| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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<br><br>The following citations represent the findings of a Health Resurvey.<br><br>The 2567 was sent electronically on 02/21/24 | F 000 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. | F 657 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/21/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 1 | F 657 | | |

The sample included 14 residents with 14 residents reviewed for care plans. Based on observation, record review, and interviews, the facility failed to revise the care plan with the relevant hospice information for Resident (R) 29. The facility also failed to revise R10's care plan with the unsuccessful attempts for nonpharmacological interventions that had been tried prior to the administration of as-needed psychotropic (alters mood or thoughts) medication. This deficient practice placed these residents at risk for impaired care due to uncommunicated care needs.

Findings included:

- R29's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of weakness, need for assistance with personal care, chronic respiratory failure, emphysema (a long-term, progressive disease of the lungs characterized by shortness of breath), muscle weakness, lack of coordination, and difficulty in walking.

The "Admission Minimum Data Set" (MDS) dated 12/22/23 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R29 was dependent on staff assistance for transfers from chair/bed-to-chair transfers. The MDS documented R29 received oxygen during the observation period.

The " Significant Change MDS" was in progress.

R29's "Functional Abilities Care Area Assessment" (CAA) dated 12/30/23 documented she required assistance with her activities of daily

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 2 | F 657 | | |

living.

R29's "Care Plan" dated 01/26/24 documented the facility would consult with the physician and social services to have hospice care for R29. R29's "Care Plan" dated 01/31/24 documented hospice would manage the plan of care to include treatment and medications. The plan of care lacked the name of the hospice provider and a description of the services provided by the hospice.

R29's EMR under the "Orders" tab revealed the following physician order:
Hospice to evaluate and treat as indicated dated 01/24/24.

A review of the communication book provided by hospice lacked a hospice care plan, signed admission paperwork with the physician documentation of a terminal diagnosis for admission to hospice services, services or equipment that would be provided, and medications that were covered by hospice.

Observation on 02/07/24 at 08:33 AM R29 requested a pink disposable pad be placed on the bed. Certified Nurse Aide (CNA) N told R29 she was out of disposable pads and staff would have to notify R29's family to bring more to the facility. CNA N placed a gait belt around R29's waist, and using the gait belt, assisted R29 into a partial standing position, then pivoted R29 onto the bed.

On 02/07/24 at 08:40 AM Certified Nurse Aide (CNA) N stated the staff had access to the plan of care and Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA N stated R29 had just recently been

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 3 | F 657 | | |

admitted to hospice services. CNA N stated she did not know what supplies the hospice provided. CNA N stated she would let the nurse know if R29 needed supplies.

On 02/07/24 at 10:09 AM Licensed Nurse (LN) G stated all staff had access to the care plan and Kardex. LN G stated the Kardex contained the information for R29's hospice services. LN G reviewed the hospice communication book for R29 and confirmed the communication book lacked a hospice care plan, signed admission paperwork with the admitting terminal diagnosis for admission to hospice services, services hospice would provide, and medication covered by hospice.

On 02/07/24 at 12:09 PM Administrative Nurse D stated R29 had been admitted to hospice on a weekend so the facility had overlooked updating the care plan. Administrative Nurse D stated the hospice provider had been contacted and the provider faxed the admission paperwork with the physician's order for hospice admission, along with the care plan which covered the services provided and the list of medication that would be covered by hospice.

The facility's "Care Planning-Interdisciplinary Teams" policy reviewed 01/2017 documented every resident would be assessed using the Minimum Data Set (MDS) according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual to assess each resident's strengths, weaknesses, and care needs.

The facility failed to ensure the relevant hospice information was on R29's care plan This deficient

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 4 | F 657 | | |

practice placed R29 at risk of impaired care due to uncommunciated care needs.

- R10's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and insomnia (inability to sleep).

The "Significant Change Minimum Data Set" (MDS) dated 07/17/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R10 had received antianxiety (class of medications that calm and relax people), anticoagulant (class of medications used to prevent the formation of blood clots), diuretic (medication to promote the formation and excretion of urine), and opioid (a class of medication used to treat pain) for seven days during the observation period.

The "Quarterly MDS" dated 01/17/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R10 had received antianxiety medication, anticoagulant medication, diuretic, and opioid medication during the observation period.

R10's "Psychotropic Drug Care Area Assessment" (CAA) dated 07/20/23 documented R10 received routine antianxiety medication.

R10's "Care Plan" dated 06/08/23 documented staff would administer medications as ordered and monitor for any side effects.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 5 | F 657 | | |

R10's EMR under the "Orders" tab revealed the following physician orders:
Benadryl (allergy medication with hypnotic qualities used to induce sleep) allergy oral tablet 25 milligrams (mg) give two tablets by mouth every 24 hours as needed for insomnia dated 09/06/23.

Clonazepam (antianxiety medication)) oral tablet 0.5mg give one tablet by mouth every four hours as needed and administer at bedtime for insomnia dated 01/29/24.

Clonazepam oral tablet 0.5mg give one tablet by mouth every 4 hours as needed for insomnia for three days a second dose can be repeated in four hours for insomnia if needed dated 01/29/24.

R10's clinical record lacked evidence of documentation of any nonpharmacological attempts or person-centered attempts to manage the symptoms prior to the administration of the as-needed psychotropic medication for R10.

Observation on 02/06/24 at 10:53 AM R10 sat in her wheelchair in the dining room and drank a cup of coffee during the resident council meeting.

On 02/06/24 at 02:01 PM Administrative Nurse E stated behavior monitoring was documented on the "Treatment Administration Record" (TAR). Administrative Nurse E stated the facility did not document any person-specific nonpharmacological attempts to manage symptoms of as-needed psychotropic medication.

On 02/08/24 at 11:19 AM Licensed Nurse (LN) G stated he was not aware of any documentation of nonpharmacological successful or unsuccessful

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 6<br>attempts to manage a resident's symptoms prior to administering as-needed psychotropic medication.<br><br>On 02/08/24 at 12:37 PM Administrative Nurse D stated that nonpharmacological attempts to manage insomnia should be provided prior to administration of as-needed medication. Administrative Nurse D stated she expected staff to document the effects of the medication administered.<br><br>The facility's "Care Planning-Interdisciplinary Teams" policy reviewed 01/2017 documented every resident would be assessed using the Minimum Data Set (MDS) according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual. To assess each resident's strengths, weaknesses, and care needs.<br><br>The facility failed to ensure nonpharmacological attempts of symptom management prior to administering as-needed psychotropic medication was included in the care plan for R10. This deficient practice placed these residents at risk for impaired care due to uncommunicated care needs. | F 657 | | |
| F 661 SS=D | Discharge Summary<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, | F 661 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 661 | Continued From page 7 | F 661 | | |

radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
The facility identified as census of 54 residents. The sample included 14 residents with two residents reviewed for discharge. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 24's discharge summary included medication reconciliation and instructions. This placed R24 at risk for not receiving timely and appropriate care.

Findings included:

- The Electronic Medical Record (EMR) for R24 documented diagnoses of atrial fibrillation (A-fib: a rapid, irregular heartbeat), hypertension (HTN-an elevated blood pressure), syncope (fainting or passing out), and transient ischemic attack (TIA-

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 661 | Continued From page 8 | F 661 | | |

temporary episode of inadequate blood supply to the brain).

The "Admission Minimum Data Set" (MDS) dated 01/23/24 documented R24 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment.

The "Functional Care Area Assessment (CAA)" dated 01/25/24 for R24 documented she was receiving skilled services and was seen by therapy with the goal of returning home. Improvement was anticipated as she worked with therapy. R24 required assistance with her activities of daily living (ADLs).

R24's "Discharge Care Plan" initiated 01/24/24 directed staff to arrange for home health services with a company of R24's choice. Staff was directed to assist as needed with R24's post-discharge follow-up appointments. Staff was directed to provide R24, her family, and/or the responsible party with written discharge instructions upon her discharge from the facility.

R24's EMR documented a "Health Status Note" dated 02/01/24 at 12:40 PM to document that R24 had been discharged home with home health services. R24 was sent home with her medications, her discharge instructions, and personal belongings. R24's medications were called to her pharmacy of choice. R24's transportation was provided by her family.

A review of R24's "Discharge Summary Form" dated 02/02/24 revealed the lack of a medication reconciliation and medication instructions.

On 02/08/24 at 11:19 AM Licensed Nurse (LN) G

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 661 | Continued From page 9 | F 661 | | |

stated the nurse would review medications and provide a copy of the current physician's medication orders to the resident at the time of discharge. LN G stated he was not sure if a copy of the current medication orders was scanned into the EMR with the discharge summary.

On 02/08/24 at 12:37 PM Administrative Nurse D stated social service staff initiated the discharge process for the residents. Administrative Nurse D stated the nursing staff reviewed any future physician appointments, current medication orders, and treatment orders with the resident prior to discharge. Administrative Nurse D stated the medications should be included in the discharge summary.

The "Discharge Summary and Plan" policy revised in November 2022 documented that the discharge plan would include resident and family/caregiver education needs and would initiate or maintain collaboration between the nursing facility and the other post-acute providers to support the resident's transition to community living. The discharge plan, instruction, and summary provided a recapitulation or summary of the resident's stay. The nurse would review discharge instructions and medications with the resident/resident representatives. A copy of the disposition of medication form would be given to the resident/resident representative and a copy scanned into the medical record. The nurse would document a discharge note in the progress notes section of the resident's medical record. The discharge note would include- a skin assessment, who the resident was discharged with, where the resident was discharged to, what belongings were sent with them, and other pertinent information.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 661 | Continued From page 10<br><br>The facility failed to ensure R24's discharge summary included medication reconciliation and instructions. This placed R24 at risk for not receiving timely and appropriate care. | F 661 | | |
| F 676 SS=D | Activities Daily Living (ADLs)/Mntn Abilities<br>CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br><br>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:<br><br>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...<br><br>§483.24(b) Activities of daily living.<br>The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:<br><br>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,<br><br>§483.24(b)(2) Mobility-transfer and ambulation, including walking,<br><br>§483.24(b)(3) Elimination-toileting,<br><br>§483.24(b)(4) Dining-eating, including meals and | F 676 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 11 | F 676 | | |

snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 54 residents. The sample included 14 residents with one sampled for activities of daily living (ADL). Based on observations, interviews, and record review, the facility failed to ensure Resident (R) 32 received supportive care and services to promote and maintain his quality of life when the facility did not implement tools and/or strategies to allow R32, who had aphasia (a condition with disordered or absent language function), to communicate his wants, needs, or feelings. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity.

