02/23 to 09/23/23 (22 days was discharged to the hospital) documented a SH was provided one day on 09/05/23, SB bath was provided one day on 09/23/23 and NA was documented 11 days on 09/03/23, 09/04/23, 09/08/23, 09/10/23, 09/12/23, 09/13/23, 09/15/23, 09/16/23, 09/19/23, 09/21/23, and 09/22/23. Reviewed from 09/26/23 to 09/28/23 (3 days was discharged to the hospital) documented one SB on 09/27/23. Reviewed from 10/03/23 to 11/13/23 (42 days) documented "Full Body Bath" (FB) two days on 10/06/23, and 10/13/23, SB three days on 10/10/23, 10/13/23, and 10/17/23 and NA was documented 12 days on 10/3/23, 10/5/23, 10/09/23, 10/13/23, 10/16/23, 10/20/23, 10/31/23, 11/03/23, 11/05/23, 11/07/23, 11/10/23, and 11/13/23. R15's clinical record revealed one refusal documented. Observation on 11/13/23 at 10:47 AM R15 sat in her wheelchair next to the bed in her room. R15 stated she was not sure what days were her scheduled bath days. R15 stated she was not always offered a shower/bath on a consistent basis. R15 stated she felt dirty at times when she did not get her bath. On 11/16/23 at 08:14 AM Certified Medication Aide (CMA) R stated the shower/bath list shows on the Kardex (nursing tool that gives a brief overview of the care needs of each resident). CMA R stated the nursing staff would approach the resident several times during the day and offer a bath. CMA R stated if the resident continued to refuse, the staff would report the refusal to the nurse and document the refusal in the resident's clinical record under the bathing task.	F 677			

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F 677	Continued From page 22 On 11/16/23 at 02:05 PM Certified Nurse Aide (CNA) N stated R15 refused most everything. CNA N stated the staff would offer alternative bathing for any resident that refused a bath. On 11/16/23 at 02:54 PM Administrative Nurse D stated the shower/bath list was found on the Kardex. Administrative Nurse D stated if the resident was to refuse their bath the CNAs would report the refusal to the nurse and the nurse would talk with the resident and document the reason in EMR under the nurse's notes. The facility's "Activities of Daily Living" (ADLs) policy dated 01/01/23 documented the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Refusal of care and treatment by the resident or his/her representative to maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative. The facility would develop a comprehensive care plan to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility would identify resident triggers through the Care Area Assessment (CAA) process to assess causal factors for decline, potential decline, or lack of improvement. The facility failed to provide consistent bathing for	F 677			

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F 677	Continued From page 23	F 677			
F 689 SS=E	R15. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. 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 63 residents. The sample included 17 residents with five residents reviewed for accidents and/or hazards. Based on observation, record review, and interview, the facility failed to secure rooms containing hazardous materials out of reach of 17 cognitively impaired /independently mobile residents. This deficient practice placed the affected residents at risk for preventable injuries and accidents. Findings included: - On 11/13/23 at 07:08AM a walkthrough of the facility revealed two Spa rooms with doors propped open. Both rooms contained boxes of COVID-19 (highly contagious respiratory virus) testing kits in an unsecured closet. Both rooms had opened germicidal cylindrical containers of wipes stored on counter with the "Keep out of reach from children" warning. Certified Nurse's Aide (CNA) N secured the room. She reported the rooms should not be left open and unattended.	F 689			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/16/2023	
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF LEAWOOD - IRON HORSE HLTH				STREET ADDRESS, CITY, STATE, ZIP CODE 5401 W 143RD STREET LEAWOOD, KS 66224			
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F 689	Continued From page 24 On 11/16/23 at Licensed Nurse H stated cleaning solutions and hazardous chemicals should be locked in the cabinets when not in use or closely monitored. On 11/16/23 at 02:23PM Administrative Nurse D reported chemical solutions should not be stored in an area residents could access. She stated the doors were usually left propped open in the morning, but the COVID-19 test kits and cleaning solutions should be secured in a locked cabinet. A review of the facility's "Accidents and Supervision" 01/2023 indicated that the resident environment will remain of accident hazards (elements of the resident environment that have the potential to cause injury or illness). The policy noted that the facility will make reasonable efforts to identify the hazards and risks in the environment. The facility failed to secure chemicals in a safe, locked area, and out of reach of the 17 cognitively impaired independently mobile residents. This placed the affected residents at risk for accidents.			F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary			F 690			

