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	175122	A. BUILDING _____ B. WING _____	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint #KS00186730. The 2567 was sent electronically on 04/04/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		

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

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

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interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 151 residents. The sample included 31 residents with one reviewed for dignity. Based on observation, record review, and interview the facility failed to treat Resident (R) 115 with dignity in one of five dining rooms, during the noon meal when staff stood over R115 while assisting him to eat. This placed the resident at risk for an undignified experience.

Findings included:

- On 03/25/24 at 11:39 AM, observation in the 300-hall dining room revealed Certified Nurse Aide (CNA) M served R115 a plate of food. CNA M stood over R115 and gave the resident bites of food. CNA M left the table several times during the noon meal to do other tasks and then returned to R115's table, stood over him, and gave him bites of food.

On 03/25/24 at 12:05 PM, Certified Dietary Manager (CDM) BB stated staff should sit in a chair next to R115 when assisting him with eating, not stand over him.

On 03/26/24 at 04:30 PM, Administrative Nurse D stated she expected staff to sit by the resident face to face when assisting the resident to eat.

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F 550	Continued From page 2 Administrative Nurse D stated staff should try to converse with the resident and that staff should not leave the table to go do other tasks until the resident was finished eating. The facility's "Resident Rights Policy," undated, documented the right to be treated with dignity and respect was the foundation on which all other resident rights and responsibilities were based. The facility failed to treat R115 with dignity when staff stood over him at the 300-hall dining room table during assisted dining. This placed the resident at risk for an undignified experience.	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		

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made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 151 residents. The sample included 31 residents with four reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to provide written notice for facility-initiated transfer to

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Resident (R) 68, R347, and R75 or their representatives, when they were transferred to the hospital. This placed the residents at risk for uninformed care choices.

Findings included:

- R68's Electronic Medical Record (EMR) documented R68 had a diagnosis of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections)

R68's "Admission Minimum Data Set" (MDS), dated 10/18/23, documented R68 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented the resident required substantial to maximal staff assistance with toileting and personal hygiene.

The " Urinary Incontinence Care Area Assessment" (CAA), dated 10/18/23, documented R68 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and instructed staff to monitor R68 for urinary tract infections (UTI-an infection in any part of the urinary system).

R68's "Care Plan," revised 10/18/23, documented R68 had an indwelling catheter and instructed staff to provide catheter care as needed (PRN) and encourage R68 to drink fluids to reduce UTI risks.

The "Progress Note," dated 03/04/2024 at 05:10 PM, documented R68 was admitted to the hospital.

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A review of R68's clinical record lacked evidence the resident or representative was provided written notice when he was transferred to the hospital.

On 03/25/24 at 04:22 PM, observation revealed R68 sat quietly in a wheelchair in his room. His indwelling foley catheter was in a privacy bag hooked on the wheelchair and the urine in the tubing had clear yellow urine.

On 03/26/24 at 10:39 AM, Administrative Staff B verified the facility lacked documentation R68 or his representative was provided written notice when the resident was transferred to the hospital. Administrative Staff B stated nursing was responsible for sending the bed hold policy with transfer papers to the hospital and she did not follow up on obtaining the signed notice.

On 03/26/24 at 10:45 AM, Administrative Nurse D stated verified the facility lacked documentation R68, or their representative was provided a written notice when the resident was transferred to the hospital.

Upon request, the facility failed to provide a policy regarding facility-initiated transfers to the hospital.

The facility failed to provide R68 or his representative written notice regarding R68's facility-initiated transfer to the hospital. This placed the resident and/or her representative at risk of uninformed care choices.

- R347's Electronic Medical Record (EMR) documented R347 had a diagnosis of disorders

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of the lungs,

R347's "Admission Minimum Data Set" (MDS), dated 01/05/24, documented R347 had a Brief Interview of Mental Status score of 15, which indicated intact cognition. The MDS documented R347 was dependent on staff for toileting, showering, lower body dressing, putting on and taking off footwear, and transfers. R347 required partial to moderate staff assistance with oral care and personal hygiene; R347 required substantial to maximal staff assistance with upper body dressing and bed mobility.

R347's " Care Plan," revised 01/05/24, instructed staff to change the oxygen tubing and water reservoir per facility protocol and administer oxygen as the physician ordered. Staff monitored R347's oxygen saturation as the physician ordered and notified the physician of abnormal readings. The care plan instructed staff to monitor R347 for shortness of breath during activity participation.