Findings included:

- R32's Electronic Medical Record (EMR) from the "Diagnoses" tab documented cerebral infarction (stroke - the 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), aphasia following cerebral infraction, hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infraction affecting the right dominate side, dysphagia (swallowing difficulty), cognitive social or emotional deficit following cerebral infraction, major depressive disorder (major mood disorder which causes persistent feelings of sadness) and anxiety (mental or emotional

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 12 | F 676 | | |

reaction characterized by apprehension, uncertainty, and irrational fear).

R32's "Admission Minimum Data Set" (MDS) dated 06/27/23 documented a Brief Interview for Mental Status was not conducted because the resident was rarely or never understood. The MDS documented that the interview for personal preferences was not conducted with R32 or his representative.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 06/27/23 documented R32 had cognitive social or emotional deficit following cerebral infraction and due to this he had severely impaired cognition.

The "Communication CAA" dated 06/27/23 documented R32 has aphasia due to cerebral infarction is rarely or never understood and rarely or never understands others.

R32's "Quarterly MDS" dated 11/03/23 documented a Brief Interview for Mental Status was not conducted because the resident was rarely or never understood. The MDS documented the resident's cognitive skills were severely impaired. The MDS documented R32 was dependent on staff for all self-care ADLs. The MDS documented R32 received scheduled pain medication but did not receive non-medication pain interventions. The MDS documented R32 received antidepressant medication (a class of medication to treat depression) during the observation period.

R32's "Care Plan" dated 06/21/22 documented he had impaired cognition. The plan directed staff to communicate with R32's family regarding his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 13 | F 676 | | |

capabilities and needs. The plan directed staff to use the resident's name and to identify themselves. R32's "Care Plan" directed staff to turn off the television to reduce distractions. The care plan dated 01/18/23 documented R32 had a communication problem and was nonverbal. R32's "Care Plan" directed staff to use communication techniques that enhanced interaction. The plan directed staff to talk to R32 while providing care, even if he did not respond. The plan directed staff to turn off the TV and radio as needed to reduce environmental noise. R32's "Care Plan" directed staff to ask yes or no questions, and to use brief, consistent words or cues.

A review of R32's "Speech Therapy Plan of Care" from June 2023 through January 2024 lacked evidence a communication system or picture board was trialed.

On 02/05/24 at 07:35 AM R32 lay in bed on his back. R32 had fall mats on both sides of the bed. R32's television was on. R32 nodded yes in response to all questions. There were no communication tools/boards visible in R32's room.

On 02/06/24 at 08:46 AM observation revealed Licensed Nurse (LN) H administered R32's morning tube feeding. LN H completed the tube feeding without speaking to R32. After the feeding was complete LN H asked R32 if everything was ok and gave the resident a thumbs-up sign. R32 responded with a thumbs-up sign. LN H asked R32 to demonstrate a thumbs-down sign, and R32 gave a thumbs-down sign. LN H stated R32 would sometimes wink if everything was ok. LN H did

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 14 | F 676 | | |

not ask R32 any further questions.

On 02/07/24 at 07:55 AM R32 lay in bed on his back. His television was on. When R32 was asked if he liked what he was watching on the television, R32 reached out and held the surveyor's hand. R32 smiled in response to all further questions and was reluctant to let go of the surveyor's hand.

On 02/08/24 at 08:25 AM R32 lay in bed on his back and watched television with the remote on the bedside table. When asked if he liked the show on the television, R32 did not gesture but he reached out to hold the surveyor's hand. There was no communication board visible in R3's room.

On 02/05/24 at 10:41 AM in a telephone interview, R32's representative stated R32 was unable to communicate with the staff that did not know him well. R32's representative stated R32 pointed at what he wanted, but the staff did not always understand what he wanted.

On 02/08/24 at 10:26 AM Certified Nurse Aide (CNA) N stated R32 pointed at things but never pressed his call light. CNA N said R32 had no way to tell staff his wants or needs; staff had to ask R32 the right questions.

On 02/08/24 at 09:43 AM CNA M stated R32 blinked once for yes and twice for no. CNA M stated R32 was unable to tell staff if he was cold, wet, or lonely. She stated staff kept R32 him on a routine to ensure he was taken care of.

On 02/08/24 at 09:37 LN G stated he thought R32 had a communication board at one time and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 15<br>said it might be in the closet. LN G stated staff asked R32 yes and no questions and made sure he had a routine. LN G stated he asked R32 to squeeze his hand in answer to questions and said he always made, sure to make eye contact with R32 to ensure the resident was well. LN G verified R32 had no way to communicate something to staff if staff did not ask directly about it.<br><br>On 02/08/24 at 12:37 Administrative Nurse D stated R32 had a brain injury and was unable to let staff know how he was feeling or what he wanted. Administrative Nurse D stated when staff changed R32, staff watched R32's face to communicate. Administrative Nurse D stated no matter what the facility tried, R32 had not been able to communicate. Administrative Nurse D stated that R32's representative was very involved with his care.<br><br>The facility did not provide a policy related to promoting effective communication with nonverbal residents.<br><br>The facility failed to ensure R32 received supportive care and services to promote and maintain R32's ability to communicate his wants, needs, or feelings. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity. | F 676 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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; | F 677 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 677 | Continued From page 16 | F 677 | | |

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 54 residents. The sample included 14 residents with five residents reviewed for activities of daily living (ADLs). Based on observations, record review, and interviews, the facility failed to provide ADL care including trimming his fingernails/toenails for Resident (R) 5. The facility also failed to provide ADL care and assistance to R9. This deficient practice placed the residents at risk for poor hygiene, decreased self-esteem, and impaired health.

Findings included:

- The "Diagnoses" tab of R5's Electronic Medical Record (EMR) documented diagnoses of chronic inflammatory demyelinating polyneuropathy (CIDP - a neurological disorder that involves progressive weakness and reduced senses in the arms and legs), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), generalized muscle weakness, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).

The "Admission Minimum Data Set (MDS)" dated 08/15/23, documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R5 required substantial assistance, where staff did more than half the effort, for eating and oral hygiene. The MDS further documented R5 was dependent on staff for toileting hygiene, bathing, dressing, transfers, and mobility.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 677 | Continued From page 17 | F 677 | | |

The "Quarterly MDS" dated 12/31/23, documented R5 was dependent on staff for eating, oral hygiene, and personal hygiene.

The "ADL Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 08/15/23, documented R5 required assistance with ADLs.

R5's "Care Plan" with an initiated date of 09/17/23, documented R5 had an ADL self-care performance deficit and both arms, hands, and legs were contracted (abnormal permanent fixation of a joint or muscle ). An intervention with an initiated date of 08/06/23 documented R5 required two staff assistance with bathing and directed staff to offer to assist with bathing twice per week and as needed. An intervention with an initiated date of 08/06/23, documented R5 required two staff assistance to reposition and turn him in bed. An intervention with an initiated date of 08/06/23, documented R5 required one staff assistance to eat. An intervention with an initiated date of 08/06/23, documented R required assistance of one staff for personal hygiene and oral care. The intervention further directed staff to use oral swabs to provide oral care upon rising, after meals, and before bed. An intervention with an initiated date of 08/06/23, documented R23 required a Hoyer (total body mechanical lift) and two staff assistance for transfers. An intervention with an initiated date of 08/31/23, directed staff to provide passive range of motion/stretching to both legs every shift.

R5's EMR lacked evidence that he refused to have his fingernails trimmed.

On 02/05/24 at 10:50 AM R5 was in his room in bed. R5's hands were closed into a fist and his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 677 | Continued From page 18 | F 677 | | |

fingernails were approximately an inch long on both hands. R5 stated his fingernails needed to be cut, but felt staff were too busy to cut them for him. R5 stated that he wanted to have his hair cut and beard trimmed as well. R5's hair and beard were unkempt, he had body odor, and dry skin on his face/beard area, hands, and feet. R5's toenails were thick and approximately half an inch long. R5 stated he did not like the way he felt with his hair, beard, and nails grown out.

On 02/08/24 at 08:37 AM R5 was in his room in bed. R5's hands were closed in a fist and his fingernails remained approximately an inch long on both hands and his toenails remained approximately half of an inch. R5's hair and beard were unkempt, he continued to have body odor and dry skin on his hands and feet. R5 stated he did not like having a beard and hoped it, and his hair would be trimmed that day. He further stated a staff member mentioned trimming his nails, but that it was not done. R5 stated he believed staff were too busy to trim them.

On 02/08/24 at 11:50 AM Licensed Nurse (LN) G stated Certified Nurse Aides (CNA) should trim R5's fingernails on his bath days. LN G stated if R5 refused a bath or to have his fingernails trimmed, the refusal would have been documented in his EMR as a progress note.

On 02/08/24 at 12:37 PM Administrative Nurse D stated CNAs and nurses were able to trim a resident's fingernails and that it would normally have been done on the resident's bath days. Administrative Nurse D stated R5's fingernails were too thick, and he was placed on a list to see a specialist to have them trimmed. Administrative Nurse D further stated R5 was sent to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 677 | Continued From page 19 | F 677 | | |

hospital and missed his appointment to have his nails trimmed. Administrative Nurse D stated if a resident missed their appointment with the specialist, then the facility would have attempted to reschedule as soon as possible, and the resident would have been placed on a list to be seen when the specialist was scheduled to return to the facility.

An ADL policy was not provided by the facility.

The facility failed to provide ADL care for R5 which included trimming his fingernails and toenails. This deficient practice had the risk of poor hygiene, decreased self-esteem, and impaired health for R5.

- R9's Electronic Medical Record (EMR) documented diagnoses of chronic osteomyelitis (local or generalized infection of the bone and bone marrow) of the left tibia (bone of the lower leg )and fibula (one of the two bones of the lower leg), repeated falls, symptoms and signs involving cognitive functions and awareness, acquired absence of the right toe, difficulty walking, muscle weakness, Stage 3 (full thickness pressure injury extending through the skin into the tissue below), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of the left hip and left and right heels.