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F 690	Continued From page 25 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included 17 residents. Based on observation, record review, and interviews, the facility failed to ensure the standard of care was provided during catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care and failed to prevent the catheter drainage bag from touching the floor for Resident (R)15 who had a history of frequent urinary tract infection (UTI-an infection in any part of the urinary system). This deficient practice placed R15 at risk	F 690			

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F 690	Continued From page 26 of catheter related complications and further UTIs. Findings included: - R15's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), and neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The "Significant Change Minimum Data Set" (MDS) dated 10/20/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R15 had an indwelling catheter during the observation period. The MDS documented R15 required substantial/maximal assistance with toileting hygiene during observation period. R15's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 10/24/23 documented she had a Foley catheter. R15's "Care Plan" dated 10/03/23 documented staff would provide catheter care every shift and as needed. Review of the EMR under "Orders" tab revealed physician orders: Nitrofurantoin microcrystal oral capsule (antibiotic) 100 milligrams (mg) give 100 mg by mouth two times a day for UTI for 5 Days dated	F 690			

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F 690	Continued From page 27 06/19/23. Ciprofloxacin HCL tablet (antibiotic) 500mg give one tablet by mouth every 12 hours for UTI for seven days dated 07/27/23. Levaquin oral tablet (antibiotic) 750mg give one tablet by mouth daily for UTI for seven days dated 08/28/23. Bactrim DS tablet (antibiotic) 800-160mg give one tablet by mouth every 12 hours for UTI for 10 Days dated 09/02/23. Linezolid Tablet (antibiotic) 600mg give one tablet by mouth every 12 hours for UTI for 8 days dated 09/26/23. Bactrim DS oral tablet (antibiotic) 800-160mg give one tablet by mouth every 12 hours for UTI for seven days dated 11/04/23. Observation on 11/14/23 at 04:10 PM R15 laid on her bed. Her catheter bag, which contained dark amber urine, laid directly on the floor. R15 stated her legs hurt, but the staff gave her something for the pain. Observation on 11/16/23 at 01:27 PM R15 laid on her bed. Certified Nurse Aide (CNA) M asked R15 if she could provide catheter care. CNA M gathered the supplies to provide catheter care, then placed items on a clean barrier on the bedside table. CNA M washed her hands, donned gloves, unfastened R15's incontinence brief, doffed gloves, then donned a clean pair of gloves without performing hand hygiene. CNA M provided catheter care then doffed gloves and donned a new pair of gloves without performing			F 690			

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F 690	Continued From page 28 hand hygiene and replaced the incontinent brief. CNA M doffed gloves washed her hands and donned new gloves. CNA M applied cream to R15 buttocks with her right hand. CNA M doffed her glove from her right hand and, without performing hand hygiene, donned a new glove on her right hand. CNA M assisted the resident with repositioning her clothes. On 11/16/23 at 01:40 PM Certified Nurse Aide (CNA) M stated she should complete hand hygiene after two glove changes. On 11/16/23 at 02:30 PM Administrative Nurse E, the facility Infection Preventionist, stated she expected staff to perform hand hygiene between glove changes and catheter bags should never be placed on the floor. Administrative Nurse E stated R15 had a history of frequent UTIs. On 11/16/23 at 02:54 PM Administrative Nurse D stated catheter bags should never be placed on the floor and hand hygiene should be performed between glove changes. The facility's "Catheter Care" policy dated 01/01/23 documented it was the policy of this facility to ensure that residents with indwelling catheters received appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. The facility failed to ensure the standard of care was provided during catheter care and failed to prevent the catheter drainage bag from touching the floor for R15 who had a history of frequent UTIs. This deficient practice placed R15 at risk of catheter related complications and further UTIs.			F 690			

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F 692 F 692 SS=D	Continued From page 29 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 63 residents. The sample included 17 residents with five residents sampled for nutrition. Based on observations, record review, and interviews, the facility failed to ensure ordered dietary supplements, to promote increased calorie intake, were monitored for effectiveness and failed to ensure weekly weights were obtained as ordered for Resident (R) 59. This deficient practice placed R59 at risk for continued weight loss and possible malnutrition. Findings included:	F 692 F 692			