The "Progress Note," dated 03/08/24 at 07:12 AM, documented R347 was admitted to the hospital.

A review of R347" 's clinical record lacked evidence the resident or representative was provided written notice when R347 was transferred to the hospital.

On 03/25/24 at 03:46 PM, observation revealed R347 sat in bed with oxygen on per nasal cannula.

On 03/26/24 at 10:39 AM, Administrative Staff B verified the facility lacked documentation R347 or

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his representative was provided written notice of the transfer to the hospital.

On 03/26/24 at 10:45 AM, Administrative Nurse D verified the facility lacked documentation R347, or the representative was provided a written notice when R347 was transferred to the hospital.

Upon request, the facility failed to provide a policy for facility-initiated transfer to the hospital.

The facility failed to provide R347 or his representative written notice regarding R347's facility-initiated transfer to the hospital. This placed the resident and/or her representative at risk of uninformed care choices.

- R75's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made, or the body cannot respond to the insulin), heart failure, hypertension (high blood pressure), and iron deficiency (too little iron in the body).

The "Quarterly Minimum Data Set" (MDS), dated 02/28/24, documented R75 had severely impaired cognition and required substantial/maximum assistance for dressing, transfer, toileting, and partial/moderate assistance for personal hygiene.

R75's "Care Plan," dated 03/12/24 and initiated on 04/12/23, documented R75 had a potential for cardiovascular problems and directed staff to administer medications as ordered, monitor vital signs as ordered, and notify the physician of any abnormal readings.

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The "Nurse's Note," dated 08/21/23 at 09:39 PM, documented R75 was admitted to the hospital on 08/16/23.

A review of R75's clinical record lacked evidence the resident or representative was provided written notice when she was transferred to the hospital.

On 03/26/24 at 08:55 AM, observation revealed R75 sat in her wheelchair and talked on the telephone in her room.

On 03/26/24 at 10:45 AM, Licensed Nurse (LN) G stated the nurse sent the bed hold policy with the resident when they went to the hospital. LN G said the staff called the resident's representative but would not send a written notice.

On 03/26/24 at 10:39 AM, Administrative Staff B stated the nurse sent the bed hold policy with transfer papers to the hospital.

On 03/26/24 at 10:45 AM, Administrative Nurse D stated the nurse sent a bed hold with residents when they were transferred to the hospital; medical records were responsible for receiving it back. Administrative Nurse D verified the facility did not notify the resident's representative in writing regarding transfers to the hospital and the reason for the transfer.

The facility's "Bed Hold" policy, undated, documented the facility notified the resident and/or representative of the bed hold policy in writing at the time of admission when transferred to the hospital or during therapeutic leave, as well as the intent for readmission according to state and federal regulations.

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F 623	Continued From page 10 The facility failed to provide R75 or her representative written notice regarding R75's facility-initiated transfer to the hospital. This placed the resident and/or her representative at risk for uninformed care choices.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		

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by:
The facility had a census of 151 residents. The sample included 31 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 68, R347, and R75 or their representative with written information regarding the facility bed hold policy when they were transferred to the hospital. This placed the residents at risk of not being permitted to return and resume residence in the nursing facility.

Findings included:

- R68's Electronic Medical Record (EMR) documented R68 had a diagnosis of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections)

R68's "Admission Minimum Data Set" (MDS), dated 10/18/23, documented R68 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented the resident required substantial to maximal staff assistance with toileting and personal hygiene.

The " Urinary Incontinence Care Area Assessment" (CAA), dated 10/18/23, documented R68 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and instructed staff to monitor R68 for urinary tract infections (UTI-an infection in any part of the urinary system).

R68's "Care Plan," revised 10/18/23, documented R68 had an indwelling catheter and instructed

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staff to provide catheter care as needed (PRN) and encourage R68 to drink fluids to reduce UTI risks.

The "Progress Note," dated 03/04/2024 at 05:10 PM, documented R68 was admitted to the hospital.

A review of R68's clinical record lacked evidence the resident or representative was provided the bed hold policy when he was transferred to the hospital.