The "Admission Minimum Data Set" (MDS) dated 10/17/23 documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R9 required partial to moderate assistance from staff for bed mobility. R9 was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 677 | Continued From page 20 | F 677 | | |

dependent on staff for all transfers and toileting hygiene. The MDS recorded R9 was always incontinent of both urine and bowel and was not on a toileting program. The MDS recorded R9 had one Stage 2 pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters), two Stage 3 pressure ulcers, one unstageable pressure ulcer (depth of the wound is unknown due to the wound bed is covered by a thick layer of other tissue and pus) and a surgical wound. The MDS documented R9 was at risk for developing pressure ulcers and had a pressure-reducing device on his bed and wheelchair. R9 received pressure ulcer care, surgical wound care, and nonsurgical dressings and ointments but not a turning or repositioning program.

The "Incontinence Care Area Assessment" (CAA) dated 10/17/23 documented R9 had chronic osteomyelitis of the left and right tibia and fibula, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) and repeated falls. R9 needed assistance with using the toilet and was incontinent.

R9's "Care Plan" dated 10/11/23 and revised on 02/04/24 documented R9 had pressure wounds to his left and right heels, left hip, and right inner ankle; he had a vascular wound (wound resulting from poor circulation) on his right foot and leg. An intervention dated 10/14/23 directed staff to offer R9 a urinal and check and change his every two to three hours and as needed (i.e., upon rising, after all meals, and before bed); check routinely throughout the night.

R9's "Care Plan" dated 10/12/23 and revised on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 677 | Continued From page 21 | F 677 | | |

10/14/23 documented R9 had an ADL self-care deficit and was non-weight bearing on his legs. The plan directed staff R9 required a full body mechanical lift (Hoyer) with assistance from two staff for all transfers and required assistance from one staff for bed mobility and repositioning. An intervention dated 10/27/23 directed staff to encourage R9 to get out of bed daily; R9 was able to tolerate being up two to three hours at a time.

On 02/06/24 at 07:38 AM Administrative Nurse E pushed R9 from his room to the dining room table in a wheelchair. R9 wore socks on both feet and his feet rested directly on the wheelchair pedals.

On 02/06/24 at 09:36 AM R9 remained in his wheelchair at the dining room table. R9 wore socks on both feet and his feet rested directly on the wheelchair pedals.

On 02/06/24 at 10:51 AM R9 sat in his wheelchair which was parked next to R9's bed. R9 leaned forward in his chair so that his upper body and head rested on his bed. R9's eyes were closed, and he appeared to be asleep.

On 02/06/24 at 01:32 PM, R9 sat in his wheelchair at the dining room table. His eyes were closed, and he appeared to be asleep.

On 02/06/24 at 01:54 PM, R9 sat in his wheelchair. His pants were visibly saturated to his mid-thigh area. Certified Nurse Aide (CNA) O and Administrative Nurse E prepared to transfer R9 into bed.

On 02/06/24 at 02:30 PM, R9 lay in bed on his right side with a pillow between his legs. His right

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 677 | Continued From page 22 | F 677 | | |

heel rested directly on the mattress.

On 02/06/24 at 02:18 PM, CNA O stated R9 had not been laid down or changed since 08:00 AM because CNA O had been busy. CNA O further stated R9 used to have pressure-relieving boots for his heels but those disappeared. She went on to say she knew how to access the resident's plan of care in the Kardex (a nursing tool that gives a brief overview of the care needs of each resident).

On 02/08/24 at 09:46 AM CNA M stated R9 should be turned toward the wall so he did not fall and did not lay on the wound vac. CNA M stated R9 should be changed every two to three hours.

On 02/08/24 at 10:29 AM CNA N stated R9 should have a pillow between his legs and R9's heels should be elevated on a pillow. CNA N said the Kardex informed staff of each resident's care needs. CNA N said R9 should be changed every two to three hours.

On 02/08/24 at 01:31 PM Administrative Nurse D stated R9 was able to talk and communicate his needs. She said she expected staff to check and change R9 every two hours and to put him down (in bed) in between meals. Administrative Nurse D said all staff knew R9 was at high risk for skin breakdown and needed to be changed frequently. Administrative Nurse D stated it was the routine process for the CNA staff to reposition R9 at least every two hours. She said R9 had a lot of wounds when he was admitted. Administrative Nurse D stated she expected staff to follow the resident's care plan.

The facility did not provide a policy related to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 677 | Continued From page 23<br>provision of care with ADL.<br><br>The facility failed to provide ADL assistance and services for R9 who was dependent on staff for transfers and toileting. This placed R9 at risk for avoidable complications and impaired quality of life. | F 677 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. The sample included 14 residents with 14 residents reviewed for quality of care. Based on observation, record review, and interview, the facility failed to apply Geri Sleeves (sleeves used to protect the skin on the arms and legs against damage caused by friction and shearing) to Resident (R) 23 per her care plan and the facility failed to follow physician ordered daily weights for R10 who required the use of a diuretic (a medication used for the formation and secretion of urine and reduce excess fluids). This deficient practice placed R23 at risk for skin injury and placed R10 at risk for excess fluid accumulation and physical complications.<br><br>Findings included: | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 684 | Continued From page 24 | F 684 | | |

- R23's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).

The "Annual Minimum Data Set" (MDS) dated 01/03/24 noted the Brief Interview for Mental Status (BIMS) assessment was unable to be completed. The MDS documented R23 had problems with recall ability and short-term and long-term memory. The MDS further documented R23 had severely impaired decision-making abilities. The MDS documented R23 required substantial assistance where staff did more than half the effort, for oral hygiene, personal hygiene, upper body dressing, and transfers. The MDS further documented R23 was dependent on staff for bathing, lower body dressing, and mobility through the use of a wheelchair. The MDS documented the resident had skin tears.

The "Cognitive Loss / Dementia Care Area Assessment" (CAA) dated 01/03/24, documented R23 had advanced dementia and memory impairment.

R23's "Care Plan" with an initiated date of 01/07/21, documented R23 was at risk for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) development related to immobility and compounded by incontinence. An intervention

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 684 | Continued From page 25 | F 684 | | |

with an initiated date of 03/11/21, directed staff to apply Geri Sleeves on bilateral (both sides) lower extremities (BLE) and bilateral upper extremities (BUE) for skin protection.

On 02/05/24 at 09:20 AM R23 was in a common area and sat in a Broda chair (specialized wheelchair with the ability to tilt and recline) in front of a TV. R23 did not have Geri Sleeves applied to her BLE or BUE.

On 02/07/24 at 02:03 PM, R23 sat in her Broda chair, in a common area, in front of a TV. R23 did not have Geri Sleeves applied to her BLE or BUE.

On 02/08/24 at 11:24 AM R23 sat in her Broda chair, in a common area, in front of a TV. R23 picked at the skin on the side of her nose and caused it to bleed. R23 did not have Geri Sleeves applied to her BLE or BUE.

R23's EMR lacked evidence the Geri Sleeves were being offered to R23 or that she had refused to use them.

On 02/08/24 at 11:29 AM Certified Nurse Aide (CNA) O stated R23 had used the Geri Sleeves before, but R23 had not worn them for a few weeks. CNA O stated R23 would scratch herself and that was why the sleeves were used. CNA O stated R23 sometimes refused to let staff put them on her, and CNA O would notify the nurse when that happened so the refusal could be documented.

On 02/08/24 at 11:50 AM Licensed Nurse (LN) G stated the care plan should have stated as needed for the Geri Sleeves. LN G further stated staff placed the sleeves on R23 when she would

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 684 | Continued From page 26 | F 684 | | |

pick at her arms. LN G stated R23 would fixate on a location, such as a sore, and that she would pick at it. LN G further stated R23 did not pick at her skin all of the time and the sleeves were placed when she did it. LN G stated refusal to wear the Geri Sleeves would have been entered as a progress note.

On 02/08/24 at 12:37 PM Administrative Nurse D stated it was not always possible to place the Geri Sleeves on R23 as it would sometimes agitate her. Administrative Nurse D went on to say staff were expected to at least try each day to place the sleeves on R23.

The facility provided a "Wound Prevention" policy, with a reviewed date of 08/2023, documented the facility would provide initial and ongoing training to all clinical staff members on wound prevention techniques, early identification of wounds, and appropriate care interventions. The policy further documented all wound prevention measures, assessments, and interventions should be documented in the resident's service plans and medical records.

The facility failed to apply the care planned Geri Sleeves to R23. This deficient practice placed R23 at risk for skin injury.

- R10's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and insomnia (inability to sleep).

The "Significant Change Minimum Data Set"

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 684 | Continued From page 27 | F 684 | | |

(MDS) dated 07/17/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R10 had received antianxiety (class of medications that calm and relax people), anticoagulant (class of medications used to prevent the formation of blood clots), diuretic (medication to promote the formation and excretion of urine), and opioid (a class of medication used to treat pain) for seven days during the observation period.

The "Quarterly MDS" dated 01/17/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R10 received antianxiety medication, anticoagulant medication, diuretic, and opioid medication during the observation period.

R10's "Psychotropic Drug Care Area Assessment" (CAA) dated 07/20/23 documented R10 received routine antianxiety medication.

R10's "Care Plan" dated 01/24/23 documented staff would obtain a daily weight related to diuretic medication. The plan of care documented the physician would be notified of a two-pound gain in 24 hours or a five-pound gain in five days.

R10's EMR under the "Orders" tab revealed the following physician orders:
Daily weight related to the use of diuretics one time a day. Notify the physician of a two-pound weight gain in 24 hours or a five-pound weight gain in five days dated 01/24/23.
Furosemide (diuretic) tablet 40 milligrams (mg) give 60mg by mouth in the evening for edema, administer at 04:00 PM dated 01/04/24.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 684 | Continued From page 28 | F 684 | | |

Review of R10's "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) from 11/01/23 to 02/05/24 (97 days) lacked evidence staff measured and recorded R10's weight on the following 10 dates 11/01/23, 11/10/23, 11/15/23, 11/24/23, 11/25/23, 12/18/23, 12/19/23, 12/24/23, 01/05/24, and 02/02/24. R10's refused on the following 26 dates for staff to obtain her daily weight on the following dates 11/06/23, 11/29/23, 12/05/23, 12/06/23, 12/15/23, 12/16/23, 12/17/23, 12/20/23, 12/21/23, 12/23/23, 12/25/23, 12/26/23, 12/27/23, 12/30/23, 01/03/24, 01/08/24, 01/09/24, 01/14/24, 01/15/24, 01/17/24, 01/18/24, 01/22/24, 01/23/24, 01/26/24, 01/28/24, 02/04/24, 02/05/24, and 02/06/24. "Not Available" was documented on the following two dates 12/28/23 and 01/02/24. "See Progress notes" was documented two times on the following dates 12/08/23 and 01/27/24. "Sleeping" was documented on 11/11/23. A weight gain of five pounds was noted on two occasions on the following dates 11/20/23 and 12/29/23. The clinical record lacked evidence of physician notification the daily weight was not obtained, refused, or the weight gain of five pounds.