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F 692	Continued From page 30 - R59's Electronic Medical Record (EMR) documented diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left side, generalized muscle weakness, other lack of coordination, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The "Admission Minimum Data Set" (MDS) dated 10/27/23 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R59 required partial/moderate assistance with less than half the effort required by staff for eating. The MDS further documented R59 had functional limitation in range of motion of the upper extremity with impairment on one side. R59's "Nutritional Status Care Area Assessment" (CAA) dated 10/27/23, documented R59 was at risk for alterations in nutritional status related to his diagnosis of hemiparesis and hemiplegia following the stroke and required assistance with eating. The CAA further documented R59 had supplements ordered and weights were monitored as ordered. R59's "Care Plan" with an initiated date of 10/23/23, documented R59 was at risk for alteration in nutritional status related to hemiparesis and hemiplegia following a stroke. An intervention with an initiated date of 10/23/23	F 692			

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F 692	Continued From page 31 directed staff to monitor and report to R59's physician as needed for signs of unexpected weight loss. An intervention with an initiated date of 11/13/23 directed staff to administer nutritional supplements as ordered. A "Physician's Order" with a start date of 11/04/23, documented an order for carnation instant breakfast, eight ounces, three times a day for supplement with medication pass. Review of R59's EMR included documentation which indicated if staff had administered R59's carnation instant breakfast supplement or not; however, R59's EMR lacked evidence that the facility monitored the actual intake of the dietary supplements for R59. A "Physician's Order" with a start date of 10/24/23, directed staff to obtain weekly weights every seven days on day shift. R59's EMR documented a weight of 195.0 pounds on 10/23/23 the day he was admitted to the facility and a second weight was documented on 11/13/23 for 188.6 with a loss of 3.28%. R59's EMR lacked evidence that weekly weights were obtained for the following weeks (2): 10/29/23 - 11/04/23 and 11/05/23 - 11/11/23. On 11/14/23 at 03:51 PM an observation reveled R59 rested in bed in his room. On 11/16/23 at 02:16 PM Certified Nurse Aide (CNA) P stated the nurses documented in a book at the nurses' station or would verbally tell the CNA what residents needed to be weighed for that day. CNA P stated there was no other way for the CNAs to know what resident needed to have	F 692			

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F 692	Continued From page 32 their weight obtained during their shift if the nurse did not document it in the book to tell them verbally. CNA P stated there was nothing in the CNA charting that would have alerted them to weigh a resident otherwise. On 11/16/23 at 02:17 PM Licensed Nurse (LN) H stated the nurses documented in a book at the nurses' station the names of the residents that required a weight that shift. LN H stated if it was not recorded in the book that the nurses would verbally notify the CNAs to obtain the required weights. LN H stated if the nurse noticed there was any weight loss, the weight would be re-checked and if the new weight confirmed the loss that the nurse would follow up with the dietitian. On 11/16/23 at 02:52 PM Administrative Nurse D stated resident weights were being done sporadically and the facility changed the process and had a designated CNA that came in every Tuesday to ensure weights had been done consistently. Administrative Nurse D stated nurses gave CNAs a list of the residents the required a weight in the mornings and there was no list/task in the CNAs charting for them to know who needed a weight. Administrative Nurse D further stated the dietitian would notify staff if there were any missing or offset weights documented in a resident's EMR. The facility provided "Weight Monitoring" policy dated 01/01/23, documented a comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status. The policy further documented interventions will be identified, implemented,	F 692			

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F 692	Continued From page 33 monitored ad modified consistent with the resident's assessed needs, choices, preferences, goals, and current professional standard to maintain acceptable parameters of nutritional status. The policy further documented weight monitoring schedule will be developed upon admission for all residents and newly admitted residents' weight would be monitored weekly for four weeks. The facility failed to ensure ordered dietary supplements, to promote increased calorie intake, was monitored for effectiveness and weekly weights were obtained as ordered for R59. This deficient practice placed R59 at risk for continued weight loss and possible malnutrition.	F 692			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756			

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F 756	Continued From page 34 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and 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 identified a census of 63 residents. The sample included 17 residents with five residents sampled for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported that Resident (R) 18's pulse was not being monitored as physician ordered prior to administration of carvedilol (beta blocker-medication used to treat high blood pressure and heart failure). This placed R18 at risk of unnecessary medication administration and possible adverse side effects. Findings included: - The electronic medical record (EMR) for R18 documented diagnosis of hypertension (HTN - elevated blood pressure), coronary artery disease	F 756			