On 03/25/24 at 04:22 PM, observation revealed R68 sat quietly in a wheelchair in his room. His indwelling foley catheter was in a privacy bag hooked on the wheelchair and the urine in the tubing had clear yellow urine.

On 03/26/24 at 10:39 AM, Administrative Staff B verified the facility lacked documentation R68, or his representative was provided the bed hold policy when R68 was transferred to the hospital. Administrative Staff B stated nursing was responsible for sending the bed hold policy with transfer papers to the hospital and she did not follow up on obtaining the signed notice.

On 03/26/24 at 10:45 AM, Administrative Nurse D verified the facility lacked documentation R68, or their representative was provided the bed hold policy when the resident was transferred to the hospital.

The facility's " Bed Hold Policy," undated, documented the facility would inform and give a written copy of this policy to the resident and/or representative upon admission and if transferred to a hospital or during therapeutic leave.

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The facility failed to provide R68 or his representative with the bed hold policy when R68 was transferred to the hospital. This placed the resident and/or her representative at risk of uninformed care choices.

- R347's "Electronic Medical Record" (EMR) documented R347 had a diagnosis of disorders of the lungs.

R347's "Admission Minimum Data Set" (MDS), dated 01/05/24, documented R347 had a Brief Interview of Mental Status score of 15, which indicated intact cognition. The MDS documented R347 was dependent on staff for toileting, showering, lower body dressing, putting on and taking off footwear, and transfers. R347 required partial to moderate staff assistance with oral care and personal hygiene; R347 required substantial to maximal staff assistance with upper body dressing and bed mobility.

R347's " Care Plan," revised 01/05/24, instructed staff to change the oxygen tubing and water reservoir per facility protocol and administer oxygen as the physician ordered. Staff monitored R347's oxygen saturation as the physician ordered and notified the physician of abnormal readings. The care plan instructed staff to monitor R347 for shortness of breath during activity participation.

The "Progress Note," dated 03/08/24 at 07:12 AM, documented R347 was admitted to the hospital.

A review of R347"s clinical record lacked

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evidence the resident or representative was provided the bed hold policy when R347 was transferred to the hospital.

On 03/25/24 at 03:46 PM, observation revealed R347 sat in bed with oxygen on per nasal cannula.

On 03/26/24 at 10:39 AM, Administrative Staff B verified the facility lacked documentation R347, or his representative was provided the bed hold policy when R347 was transferred to the hospital.

On 03/26/24 at 10:45 AM, Administrative Nurse D verified the facility lacked documentation R347, or the representative was provided the bed hold policy when R347 was transferred to the hospital.

The facility's " Bed Hold Policy," undated, documented the facility would inform and give a written copy of this policy to the resident and/or representative upon admission and if transferred to a hospital or during therapeutic leave.

The facility failed to provide R347 or his representative with the bed hold policy when R347 was transferred to the hospital. This placed the resident and/or her representative at risk of uninformed care choices.

- R75's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made, or the body cannot respond to the insulin), heart failure, hypertension (high blood pressure), and iron deficiency (too little iron in the body).

The "Quarterly Minimum Data Set" (MDS), dated

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02/28/24, documented R75 had severely impaired cognition and required substantial/maximum assistance for dressing, transfer, toileting, and partial/moderate assistance for personal hygiene.

R75's "Care Plan," dated 03/12/24 and initiated on 04/12/23, documented R75 had a potential for cardiovascular problems and directed staff to administer medications as ordered, monitor vital signs as ordered, and notify the physician of any abnormal readings.

The "Nurse's Note," dated 08/21/23 at 09:39 PM, documented R75 was admitted to the hospital on 08/16/23.

A review of R75's clinical record lacked evidence the resident or representative was provided the facility's bed hold policy when R75 went to the hospital.

On 03/26/24 at 08:55 AM, observation revealed R75 sat in her wheelchair and talked on the telephone in her room.

On 03/26/24 at 10:45 AM, Licensed Nurse (LN) G stated the nurse sent the bed hold policy with the resident when they went to the hospital. LN G said the staff called the resident's representative but would not send a written notice.

On 03/26/24 at 10:39 AM, Administrative Staff B stated the nurse sent the bed hold policy with transfer papers to the hospital.