Observation on 02/06/24 at 10:53 AM R10 sat in her wheelchair in the dining room and drank a cup of coffee during the resident council meeting.

On 02/08/24 at 11:05 AM Certified Medication Aide (CMA) R stated the nurse let the staff know who needed a daily weight. CMA R stated the nursing staff would notify the nurse of the resident's weight.

On 02/08/24 at 11:19 AM Licensed Nurse (LN) G stated the facility would honor a resident's right to refuse their daily weight. LN G stated the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 684 | Continued From page 29<br>physician should be notified if the resident would refuse frequently to be weighed daily when monitoring for edema; the nurse documented in the clinical record when the physician was notified and the physician's response.<br><br>On 02/08/24 at 12:37 PM Administrative Nurse D stated the physician should be notified a resident had refused to be weighed daily as ordered or notified of a weight gain. Administrative Nurse D stated the nurse would document the notification in the EMR.<br><br>The facility was unable to provide a policy related physician notification of weight monitoring for diuretic medication.<br><br>The facility failed to follow a physician's order for daily weights to monitor weight gain for fluid overload for R10 who had edema and received a diuretic medication. This deficient practice placed R10 at risk of adverse side effects from unnecessary medication or complications related to fluid overload. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent | F 686 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 686 | Continued From page 30 | F 686 | | |

with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 54 residents. The sample included 14 residents with two sampled for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). based on observation, interviews, and record reviews the facility failed to ensure staff implemented the care plan interventions for Resident (R) 9 who had multiple pressure-related injuries and remained at risk for the development of pressure ulcers. This deficient practice placed R9 at risk for delayed healing, new pressure injuries, and related complications.

Findings included:

- R9's Electronic Medical Record (EMR) documented diagnoses of chronic osteomyelitis (local or generalized infection of the bone and bone marrow) of the left tibia (bone of the lower leg )and fibula (one of the two bones of the lower leg), repeated falls, symptoms and signs involving cognitive functions and awareness, acquired absence of the right toe, difficulty walking, muscle weakness, Stage 3 (full thickness pressure injury extending through the skin into the tissue below), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of the left hip and left and right heels.

The "Admission Minimum Data Set" (MDS) dated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 686 | Continued From page 31 | F 686 | | |

10/17/23 documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R9 required partial to moderate assistance from staff for bed mobility. R9 was dependent on staff for all transfers and toileting hygiene. R9's MDS documented R9 received scheduled pain medication but no as-needed pain medications and did not receive any non-medicinal pain interventions. The MDS recorded R9 was always incontinent of both urine and bowel and was not on a toileting program. The MDS recorded R9 had one Stage 2 pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters), two Stage 3 pressure ulcers, one unstageable pressure ulcer (depth of the wound is unknown due to the wound bed is covered by a thick layer of other tissue and pus) and a surgical wound. The MDS documented R9 was at risk for developing pressure ulcers and had a pressure-reducing device on his bed and wheelchair. R9 received pressure ulcer care, surgical wound care, and nonsurgical dressings and ointments but not a turning or repositioning program.

The "Pressure Ulcer Care Assessment" (CAA) dated 10/17/23 documented R9 had chronic osteomyelitis of the left and right tibia and fibula, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) and repeated falls. R9 needed assistance with bed mobility and was incontinent. R9 was admitted with multiple pressure injuries.

R9's "Care Plan" dated 10/11/23 and revised on 02/04/24 documented R9 had pressure wounds

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 686 | Continued From page 32 | F 686 | | |

to his left and right heels, left hip, and right inner ankle; he had a vascular wound (wound resulting from poor circulation) on his right foot and leg. The plan directed staff to administer R9's treatments and medications as ordered and shearing while repositioning in bed. Interventions dated 10/14/23 directed staff to float R9's bilateral (both sides) heels on a pillow when R9 was in bed as tolerated and ensure a pressure-reducing cushion was placed in the chair when R9 was up to his chair. An intervention dated 10/14/23 directed staff to offer R9 a urinal and check and change his every two to three hours and as needed (i.e., upon rising, after all meals, and before bed); check routinely throughout the night.

R9's "Care Plan" dated 10/12/23 and revised on 10/14/23 documented R9 had an ADL self-care deficit and was non-weight bearing on his legs. The plan directed staff R9 required a full body mechanical lift (Hoyer) with assistance from two staff for all transfers and required assistance from one staff for bed mobility and repositioning. An intervention dated 10/27/23 directed staff to encourage R9 to get out of bed daily; R9 was able to tolerate being up two to three hours at a time.

On 02/05/24 at 08:25 AM observation revealed R9 laid in bed on his right side, with his head against the wall. R9's feet and heels rested directly on the mattress with no evidence of a pillow or device in use for floating. There were visibly soiled sheets wadded on the left side of R9 in the bed. There was a foul odor noted and R9's negative-pressure wound-vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal) did not make an audible alarm though the screen

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 686 | Continued From page 33 | F 686 | | |

indicated a leak alert.

On 02/06/24 at 01:58 PM observation revealed R9 laid in bed, turned to his right side. There was no fall mat on the floor next to his bed. R9's feet and heels rested directly on the mattress with no evidence of a pillow or device in use for floating.

On 02/06/24 at 07:38 AM Administrative Nurse E pushed R9 from his room to the dining room table in a wheelchair. R9 wore socks on both feet and his feet rested directly on the wheelchair pedals.

On 02/06/24 at 09:36 AM R9 remained in his wheelchair at the dining room table. R9 wore socks on both feet and his feet rested directly on the wheelchair pedals.

On 02/06/24 at 10:51 AM R9 sat in his wheelchair which was parked next to R9's bed. R9 leaned forward in his chair so that his upper body and head rested on his bed. R9's eyes were closed, and he appeared to be asleep.

On 02/06/24 at 01:32 PM, R9 sat in his wheelchair at the dining room table. His eyes were closed, and he appeared to be asleep.

On 02/06/24 at 01:54 PM, R9 sat in his wheelchair. His pants were visibly saturated to his mid-thigh area. Certified Nurse Aide (CNA) O and Administrative Nurse E prepared to transfer R9 into bed.

On 02/06/24 at 02:18 PM, CNA O stated R9 had not been laid down or changed since 08:00 AM because CNA O had been busy. CNA O further stated R9 used to have pressure-relieving boots for his heels but those disappeared. She went on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 686 | Continued From page 34 | F 686 | | |

to say she knew how to access the resident's plan of care in the Kardex (a nursing tool that gives a brief overview of the care needs of each resident).

On 02/06/24 at 02:30 PM, R9 lay in bed on his right side with a pillow between his legs. His right heel rested directly on the mattress.

On 02/08/24 at 09:46 AM CNA M stated R9 should be turned toward the wall so he did not fall and did not lay on the wound vac. CNA M said R9 should have a pillow placed under his feet for floating his heels. CNA M stated R9 should be changed every two to three hours.

On 02/08/24 at 10:29 AM CNA N stated R9 should have a pillow between his legs and R9's heels should be elevated on a pillow. CNA N said the Kardex informed staff of each resident's care needs. CNA N said R9 should be changed every two to three hours.

On 02/08/24 at 01:31 PM Administrative Nurse D stated R9 was able to talk and communicate his needs. She said she expected staff to check and change R9 every two hours and to put him down (in bed) in between meals. Administrative Nurse D said all staff knew R9 was at high risk for skin breakdown and needed to be changed frequently. Administrative Nurse D stated it was the routine process for the CNA staff to reposition R9 at least every two hours. She said R9 had a lot of wounds when he was admitted. Administrative Nurse D stated she expected staff to follow the resident's care plan.

The facility policy "Pressure Ulcer/Pressure Injury Prevention " revised on 03/2022 recorded that the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 686 | Continued From page 35<br>first step in the prevention of pressure ulcers/injuries was the identification of the resident at risk for developing pressure-related injuries. That was followed by the implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions.<br><br>The facility failed to ensure R9's interventions were implemented consistently to prevent new pressure injuries and to promote the healing of the existing pressure wounds. This placed R9 at risk for delayed healing, new pressure injuries, and related complications. | F 686 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. | F 688 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 36 | F 688 | | |

The sample included 14 residents with three reviewed for range of motion. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 5 received services/interventions to prevent a reduction of range of motion (ROM) and contractures (abnormal permanent fixation of a joint or muscle). This deficient practice left R5 at risk for further decline and decreased ROM or mobility.

Findings included:

- The "Diagnoses" tab of R5's Electronic Medical Record (EMR) documented diagnoses of chronic inflammatory demyelinating polyneuropathy (CIDP - a neurological disorder that involves progressive weakness and reduced senses in the arms and legs), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), generalized muscle weakness, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).

The "Admission Minimum Data Set (MDS)" dated 08/15/23, documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R5 required substantial assistance, where staff did more than half the effort, for eating and oral hygiene. The MDS further documented R5 was dependent on staff for toileting hygiene, bathing, dressing, transfers, and mobility.

The "Quarterly MDS" dated 12/31/23, documented R5 was dependent on staff for eating, oral hygiene, and personal hygiene.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 37 | F 688 | | |

The "ADL Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 08/15/23, documented R5 required assistance with ADLs.

R5's "Care Plan" with an initiated date of 09/17/23, documented R5 had an ADL self-care performance deficit and both arms, hands, and legs were contracted. An intervention with an initiated date of 08/31/23, directed staff to provide passive range of motion/stretching to both legs every shift.