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F 756	Continued From page 35 (CAD- abnormal condition that may affect the flow of oxygen to the heart), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The "Admission Minimum Data Set (MDS)" dated 01/25/23 documented a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognition. R18 was independent for cares but required partial to moderate assistance of staff for toileting. R18 utilized a walker to assist with ambulation. R18 required supplemental oxygen. The "Quarterly MDS" dated 09/26/23 for R18 documented a BIMS score of 13 which indicated intact cognition. R18 required supervision to partial assistance from staff for functional abilities. R18 used a manual wheelchair for mobility assistance. R18 required the use of supplemental oxygen. The "Cognition Care Area Assessment (CAA)" dated 01/31/23 documented R18 had impaired cognition related to respiratory failure (low level of oxygen in the blood), COPD, HTN, and pneumonia (inflammation of the lungs). R18 was able to make his needs known. The "Hypertension Care Plan" revised on 01/22/23 for R18 directed staff to administer carvedilol as ordered. The "Order Summary" for R18 documented an order dated 01/19/23 for carvedilol 25 milligrams (mg) by mouth two times daily for HTN. Hold and	F 756			

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F 756	Continued From page 36 notify provider if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was below 110 and/or heart rate was below 60. Review of the CP's monthly "Medication Regimen Review (MRR)" of R18's medications from January 2023 to October 2023 revealed that the CP did not identify and report that R18's pulse was not being monitored prior to administration of carvedilol. Upon review of R18's "Medication Administration Record" (MAR) from admission on 01/19/23 to present revealed that R18's pulse was not being monitored and documented prior to administration of the carvedilol. (26 opportunities in January 2023; 56 opportunities in February 2023; 62 opportunities in March 2023; 60 opportunities in April 2023; 62 opportunities in May 2023; 60 opportunities in June 2023; 62 opportunities in July 2023; 62 opportunities in August 2023; 60 opportunities in September 2023; 62 opportunities in October 2023; and 28 opportunities in November 2023). On 11/13/23 at 09:26 AM R18 sat in his wheelchair in his room with a nasal cannula (medical device to provide supplemental oxygen therapy to people who have lower oxygen levels) on. On 11/16/23 at 02:50 PM Administrative Nurse D stated that if there were hold parameters for the blood pressure and/or pulse then she would expect them to be monitored prior to administration of the medication. Administrative Nurse D stated the CP reviewed the medical charts monthly and made recommendations for	F 756			

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F 756	Continued From page 37 irregularities found. On 11/20/23 at 09:54 Consultant GG stated that typically recommendations would be reported if a resident's pulse was not being monitored prior to administration of a beta blocker but would also depend on if the resident has had a history of bradycardia (low heart rate, less than 60 beats per minute) and would need to be closely monitored. The facility policy "Medication Regimen Review" last revised 01/01/23 documented: the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities. The pharmacist shall communicate any irregularities to the facility. The facility failed to ensure the CP identified and reported that facility staff was not monitoring R18's pulse prior to the administration of carvedilol as physician ordered. This placed R18 at risk for unnecessary medication administration and possible adverse side effects.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757			

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F 757	Continued From page 38 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included 17 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure dosing instructions for Voltaren (topical pain reliever medication) gel for Resident (R) 15. The facility also failed to follow physician ordered parameters for R18's antihypertensive beta-blocker (class of medication used to treat high blood pressure). This deficient practice had the risk for unnecessary medication use and physical complications for the affected residents. Findings included: - R15's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), and neuromuscular			F 757			

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F 757	Continued From page 39 dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The "Significant Change Minimum Data Set" (MDS) dated 10/20/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R15 had received scheduled and as needed pain medication during the observation period. The MDS documented R15 had not received non-medication interventions. The MDS documented a pain assessment interview should be conducted and documented pain was not present at the time of the interview but lacked documentation of the frequency of the pain or of the pain effected R15's sleep. R15's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 10/24/23 documented she was at risk for alterations in her cognition, but she was able to make her needs known. R15's "Care Plan" dated 06/17/23 documented staff would administer medications as ordered and would monitor/document for any side effects and effectiveness. Review of the EMR under "Orders" tab revealed physician orders: Voltaren external gel (anti-inflammatory class of medication used to reduce inflammation) one percent (%) (diclofenac sodium) (topical), apply to knee topically every morning and at bedtime for pain dated 10/19/23. The order lacked a dose. Observation on 11/14/23 at 04:10 PM R15 laid on her bed. Her catheter (a flexible tube inserted through a narrow opening into a body cavity,			F 757			