R5's "Care Plan" lacked evidence of any interventions to address the contractures to his hands and arms.

The "Safe Transitions Goals/Functional Maintenance Plan" with a program start date of 08/31/23, for R5, directed staff to perform passive range of motion/stretching within tolerance one time per shift for contracture management. The maintenance plan lacked information regarding which contractures were being managed with this plan.

R5's "Documentation Survey Report" for 01/01/24 - 01/31/24 had an intervention/task for a restorative program for staff to provide passive range of motion/stretching to both legs every shift. 27 shifts out of 62 were documented as not applicable, eight out of 62 shifts were documented as refused, and 20 shifts out of 62 lacked any documentation. R5's "Documentation Survey Report" for 01/01/24 - 01/31/24 lacked evidence of any restorative intervention/task for R5's hands or arms.

On 02/05/24 at 10:50 AM R5 was in his room in bed. R5's hands were closed into a fist and his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 38 | F 688 | | |

fingernails were approximately an inch long on both hands. R5 stated he did not have any brace/cushion for his hands and that the staff did not perform any exercises/stretches on his hands.

On 02/08/24 at 08:37 AM R5 was in his room in bed. R5's hands were closed into a fist, and he rested them on his chest.

On 02/08/24 at 11:29 AM Certified Nurse Aide (CNA) O stated staff would try performing leg exercises with R5; however, CNA O stated R5 would refuse and state that the exercises were painful. CNA O stated staff were supposed to raise R5's legs up and down for one to two minutes a shift. CNA O stated physical therapy instructed staff and demonstrated the exercises staff were expected to do with R5. CNA O Further stated staff were not doing any exercises/stretches with R5's hands. CNA O stated R5 had refused the exercises/stretches several times so staff would mark not applicable in his EMR and not ask him if he wanted to do them due to refusals. CNA O stated sometimes staff would ask R5 if he wanted to do them, and sometimes they wouldn't.

On 02/08/24 at 11:50 AM Licensed Nurse (LN) G was not sure about R5's current restorative program. LN G stated therapy had tried a brace/palm pillow for R5's hands before, but R5 didn't care for them so the staff did not apply them very often.

On 02/08/24 at 12:37 PM Administrative Nurse D stated the facility did not have a formal restorative program. Administrative Nurse D stated the facility was still doing restorative interventions for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 39<br>some residents despite not having a formal program and the exercises would have been in the resident's care plan. Administrative Nurse D further stated she expected staff to work with a resident's hands and joints during baths or clothing changes. Administrative Nurse D stated she did not believe staff had specific training for restorative/ROM training and all staff were expected to monitor for decline and were to report any noted change to physical therapy or clinical management.<br><br>A ROM/restorative policy was not provided by the facility.<br><br>The facility failed to ensure R5 received services/interventions to prevent a reduction of ROM and contractures. This deficient practice left R5 at risk for further decline and decreased ROM or mobility. | F 688 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. The sample included 14 residents with three residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure staff followed the care plan | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 40 | F 689 | | |

for safe transfers for Resident (R) 29 and the facility also failed to ensure staff placed a fall mat next to R9's bed per his plan of care. These deficient practices placed these residents at risk for falls and possible injuries related to falls.

Findings included:

- R29's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of weakness, need for assistance with personal care, chronic respiratory failure, emphysema (a long-term, progressive disease of the lungs characterized by shortness of breath), muscle weakness, lack of coordination, and difficulty in walking.

The "Admission Minimum Data Set" (MDS) dated 12/22/23 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R29 was dependent on staff assistance for transfers from chair/bed-to-chair transfers. The MDS documented R29 received oxygen during the observation period.

R29's "Functional Abilities Care Area Assessment" (CAA) dated 12/30/23 documented she required assistance with her activities of daily living.

R29's "Care Plan" last revised on 12/27/23 documented R29 required the Hoyer (total body mechanical lift) for transfers with the assistance of two staff members.

Observation on 02/07/24 at 08:33 AM Certified Nurse Aide (CNA) N placed a gait belt around R29's waist, and using the gait belt, assisted R29

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 41 | F 689 | | |

into a partial standing position, then pivoted R29 onto the bed.

On 02/07/24 at 08:40 AM, CNA N stated the staff had access to the plan of care and Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA N stated she would find the information on how R29 transferred to the Kardex. CNA N stated therapy determined the safest mode of transfer for each resident.

On 02/07/24 at 10:09 AM Licensed Nurse (LN) G stated all staff had access to the care plan and Kardex. LN G stated the Kardex contained the information for R29's mode of transfer.

On 02/07/24 at 10:49 AM Consultant Physical Therapist HH stated R29 had not been reevaluated for therapy since her recent return from a hospitalization on 01/09/24. Consultant Physical Therapist HH stated R29 was transferred with a Hoyer lift, then worked with therapy to transfer with a gait belt, but recently had a decline and was using the Hoyer lift at times.

On 02/07/24 at 12:09 PM Administrative Nurse D stated the plan of care or Kardex should be reviewed on a daily basis to know each resident's level of assistance needed for activities of daily living. Administrative Nurse D stated R29's care plan was updated for staff to use a gait belt along with stand/pivot transfer and staff could also use the Hoyer lift with two people.

The facility's "Falls" policy last revised on 09/17/19 documented the purpose of the fall management program was to develop, implement, monitor, and evaluate an

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 42 | F 689 | | |

interdisciplinary team's fall prevention approach and manage strategies and interventions that foster resident independence and quality of life. The fall management program promotes the safety, prevention, and education of both staff and residents.

The facility failed to ensure staff transferred R29 with a Hoyer lift and the assistance of two staff members as care planned to prevent falls or injuries. This deficient practice placed R29 at risk for falls and possible injuries.
- R9's Electronic Medical Record (EMR) documented diagnoses of chronic osteomyelitis (local or generalized infection of the bone and bone marrow) of the left tibia (bone of the lower leg )and fibula (one of the two bones of the lower leg), repeated falls, symptoms and signs involving cognitive functions and awareness, acquired absence of the right toe, difficulty walking, muscle weakness, Stage 3 (full thickness pressure injury extending through the skin into the tissue below), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of the left hip and left and right heels.

The "Admission Minimum Data Set" (MDS) dated 10/17/23 documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R9 required partial to moderate assistance from staff for bed mobility. R9 was dependent on staff for all transfers and toileting needs. The facility was unable to determine if the resident had any falls before admitting to the facility.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 43 | F 689 | | |

The "Pressure Ulcer Care Assessment" (CAA) dated 10/17/23 documented R9 had chronic osteomyelitis of the left and right tibia and fibula sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) and repeated falls. R9 needed assistance with bed mobility and was incontinent. R9 was admitted with multiple pressure injuries.

R9's "Care Plan" dated 10/12/23 documented staff would place R9's fall mat at the bedside when he was in bed. The plan directed staff to place the bed in a low position.

The "Physician's order" dated 01/19/24 ordered a fall mat at R9's bedside.

On 02/05/24 at 08:25 AM observation revealed R9 laid in bed on his right side, with his head against the wall. R9's bed was in a high position. There was no fall mat on the floor next to R9's bed.

On 02/06/24 at 01:58 PM observation revealed R9 laid in bed, turned to his right side. There was no fall mat on the floor next to his bed. Further observation revealed no fall mat in R9's room.

On 02/08/24 at 09:46 AM Certified Nurses Aid (CNA) M stated R9 should be turned toward the wall so he does not fall. CNS M said R9 should not lay on the wound vac. CNA M said R9 should have a pillow placed under his feet for floating the heels, CNA M stated the fall mat should be placed on the right side of the bed, and the bed should be in the lowest position.

On 02/08/24 at 10:29 AM, CNA N stated R9

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 44<br>should have a pillow between legs. R9's heels should be elevated on a pillow and his fall mat should be placed by his bed. CNA N stated she could find the information on how to care for the resident in the Kardex (a nursing tool that gives a brief overview of the care needs of each resident).<br><br>On 02/08/24 at 10:19 AM LN G stated R9's bed should be left in a low position and his mat placed on the side of his bed.<br><br>On 02/08/24 at 01:31 PM Administrative Nurse D stated she expected the nursing staff to put R9's bed in the lowest position and his fall mat in place. Administrative Nurse D stated the fall mat was picked up for some reason, either for room changes or cleaning, and was not put back in place. She stated she expected staff to follow the care plan and ensure R9's fall mat was in place and his bed was in a low position.<br><br>The facility's "Falls" policy last revised on 09/17/19 documented that the purpose of the fall management program was to develop, implement, monitor, and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that foster resident independence and quality of life. The fall management program promotes the safety, prevention, and education of both staff and residents.<br><br>The facility failed to ensure R9's bed was in the lowest position and his fall mat was in place per his plan of care. This deficient practice placed R9 at risk for falls and fall-related injuries. | F 689 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning | F 695 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 695 | Continued From page 45<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. The sample included 14 residents with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure there was a physician indication for oxygen administration for Resident (R)29 and failed to ensure the oxygen tubing was stored in a sanitary manner to decrease exposure and contamination. This placed R29 at increased risk for respiratory infection and complications.<br><br>Findings included:<br><br>- R29's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of weakness, need for assistance with personal care, chronic respiratory failure, emphysema (a long-term, progressive disease of the lungs characterized by shortness of breath), muscle weakness, lack of coordination, and difficulty in walking.<br><br>The "Admission Minimum Data Set" (MDS) dated 12/22/23 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS | F 695 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 695 | Continued From page 46 | F 695 | | |

documented R29 was dependent on staff assistance for transfers from chair/bed-to-chair transfers. The MDS documented R29 received oxygen during the observation period.

R29's "Functional Abilities Care Area Assessment" (CAA) dated 12/30/23 documented she required assistance with her activities of daily living.

R29's "Care Plan" dated 12/18/23 documented staff would change oxygen tubing weekly on Sunday. The plan of care lacked direction to staff of oxygen tubing storage when not in use by R29.

R29's EMR under the "Orders" tab revealed the following physician orders:
Oxygen at two liters continuous dated 12/16/23. The order lacked an indication for administration.

Observation on 02/07/24 at 08:02 AM R29's oxygen nasal cannula laid directly on the floor beside her bed.