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F 757	Continued From page 40 particularly the bladder, for removing fluid) bag which contained dark amber urine laid directly on the floor. R15 stated her legs hurt, but the staff had given her something for the pain. On 11/16/23 at 01:25 PM Licensed Nurse (LN) G stated she was unable to locate R15's Voltaren topical medication. LN G stated she had just reordered the medication that morning. LN G stated she would call the physician and clarify the dosage for R15's Voltaren medication. On 11/26/23 at 02:54 PM Administrative Nurse D stated she expected the nurse administering the topical medication to clarify the dose that the physician wanted applied. The facility's "Unnecessary Drugs-Without Adequate Indication for Use" policy dated 01/01/23 documented it was the facility's policy that each resident's drug regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being free from unnecessary drugs. "Dose" was the total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the daily dose. The facility failed to ensure dosing instructions for Voltaren gel for R15. This deficient practice placed R15 at risk for unnecessary medication use, side effects and physical complications. - The electronic medical record (EMR) for R18 documented diagnosis of hypertension (HTN -	F 757			

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F 757	Continued From page 41 elevated blood pressure), coronary artery disease (CAD- abnormal condition that may affect the flow of oxygen to the heart), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The "Admission Minimum Data Set (MDS)" dated 01/25/23 documented a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognition. R18 was independent for cares but required partial to moderate assistance of staff for toileting. R18 utilized a walker to assist with ambulation. R18 required supplemental oxygen. The "Quarterly MDS" dated 09/26/23 for R18 documented a BIMS score of 13 which indicated intact cognition. R18 required supervision to partial assistance from staff for functional abilities. R18 used a manual wheelchair for mobility assistance. R18 required the use of supplemental oxygen. The "Cognition Care Area Assessment (CAA)" dated 01/31/23 documented R18 had impaired cognition related to respiratory failure (low level of oxygen in the blood), COPD, HTN and pneumonia (inflammation of the lungs). R18 was able to make his needs known. The "Hypertension Care Plan" revised on 01/22/23 for R18 directed staff to administer carvedilol (beta-blocker) as ordered. The "Order Summary" for R18 documented an order dated 01/19/23 for carvedilol 25 milligrams (mg) by mouth two times daily for HTN. Hold and			F 757			

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F 757	Continued From page 42 notify provider if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was below 110 and/or heart rate was below 60. Upon review of R18's "Medication Administration Record" (MAR) from admission on 01/19/23 to present revealed that R18's pulse was not being monitored and documented prior to administration of the carvedilol. (26 opportunities in January 2023; 56 opportunities in February 2023; 62 opportunities in March 2023; 60 opportunities in April 2023; 62 opportunities in May 2023; 60 opportunities in June 2023; 62 opportunities in July 2023; 62 opportunities in August 2023; 60 opportunities in September 2023; 62 opportunities in October 2023; and 28 opportunities in November 2023). On 11/13/23 at 09:26 AM R18 sat in his wheelchair in his room with a nasal cannula (medical device to provide supplemental oxygen therapy to people who have lower oxygen levels) on. On 11/16/23 at 01:21 PM Certified Medication Aide (CMA) R stated for the medication carvedilol the pulse should be monitored. CMA R stated some of the physicians do have parameters for medications for certain residents but not all. CMA R stated she was not aware that R18's pulse was not being monitored prior to administration of the carvedilol. On 11/16/23 at 01:27 PM Licensed Nurse (LN) G stated that R18 did have a hold parameter on his carvedilol and his pulse should have been monitored prior to administration of the medication.	F 757			

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F 757	Continued From page 43 On 11/16/23 at 02:50 PM Administrative Nurse D stated it was up to the physician whether a medication had parameters. Administrative Nurse D stated that if there were hold parameters for the blood pressure and/or pulse then she would expect them to be monitored prior to administration of the medication. The facility policy "Unnecessary Drugs - Without Adequate Indication for Use" dated 01/01/23 documented: The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen. Each resident's drug regimen would be reviewed on an ongoing basis which would include adequate monitoring for efficacy and adverse consequences. The facility failed to ensure staff monitored R 18's pulse prior to the administration of carvedilol as physician ordered. This placed R18 at risk for unnecessary medication administration and possible adverse side effects.	F 757			
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803			