Observation on 02/07/24 at 08:33 AM Certified Nurse Aide (CNA) N pushed R29 in the wheelchair into R29's room and stepped onto the nasal cannula on the floor as she pulled the bedding down on R29's bed. CNA N moved the nasal cannula from the floor and placed the cannula onto the oxygen concentrator. CNA N removed the oxygen tubing connected to the portable oxygen tank from R29's nose and placed the oxygen tubing in a plastic bag that was attached to R29's wheelchair. CNA N placed a gait belt around R29's waist, and using the gait belt, assisted R29 into a partial standing position, then pivoted R29 onto the bed. CNA N then placed the oxygen nasal cannula that was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 695 | Continued From page 47 | F 695 | | |

stepped on into R29's nostrils.

On 02/07/24 at 08:40 AM Certified Nurse Aide (CNA) N stated the oxygen tubing was not on the floor but was wrapped around the oxygen concentrator. CNA N stated it was not stored in the plastic bag attached to the oxygen concentrator. CNA N stated she would change the nasal cannula if it was soiled. CNA N stated she knew what to set the oxygen flow at by reviewing R29's care plan. CNA N stated the nasal cannula should be stored in a clear plastic bag attached to the oxygen concentrator when not in use.

On 02/07/24 at 10:09 AM Licensed Nurse (LN) G stated all staff had access to the care plan and Kardex. LN G stated the Kardex contained the information for R29's oxygen care and administration. LN G stated the oxygen tubing should be changed weekly7 and stored in the clear plastic bag attached to the wheelchair or oxygen concentrator when not in use by R29.

On 02/08/24 at 12:37 PM Administrative Nurse D stated oxygen tubing was changed weekly and should be stored in a clear plastic bag when not in use. Administrative Nurse D stated a nasal cannula should never be stored on the floor and should be replaced immediately.

The facility's "Oxygen Administration" policy reviewed 01/2017 documented that staff would verify that there was a physician's order for this procedure for oxygen administration; the date and time that the procedure was performed; the rate of oxygen flow and route; the frequency and duration of the treatment and the reason for as-needed administration.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 695 | Continued From page 48<br><br>The facility failed to ensure R29's there was an indication for oxygen administration and the oxygen tubing was stored in a sanitary manner to decrease exposure and contamination. This placed R29 at increased risk for respiratory infection and complications. | F 695 | | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. The sample included 14 residents with two residents reviewed for dialysis (a procedure where impurities or wastes were removed from the blood). Based on observation, record review, and interview, the facility failed to obtain Resident (R) 102's weight before hemodialysis (a machine filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) treatment. This placed R102 at risk for complications related to dialysis.<br><br>Findings included:<br><br>- The electronic medical record (EMR) for R102 documented diagnosis of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on renal dialysis. | F 698 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 698 | Continued From page 49 | F 698 | | |

R102's "Admission Minimum Data Set (MDS)" dated 12/21/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R102 was on dialysis at the time of admission.

R102's "Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA)" dated 12/27/23 documented she was skilled and was seen by therapy with the goal of returning home. Improvement was anticipated as she worked with therapy with the goal of returning home. R102 needed assistance with toileting and was incontinent.

R102's "Care Plan" initiated 12/16/23 directed staff to monitor weight before and after dialysis and then document weight on the resident's flowsheet and in the EMR. The care plan lacked direction for dialysis vascular access site care.

R102's EMR under the"Orders" tab revealed the physician order:
Monitor weight before and after hemodialysis, morning and at bedtime every Tuesday, Thursday, and Sunday dated 02/06/24.

A review of R102's EMR under the "Vital Sign" tab lacked evidence staff obtained a weight before dialysis on 02/06/24.

Observation 02/07/24 at 09:26 AM R102 walked in the hallway with the assistance of physical therapy.

On 02/08/24 at 11:19 AM Licensed Nurse (LN) G stated the nurse would complete an assessment that included vital signs and the weight of a resident before a dialysis appointment. LN G

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 698 | Continued From page 50<br>stated the vital signs and weight would be documented in the EMR.<br><br>On 02/08/24 at 12:37 PM Administrative Nurse D stated the nursing staff would document the vital signs and weight in the resident's EMR and on the dialysis communication form. Administrative Nurse D stated if the resident's EMR lacked the documentation of the weight, then it was not obtained.<br><br>The "Hemodialysis Access Care" policy revised in January 2017 documented that care involved the primary goals of preventing infection and maintaining patency of the catheter (a flexible tube inserted into a body cavity to remove fluid). The nurse should document in the EMR if the access site was a shunt (tube or device implanted in the body to redirect a body fluid from one cavity to another) the presence of thrill (a fine vibration felt which reflects the blood flow by a dialysis resident's shunt) and bruit (blowing or swishing sound heard when blood flows through a shunt). Notify the medical practitioner of any issues with the dialysis access site.<br><br>The facility failed to obtain R102's weight before hemodialysis treatment. This placed R102 at risk for complications related to dialysis. | F 698 | | |
| F 726 SS=E | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial | F 726 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 726 | Continued From page 51 | F 726 | | |

well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 54 residents. Based on record review and interview, the facility failed to ensure Licensed Nurse (LN) staff possessed the required skills and competencies to administer medication intravenously (IV-administered through a vein directly into the bloodstream). This placed all residents with IV medications at risk for medication errors and adverse outcomes. (Refer to F760)

Findings included:

- An "SBAR Communication Form and progress

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 726 | Continued From page 52 | F 726 | | |

note -V 2" under the "Assessments" tab in R47's EMR recorded in the Situation section, documented the wrong IV antibiotic was administered on 12/13/24. The form was signed by Administrative Nurse F on 12/15/24.

The facility's report "#74 Med Error," dated 12/13/23, documented the wrong IV antibiotic medication was administered to R47. The document further recorded R47 received Unasyn (antibiotic) instead of the ordered Rocephin. The document recorded that the IV medication was stopped, R47's provider was notified and R47 went to the hospital. The report documented "None" to the predisposing environment, physiological and situational factors. The report lacked a root cause analysis.

The facility provided a "Seminar/Training Sign-In Sheet" dated 12/20/23 which indicated education on the Five Rights of Medication Administration was provided by Administrative Nurse F.

A review of Administrative Nurse F's "Licensed Nurse Competency Validation Checklist" revised 08/2018 revealed Administrative Nurse F was hired on 10/31/23. The checklist listed a section for Procedures/Skills Checks. The section included validation sign-off for administration of eye drops, medications via a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach), nebulized (medications converted to mist for inhalation) medication, oral medication, oral inhalers, intramuscular (given via injection into a muscle) medications, subcutaneous (SQ- beneath the skin) medications, intradermal (given into the second layer of the skin) medication, transdermal ( through the skin) patches, eye ointment and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 726 | Continued From page 53 | F 726 | | |

insulin (hormone that lowers the level of glucose in the blood) via a flex pen from 11/02/23 through11/03/23. The competency validation checklist lacked a skill check for IV medication administration. The checklist did include the insertion of an IV catheter (a small tube inserted into the vein used to administer the medication directly into the bloodstream) and a peripherally inserted central catheter (PICC-a form of access directly into the bloodstream via a vein that can be used for a prolonged period) dressing change though those competencies were not documented as assessed.

Upon request for Administrative Nurse F's competency checks, the facility provided multiple checklists for Administrative Nurse F which included the following: "Skills Checklist for Head to Toe Assessment;" "Check Skin;" "Code Status Competency for Nurse;" "Elopement Process Competency;" "Fall Program Competency for nurses;" "Skills Checklist Handwashing;" "Skills Checklist Glucometer Cleaning;" "Skills Checklist Blood Glucose Monitoring;" and "Skills Checklist Personal Protective Equipment."

Upon request for Administrative Nurse F's computer-based training, the facility provided a list of trainings though none had to do with medication administration or IV medication administration.

On 02/08/24 at 12:01 PM Licensed Nurse (LN) I stated she was new to the facility and had only worked for a few weeks. LN I stated she had previous training on how to insert and administer medication through an IV before working at the facility. LN I stated that she did not receive any additional training or a skills check-off at the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 726 | Continued From page 54 | F 726 | | |

facility as she stated she already knew how to administer medications through an IV. LN I stated staff showed her where the supplies were and how to set everything up to start an IV but did not provide any additional training.

On 02/07/24 at 03:33 PM Administrative Nurse F stated the nurse on duty at the time of the incident was not IV certified and staff asked Administrative Nurse F to administer R47's IV ceftriaxone. Administrative Nurse F stated she went into the medication storage room to get the ceftriaxone and there was more than one type of IV antibiotic in the medication storage room. Administrative Nurse F stated she grabbed what she believed was the ceftriaxone and administered it to R47. Administrative Nurse F further stated she realized she had hung the wrong IV antibiotic, so she stopped the antibiotic, obtained vitals on R47, and contacted R47's doctor. Administrative Nurse F stated after the incident, staff education was provided on the five rights of medication administration (standard medication practice used to ensure the right patient, the right drug, the right time, the right dose, and the right route are correct before medications are administered), and risk management was completed. Administrative Nurse F stated the facility had adequate staff at the time of the event and she was unsure why she did not look to check for the right medication or the resident's name on the medication. Administrative Nurse F stated she felt perhaps she had too much going on.

On 02/07/24 at 03:40 PM Administrative Nurse D stated the five rights of medication administration were not followed which led to the medication error. Ad Administrative Nurse D verified the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 726 | Continued From page 55<br>facility had not attempted to determine why Administrative Nurse F did not follow the rights of medication administration and stated the facility did not assess each nurse's competency with IV medication administration as the LN would have learned the skill in school but went on to say the electronic training forum did have training for the topic.<br><br>The facility did not provide a policy on competency assessment for nurses.<br><br>The facility failed to ensure LN staff possessed the required skills and competencies to administer IV medication. This placed all residents with IV medications at risk for medication errors and adverse outcomes. (Refer to F760) | F 726 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a | F 758 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 758 | Continued From page 56 | F 758 | | |

specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 54 residents. The sample included 14 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure nonpharmacological attempts of symptom management prior to administering as-needed psychotropic (alters mood or thought) medication

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 758 | Continued From page 57 | F 758 | | |

for Resident (R) 10. The facility also failed to ensure a duration for an as-needed psychotropic medication for R101. These deficient practices placed these residents at risk for unnecessary psychotropic medication and related complications.