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F 803	Continued From page 44 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included 17 residents with three reviewed for dietary preferences. Based on observation, record review, and interviews, the facility failed to follow Resident (R)26's cultural dietary preferences. This deficient practice placed R26 at risk for decreased psychosocial wellbeing and weight loss. Findings Included: - The "Medical Diagnosis" section within R26s Electronic Medical Records (EMR) included diagnoses of quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), major depressive disorder (major mood disorder), muscle weakness, abnormal posture, and multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord). R26's "Quarterly Minimum Data Set (MDS)" dated			F 803			

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F 803	Continued From page 45 08/22/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted she required set-up assistance from meals. The MDS noted no weight loss or swallowing disorders. R26's "Nutritional Care Area Assessment (CAA)" completed 01/26/23 indicated she was at risk for weight loss due to her medical diagnoses. The CAA indicated she required staff assistance with most of her activities of daily living (ADLs) including meal set-up. The CAA encouraged staff to provide assistance with meals when needed. R26's "Care Plan" initiated 01/20/21 noted she was at risk for an alteration in nutrition related to her medical diagnoses. The plan instructed staff to encourage and reinforce the importance of maintaining her ordered diet. The plan indicated she was able to feed herself. The plan indicated she was on a regular diet but directed "no pork" (01/20/21). R26's "Physician's Orders" revealed a dietary order dated 02/02/21 R26 was served a regular textured diet with thin liquids. The order specified "no pork." On 11/15/23 at 11:05AM R26 stated the facility continually served her pork products even though she preferred not to eat pork products. On 11/16/23 at 08:05AM R26 sat in her room and stated she was waiting on breakfast to arrive. At 08:10AM Certified Nurse's Aide (CNA) N entered the room with R26's meal tray. CNA N brought R26's plate to her bedside table and stated it was biscuits and gravy. R26 immediately refused the plate. An inspection of the plate revealed the			F 803			

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F 803	Continued From page 46 gravy had pepper sausage. CNA N stated all the resident received the same meals for breakfast. An inspection of the meal ticket revealed the sausage gravy was scratched out. CNA N confirmed the sausage-based gravy was on the plate. On 11/16/23 at 12:13PM Dietary staff BB stated each resident's diet and preferences were recorded in a binder kept in the kitchen. He stated staff were to review each dietary ticket for accuracy. He stated the food was delivered to the kitchenette and served to the residents based on the tickets. He stated the gravy served at breakfast was pork based and staff should have checked the ticket before it was served. On 11/16/23 at 02:23 Administrative Nurse D stated direct care staff were responsible for checking each resident's dietary meal ticket during meals service. A review of the facility's "Nutritional Management" policy dated 01/2023 indicated the facility would provide cares and service to ensure each resident's diet was maintained based on their nutritional status, weight, risk factors, and preferences. The policy indicated staff will strictly follow the dietary orders and care planned interventions provided by the interdisciplinary team. The facility failed to follow R26's cultural dietary preferences related to pork products at meal services. This deficient practice placed R26 at risk for decreased psychosocial wellbeing and weight loss.	F 803			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812			

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F 812	Continued From page 47 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The facility had one main kitchen and two kitchenette serving areas. Based on observation, record review and interview, the facility failed to ensure that dietary staff appropriately dated, labeled, and stored opened foods. This deficient practice had the potential for food borne illnesses for residents. Findings included: - On 11/13/23 at 07:37 AM during the initial tour of the facility's main kitchen observation revealed an opened box of cream of wheat in the dry storage area with a piece of plastic wrap over the top of the box; it was not in a sealed			F 812			

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F 812	Continued From page 48 bag/container. There was a bag of spaghetti that was wrapped in plastic wrap that did not have a date on it. On 11/13/23 at 07:40 AM observation of the walk-in refrigerator revealed an open gallon plastic container of hard-boiled eggs. The lid was not closed to the container and there was no label that indicated the open date. There was an opened bag of diced potatoes that was not labeled and/or dated and was not stored in a sealed bag. There was an opened bag of pepperoni in a box that had not been placed in a sealed bag and did not have an open date on it. On 11/13/23 at 07:50 AM Dietary Staff BB stated he did his best to keep everything labeled and dated and in sealed containers, but he was just one person and was not always able to make sure everything was labeled and dated as they should be. On 11/14/23 at 10:30 AM Dietary Staff CC stated she had been working with dietary staff to ensure that they dated and labeled and stored opened items in a sealed container. Dietary Staff CC stated she had been educating staff on the proper storage of foods. The facility policy "Food Safety Requirements" revised 01/01/23 documented: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will be stored, prepared, distributed, and served in accordance with professional standards for food service safety. Storage of food in a manner that prevents deterioration or contamination of the food, including growth of microorganisms (a living thing	F 812			

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F 812	Continued From page 49 that cannot be seen with the naked eye). Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage. Dry food storage - keep foods/beverages in a clean, dry area off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it was used by its use-by date, or frozen/discarded; and keeping foods covered or in a tight container.	F 812			
F 880 SS=E	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, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880			

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F 880	Continued From page 50 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 corrective actions taken by the facility. §483.80(e) Linens.	F 880			

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F 880	Continued From page 51 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 identified a census of 63 residents. Based on observations, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care, disinfecting shared equipment, and storage of oxygen tubing when not in use. This deficient practice placed the residents at risk for complications related to infectious diseases. Findings included: - On 11/13/23 at 09:26 AM Resident (R) 18 sat in his wheelchair in his room with a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) on. In R18's bathroom, there was an oxygen concentrator (a device that provides supplemental oxygen) and the nasal cannula was lying on the floor. R18's continuous positive airway pressure (CPAP - a machine that used mild air pressure to keep breathing airways open while you sleep) mask was draped over the bedrail and not stored in a bag. Observation on 11/14/23 at 04:10 PM R15 laid on her bed. Her catheter bag laid directly on the floor. R15 stated her legs hurt, but the staff gave her something for the pain.	F 880			

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F 880	Continued From page 52 Observation on 11/16/23 at 08:21 AM Certified Nurse Aide (CNA) M completed a Hoyer (total body mechanical lift) transfer for R23. CNA M pushed the Hoyer lift from the room and into the hallway without disinfecting the lift. CNA M then left the Hoyer lift in the hallway and entered another room. Observation on 11/16/23 at 01:27 PM R15 laid on her bed. CNA M asked R15 if she could provide catheter care. CNA M gathered the supplies to provide catheter care, then placed items on a clean barrier on the bedside table. CNA M washed her hands, donned gloves, unfastened R15's incontinence brief, doffed gloves, then donned a clean pair of gloves without performing hand hygiene. CNA M provided catheter care then doffed gloves and donned a new pair of gloves without performing hand hygiene and replaced the incontinent brief. CNA M doffed gloves washed her hands and donned new gloves. CNA M applied cream to R15 buttocks with her right hand. CNA M doffed her glove from her right hand and without performing hand hygiene, donned a new glove on her right hand. CNA M assisted the resident with repositioning her clothes. On 11/16/23 at 08:41 AM CNA M stated the mechanical lifts were disinfected on the night shift. On 11/16/23 at 01:14 PM Certified Nurse Aide (CNA) N stated that the nasal cannula and CPAP masks should be stored in a plastic bag when not being used. On 11/16/23 at 01:27 PM Licensed Nurse (LN) G	F 880			

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F 880	Continued From page 53 stated oxygen tubing and the CPAP masks should be stored in a bag when not being used. On 11/16/23 at 02:30 PM Administrative Nurse E, the facility Infection Preventionist, stated she expected staff to perform hand hygiene between glove changes and catheter bags should never be placed on the floor. Administrative Nurse E stated R15 had a history of frequent UTIs. On 11/16/23 at 02:50 PM Administrative Nurse D stated she expected staff to ensure that nasal cannulas and CPAP masks should be stored in a plastic bag when not in use. Administrative Nurse D stated R18 had been educated numerous times about the proper storage of this cannula and mask. Administrative Nurse D stated catheter bags should never be placed on the floor and hand hygiene should be performed between glove changes. The facility's "Cleaning and Disinfection of Resident-Care Equipment" policy dated 01/01/23 documented resident-care equipment could be a source of indirect transmission of pathogens. Reusable resident-care equipment would be cleaned and disinfected in accordance with current Center of Disease Control recommendations in order to break the chain of infection. "Disinfection" refers to thermal or chemical destruction of pathogenic and other types of microorganisms. Staff would follow established infection control principles for cleaning and disinfecting reusable, non- critical equipment. General guidelines include: Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident.	F 880			

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F 880	Continued From page 54 The facility failed to ensure proper infection control standards were followed related to hand hygiene during catheter care, catheter bags resting on the floor, disinfecting of shared equipment, and storage of oxygen tubing when not in use. This deficient practice placed the residents at risk for complications related to infectious diseases.	F 880			