Findings included:

- R10's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and insomnia (inability to sleep).

The "Significant Change Minimum Data Set" (MDS) dated 07/17/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R10 had received antianxiety (class of medications that calm and relax people), anticoagulant (class of medications used to prevent the formation of blood clots), diuretic (medication to promote the formation and excretion of urine), and opioid (a class of medication used to treat pain) for seven days during the observation period.

The "Quarterly MDS" dated 01/17/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R10 had received antianxiety medication, anticoagulant medication, diuretic, and opioid medication during the observation period.

R10's "Psychotropic Drug Care Area Assessment" (CAA) dated 07/20/23 documented

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 758 | Continued From page 58 | F 758 | | |

R10 received routine antianxiety medication.

R10's "Care Plan" dated 06/08/23 documented staff would administer medications as ordered and monitor for any side effects.

R10's EMR under the "Orders" tab revealed the following physician orders:
Benadryl (allergy medication with hypnotic qualities used to induce sleep) allergy oral tablet 25 milligrams (mg) give two tablets by mouth every 24 hours as needed for insomnia dated 09/06/23.

Clonazepam (antianxiety medication)) oral tablet 0.5mg give one tablet by mouth every four hours as needed and administer at bedtime for insomnia dated 01/29/24.

Clonazepam oral tablet 0.5mg give one tablet by mouth every 4 hours as needed for insomnia for three days a second dose can be repeated in four hours for insomnia if needed dated 01/29/24.

R10's clinical record lacked evidence of documentation of any nonpharmacological attempts or person-centered attempts to manage the symptoms prior to the administration of the as-needed psychotropic medication for R10.

Observation on 02/06/24 at 10:53 AM R10 sat in her wheelchair in the dining room and drank a cup of coffee during the resident council meeting.

On 02/06/24 at 02:01 PM Administrative Nurse E stated behavior monitoring was documented on the "Treatment Administration Record" (TAR). Administrative Nurse E stated the facility did not document any person-specific

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 758 | Continued From page 59 | F 758 | | |

nonpharmacological attempts to manage symptoms of as-needed psychotropic medication.

On 02/08/24 at 11:19 AM Licensed Nurse (LN) G stated he was not aware of any documentation of nonpharmacological successful or unsuccessful attempts to manage a resident's symptoms prior to administering as-needed psychotropic medication.

On 02/08/24 at 12:37 PM Administrative Nurse D stated that nonpharmacological attempts to manage insomnia should be provided prior to administration of as-needed medication. Administrative Nurse D stated she expected staff to document the effects of the medication administered.

The facility's "Psychotropic Medication Use" policy last reviewed 09/2022 documented residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to antipsychotics; antidepressants; antianxiety; and hypnotics. The time frame for as-needed psychotropic medications, which are not antipsychotic medications, would be limited to 14 days unless a longer time frame was deemed appropriate by the attending physician or the prescribing practitioner.

The facility failed to ensure nonpharmacological attempts at symptom management prior to administering as-needed psychotropic medication for R10. This deficient practice placed her at risk for unnecessary psychotropic medication and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 758 | Continued From page 60 | F 758 | | |

related complications.

- R101's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of an anxiety disorder (a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder), and muscle weakness.

R101's "Admission Minimum Data Set (MDS)" completed 02/08/24 was in progress.

R101's "Care Area Assessment" (CAA) was in progress.

R101's "Care Plan" dated 02/04/24 directed staff to administer medication as ordered.

R101's EMR under the "Orders" tab revealed the following physician orders:
Lorazepam (antianxiety is a class of medications that calm and relax people)) oral tablet 0.5 milligrams (mg) give one tablet by mouth every six hours as needed for anxiety/agitation dated 02/06/24. The as-needed antianxiety medication lacked a 14-day stop date or a physician-ordered specific duration.

Observation on 02/06/24 at 09:04 AM R010 laid on her back on the bed, the head of the bed was elevated. R101 denied any pain or discomfort when asked.

On 02/08/24 at 11:119 AM Licensed Nurse (LN) G stated as needed psychotropic medication should have a 14-day stop date. LN G stated the duration would be clarified with the physician when the order was given.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 758 | Continued From page 61<br><br>On 02/08/24 at 12:37 PM Administrative Nurse D stated any as-needed psychotropic medication should only be scheduled for 14 days and then reordered if needed.<br><br>The facility's "Psychotropic Medication Use" policy last reviewed 09/2022 documented residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to antipsychotics; antidepressants; antianxiety; and hypnotics. The time frame for as-needed psychotropic medications, which are not antipsychotic medications, would be limited to 14 days unless a longer time frame was deemed appropriate by the attending physician or the prescribing practitioner.<br><br>The facility failed to ensure that R101's as-needed psychotropic lorazepam had a stop date or a physician-ordered specified duration for administration. This deficient practice placed R101 at risk for potential harm and adverse side effects related to unnecessary medications. | F 758 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. The sample included 14 residents with two | F 760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 760 | Continued From page 62 | F 760 | | |

reviewed for discharge. Based on observation, record review, and interviews, the facility failed to prevent a significant medication error when Resident (R) 47 received an incorrect antibiotic (medication used to treat bacterial infections) intravenously (IV-administered via the vein directly into the bloodstream). This placed the resident at risk for adverse drug effects and ineffective antibiotic therapy.

Findings included:

- R47's Electronic Medical Record (EMR) documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), fracture of the skull and facial bones, compression of the brain, and generalized muscle weakness.

The "Admission Minimum Data Set (MDS)" dated 11/05/23 documented a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. The MDS documented R47 used a walker and was independent for personal hygiene. R47 required substantial assistance, where the helper did more than half of the effort, for toileting hygiene, lower body dressing, and partial/moderate assistance with bathing and upper body dressing. The MDS documented R47 received an antibiotic.

The "Cognitive Loss / Dementia Care Area Assessment (CAA)" dated 11/05/23, documented R47 scored an 11 on her BIMS which indicated moderate cognitive impairment.

R47's "Care Plan" with an initiated date of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 760 | Continued From page 63 | F 760 | | |

11/23/23, documented R47 had impaired cognitive function and thought processes.

A review of R47's "Medication Administration Record" (MAR) from 12/01/23 - 12/31/23, documented an order for ceftriaxone sodium (Rocephin - an antibiotic used to treat bacterial infections in many different parts of the body) 1 gram every 24 hours for infection with a start date of 12/11/23 and an end date of 12/14/23. The MAR documented ceftriaxone sodium 1 gram was administered on 12/11/23, 12/12/23, and 12/13/23.

A "Health Status Note" dated 12/13/23, documented R47 received the wrong IV antibiotic.

An 'SBAR Communication Form and progress note -V 2" under the "Assessments" tab in R47's EMR recorded in the Situation section, documented the wrong IV antibiotic was administered on 12/13/24. The forms were signed by Administrative Nurse F on 12/15/24.

The facility's report "#74 Med Error," dated 12/13/23, documented the wrong IV antibiotic medication was administered to R47. The document further recorded R47 received Unasyn (antibiotic) instead of the ordered Rocephin. The document recorded that the IV medication was stopped, R47's provider was notified and R47 went to the hospital. The report documented "None" to the predisposing environment, physiological and situational factors. The report lacked a root cause analysis.

The facility provided a "Seminar/Training Sign-In Sheet" dated 12/20/23 which indicated education on the Five Rights of Medication Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 760 | Continued From page 64 | F 760 | | |

was provided by Administrative Nurse F.

On 02/07/24 at 03:33 PM Administrative Nurse F stated the nurse on duty at the time of the incident was not IV certified and staff asked Administrative Nurse F to administer R47's IV ceftriaxone. Administrative Nurse F stated she went into the medication storage room to get the ceftriaxone and there was more than one type of IV antibiotic in the medication storage room. Administrative Nurse F stated she grabbed what she believed was the ceftriaxone and administered it to R47. Administrative Nurse F further stated she realized she had hung the wrong IV antibiotic, so she stopped the antibiotic, obtained vitals on R47, and contacted R47's doctor. Administrative Nurse F stated after the incident, staff education was provided on the five rights of medication administration (standard medication practice used to ensure the right patient, the right drug, the right time, the right dose, and the right route are correct before medications are administered), and risk management was completed. Administrative Nurse F stated the facility had adequate staff at the time of the event and she was unsure why she did not look to check for the right medication or the resident's name on the medication. Administrative Nurse F stated she felt perhaps she had too much going on.

On 02/07/24 at 03:40 PM Administrative Nurse D stated the five rights of medication administration were not followed which led to the medication error. Administrative Nurse D further stated the IV antibiotic was not checked before administration as Administrative Nurse F assumed the antibiotic was correct when it was obtained from the medication storage room. Administrative Nurse D

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 760 | Continued From page 65<br>stated Administrative Nurse F tried to help, but she did not check the antibiotic before administration. Administrative Nurse D verified the facility had not attempted to determine why Administrative Nurse F did not follow the rights of medication administration.<br><br>The facility provided a "General Dose Preparation and Medication Administration" policy with a revision date of 01/01/22, which documented facility staff should comply with facility policy, applicable law, and the State Operations Manual when administering medications. The policy further documented that facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record.<br><br>The facility failed to prevent a significant medication error when R47 received an incorrect IV antibiotic. This placed the resident at risk for adverse drug effects and ineffective antibiotic therapy. | F 760 | | |
| F 838 SS=F | Facility Assessment<br>CFR(s): 483.70(e)(1)-(3)<br><br>§483.70(e) Facility assessment.<br>The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must | F 838 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 838 | Continued From page 66 | F 838 | | |

address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 838 | Continued From page 67<br>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.<br><br>§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. Based on observation, record review, and interviews, the facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 54 residents residing in the facility.<br><br>Findings included:<br><br>- A review of the "Facility Assessment" dated 06/07/23 provided by the facility revealed the assessment listed the number and types of admissions for the past year to date. The assessment sections were not completed in the sections that documented the staffing level, competencies required, equipment, and physical or environmental needs to address the facility's specific resident population and acuity.<br><br>On 02/08/24 at 02:37 PM Administrative Staff A stated he was not aware the assessment of the facility did not meet the requirements needed to determine the staff and other critical elements necessary for the care of the residents that resided in the facility. | F 838 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 838 | Continued From page 68<br>On 02/08/24 at 02:54 PM Administrative Staff B reviewed the "Facility Assessment" that was provided during the survey and confirmed it lacked necessary elements.<br><br>The facility did not provide a policy related to the development of a facility assessment.<br><br>The facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 54 residents residing in the facility. | F 838 | | |
| F 849 SS=D | Hospice Services<br>CFR(s): 483.70(o)(1)-(4)<br><br>§483.70(o) Hospice services.<br>§483.70(o)(1) A long-term care (LTC) facility may do either of the following:<br>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.<br>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.<br><br>§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:<br>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and | F 849 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 849 | Continued From page 69 | F 849 | | |

to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 849 | Continued From page 70 | F 849 | | |

resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 849 | Continued From page 71 | F 849 | | |

LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Hospice election form.

(C) Physician certification and recertification of the terminal illness specific to each patient.

(D) Names and contact information for hospice personnel involved in hospice care of each patient.

(E) Instructions on how to access the hospice's 24-hour on-call system.

(F) Hospice medication information specific to each patient.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 849 | Continued From page 72<br>(G) Hospice physician and attending physician (if any) orders specific to each patient.<br>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.<br><br>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 54 residents. The sample included 14 residents with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider, and a failed to provide a description of the services, medication, and equipment provided to Resident (R) 29 by hospice. This deficient practice created a risk for missed or delayed services and impaired physical, and psychosocial care for R29.<br><br>Findings included:<br><br>- R29's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of weakness, need for assistance with personal care, chronic respiratory failure, emphysema (a long-term, progressive disease of the lungs | F 849 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 849 | Continued From page 73 | F 849 | | |

characterized by shortness of breath), muscle weakness, lack of coordination, and difficulty in walking.

The "Admission Minimum Data Set" (MDS) dated 12/22/23 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R29 was dependent on staff assistance for transfers from chair/bed-to-chair transfers. The MDS documented R29 received oxygen during the observation period.

The " Significant Change MDS" was in progress.

R29's "Functional Abilities Care Area Assessment" (CAA) dated 12/30/23 documented she required assistance with her activities of daily living.

R29's "Care Plan" dated 01/26/24 documented the facility would consult with the physician and social services to have hospice care for R29. R29's "Care Plan" dated 01/31/24 documented hospice would manage the plan of care to include treatment and medications. The plan of care lacked the name of the hospice provider and a description of the services provided by the hospice.

R29's EMR under the "Orders" tab revealed the following physician order:
Hospice to evaluate and treat as indicated dated 01/24/24.

A review of the communication book provided by hospice lacked a hospice care plan, signed admission paperwork with the physician documentation of a terminal diagnosis for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 849 | Continued From page 74 | F 849 | | |

admission to hospice services, services or equipment that would be provided, and medications that were covered by hospice.

Observation on 02/07/24 at 08:33 AM R29 requested a pink disposable pad be placed on the bed. Certified Nurse Aide (CNA) N told R29 she was out of disposable pads and staff would have to notify R29's family to bring more to the facility. CNA N placed a gait belt around R29's waist, and using the gait belt, assisted R29 into a partial standing position, then pivoted R29 onto the bed.

On 02/07/24 at 08:40 AM Certified Nurse Aide (CNA) N stated the staff had access to the plan of care and Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA N stated R29 had just recently been admitted to hospice services. CNA N stated she did not know what supplies the hospice provided. CNA N stated she would let the nurse know if R29 needed supplies.

On 02/07/24 at 10:09 AM Licensed Nurse (LN) G stated all staff had access to the care plan and Kardex. LN G stated the Kardex contained the information for R29's hospice services. LN G reviewed the hospice communication book for R29 and confirmed the communication book lacked a hospice care plan, signed admission paperwork with the admitting terminal diagnosis for admission to hospice services, services hospice would provide, and medication covered by hospice.

On 02/07/24 at 12:09 PM Administrative Nurse D stated R29 had been admitted to hospice on a weekend so the facility had overlooked updating the care plan. Administrative Nurse D stated the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 849 | Continued From page 75<br>hospice provider had been contacted and the provider faxed the admission paperwork with the physician's order for hospice admission, along with the care plan which covered the services provided and the list of medication that would be covered by hospice.<br><br>The facility was unable to provide a policy related to hospice.<br><br>The facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider and failed to provide a description of the services, medication, and equipment provided to R29 by hospice. This deficient practice placed R29 at risk for delayed services which could affect her mental, and psychosocial well-being. | F 849 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 880 | Continued From page 76 | F 880 | | |

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 880 | Continued From page 77 | F 880 | | |

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 54 residents. Based on observation, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to the implementation of procedures to monitor and prevent Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations) or other opportunistic waterborne pathogens and failed to ensure sanitary storage of respiratory equipment. These deficient practices placed the residents at risk for complications related to infectious diseases.

Findings included:

- Observation on 02/07/24 at 08:33 AM Certified Nurse Aide (CNA) N pushed R29 in the wheelchair into R29's room and stepped onto the nasal cannula on the floor as she pulled the bedding down on R29's bed. CNA N moved the nasal cannula from the floor and placed the cannula onto the oxygen concentrator. CNA N removed the oxygen tubing connected to the portable oxygen tank from R29's nose and placed the oxygen tubing in a plastic bag that was attached to R29's wheelchair. CNA N placed a gait belt around R29's waist, and using the gait belt, assisted R29 into a partial standing position,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 880 | Continued From page 78 | F 880 | | |

then pivoted R29 onto the bed. CNA N then placed the oxygen nasal cannula that was stepped on into R29's nostrils.

On 02/07/24 the facility provided a policy related to Legionella testing but was unable to provide a risk assessment with a diagram of the facility water flow map that identified weak areas. The policy lacked a plan for empty rooms, the frequency of monitoring the at-risk areas, or who was responsible for the monitoring.

On 02/07/24 at 08:40 AM Certified Nurse Aide (CNA) N stated the oxygen tubing was not on the floor but was wrapped around the oxygen concentrator. CNA N stated it was not stored in the plastic bag attached to the oxygen concentrator. CNA N stated she would change the nasal cannula if it was soiled. CNA N stated she knew what to set the oxygen flow at by reviewing R29's care plan. CNA N stated the nasal cannula should be stored in a clear plastic bag attached to the oxygen concentrator when not in use.

On 02/07/24 at 10:09 AM Licensed Nurse (LN) G stated all staff had access to the care plan and Kardex. LN G stated the Kardex contained the information for R29's oxygen care and administration. LN G stated the oxygen tubing should be changed weekly7 and stored in the clear plastic bag attached to the wheelchair or oxygen concentrator when not in use by R29.

On 02/08/24 at 11:45 AM Maintenance Director U provided a diagram that lacked a map of the facility's water flow which identified the at-risk areas.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 880 | Continued From page 79<br>On 02/08/24 at 12:37 PM Administrative Nurse D stated oxygen tubing was changed weekly and should be stored in a clear plastic bag when not in use. Administrative Nurse D stated a nasal cannula should never be stored on the floor and should be replaced immediately.<br><br>On 02/08/24 at 02:37 PM Administrative Staff A stated he was not aware the water management plan/policy did not meet the required components for the monitoring and prevention of Legionella disease and other opportunistic waterborne pathogens.<br><br>The facility's "Oxygen Administration" policy reviewed 01/2017 documented that staff would verify that there was a physician's order for this procedure for oxygen administration; the date and time that the procedure was performed; the rate of oxygen flow and route; the frequency and duration of the treatment and the reason for as-needed administration.<br><br>The facility failed to implement appropriate infection control practices. This placed the residents at risk for transmission of infectious diseases. | F 880 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; | F 883 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 883 | Continued From page 80<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits | F 883 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 883 | Continued From page 81 | F 883 | | |

and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 54 residents. The sample included 14 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to provide Resident (R)39 with the pneumococcal conjugate vaccine (PCV20- vaccination for bacterial lung infections) as consented. This placed R39 at increased risk for complications related to pneumonia ( bacterial infection in the lungs).

Findings included:

R39's Electronic Medical Record (EMR) revealed he was eligible and within the required vaccination date range to receive the PCV20 vaccination.

R39's EMR under the "Misc" tab revealed he gave verbal consent on a "Pneumococcal Vaccination" form to receive the PCV20 vaccination on 10/11/23. The form indicated R39 was provided educational information related to the vaccination but never received the PCV20 vaccination. The facility was unable to provide evidence the PCV20 was administered to R39 upon request.

On 02/05/24 at 07:25 AM Administrator Staff A stated Administrative Nurse E was responsible for tracking resident vaccinations.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STRATFORD COMMONS REHAB & HEALTH CARE CENTER | 12340 QUIVIRA ROAD OVERLAND PARK, KS 66213 |

| (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 883 | Continued From page 82<br><br>On 02/08/24 at 11:34 AM Administrative Nurse E, the facility's infection preventionist, stated vaccinations are offered at the time of admission. Administrative Nurse E stated the vaccination was ordered from the pharmacy if a resident consented to receive the vaccination. Administrative Nurse E stated the vaccination was then placed as an order on the "Medication Administration Record" (MAR), then administered to the resident upon delivery from the pharmacy and updated under the "Immunization" tab in the resident's EMR.<br><br>On 02/08/24 at 12:37 PM Administrative Nurse D stated immunizations were tracked at the time of admission and administered to the resident. Administrative Nurse D stated the resident's EMR was updated under the "Immunization" tab once the vaccination was given.<br><br>The facility's "Pneumococcal Vaccine" policy revised 08/2008 indicated all residents will be offered the pneumococcal vaccine to aid in preventing pneumococcal infections. The policy indicated the facility will provide an assessment upon admission to identify each resident's eligibility and when indicated. The policy indicates the facility will offer and document the consent, refusal, and maintain documentation related to the vaccination given. The policy indicated the facility will follow the Centers for Disease Control and Prevention (CDC) recommendations for vaccinations.<br><br>The facility failed to provide R39 with the PCV20 vaccination as consented. This placed R39 at increased risk for complications related to pneumonia. | F 883 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175549 | A. BUILDING _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STRATFORD COMMONS REHAB & HEALTH CARE CENTER** | **12340 QUIVIRA ROAD OVERLAND PARK, KS 66213** |

| (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 |
|---|---|---|---|---|
| | | | | |