On 03/26/24 at 10:45 AM, Administrative Nurse D stated the nurse sent a bed hold with residents when they were transferred to the hospital;

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F 625	Continued From page 16 medical records were responsible for receiving it back. Administrative Nurse D verified the facility did not notify the resident's representative in writing regarding transfers to the hospital and the reason for the transfer. The facility's "Bed Hold" policy, undated, documented the facility permits residents to return to the facility after they are hospitalized or placed on therapeutic leave and if a resident who was hospitalized exceeds the bed-hold period under the State plan, may return to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility and was eligible for Medicare/Managed Care skilled nursing services or Medicaid. The facility failed to provide R75 or his representatives with the bed hold policy when they were transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 645		

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performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in

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the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 151 residents. The sample included 31 residents. Based on observation, interview, and record review the facility failed to ensure Residents (R) 87, R68, and R110 received a Preadmission Screening and Resident Review (PASRR- a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) to identify potential care needs related to a mental disorder (MD) or intellectual disability (ID). This placed the residents at risk for unidentified needs and inadequate care.

Findings included:

- R87's Electronic Medical Record (EMR) documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), asthma (a disorder of narrowed airways that caused wheezing and shortness of breath), and bipolar disorder (a major mental illness that caused people to have

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episodes of severe high and low moods).

The "Quarterly Minimum Data Set" (MDS), dated 01/14/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R87 had no mood or behaviors during the observation period. R87 required set up for eating, verbal cues for bathing, and dressing, and moderate assistance for toileting, and transfers.

R87's "Care Plan," dated 3/16/24, stated he preferred to stay in his room and was most comfortable when around familiar people. He would occasionally attend the group setting although he tended to leave early related to emotional comfort as big groups made him anxious.

R87's clinical record lacked evidence a PASRR was completed.

On 03/26/24 at 07:40 AM, observation revealed R87 independently ate hot cereal while holding the bowl in his lap.

On 3/26/24 at 08:20 AM, Administrative Staff A stated the resident was admitted from the Veteran's Administration (VA) and the VA did not perform a PASRR.

Upon request, the facility did not provide a policy.

The facility failed to ensure a PASRR was completed for R87 before admission. This placed the residents at risk for unidentified needs and inadequate care.

- R68's Electronic Medical Record (EMR)

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documented diagnoses of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).

R68's "Admission Minimum Data Set" (MDS), dated 02/07/23, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R68 had no mood or behaviors during the observation period. The MDS documented R68 required substantial to maximal staff assistance with activities of daily living (ADLs).

R68's "Care Plan," revised 09/12/23, documented R68 preferred privacy when staff provided care as well as when discussing personal issues and instructed staff to provide care in a calm, patient, non-judgmental manner. Staff were to explain what task was to be done before beginning the task.

R68's clinical record lacked evidence a PASRR was completed.

On 03/25/24 at 04:22 PM, observation revealed R68 sat quietly in a wheelchair in his room.

On 3/26/24 at 08:20 AM, Administrative Staff A stated the resident was admitted from the Veteran's Administration (VA) and the VA did not perform a PASRR.

Upon request, the facility did not provide a policy.

The facility failed to ensure a PASRR was

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completed for R68 before admission. This placed the residents at risk for unidentified needs and inadequate care.

- R110 was admitted to the facility on 05/04/23.

R110's Electronic Health Record (EHR), recorded the diagnoses of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress,) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear.)

R110's "Quarterly Minimum Data Set" (MDS), dated 01/18/24, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, with intact cognition. The MDS documented the resident had verbal behaviors directed towards others.

R110's "Care Plan," dated 03/21/24, indicated R110 had a history of behavioral symptoms and had a history of being manipulative, making statements that were exaggerated or false about events, care, and medications, and often wanting to manipulate staff's time.

R110's EHR lacked evidence a PASRR assessment was completed as required.

The facility was unable to provide a PASRR screening for R110 upon request.

On 03/25/24 at 02:10 PM, observation revealed

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F 645	Continued From page 22 R110 sat in a recliner in his room watching TV. On 03/26/24 at 08:20 AM, Administrative Staff A verified R110 lacked a PASRR assessment before admission to the facility. Administrative Nurse D stated the resident was from the Veterans Hospital (VA) and the VA did not assess for PASRR upon admission. Upon request, the facility did not provide a policy. The facility failed to adequately assess the resident for placement in the facility by obtaining a PASRR screening as required. This placed R110 at risk for inadequate facility care and unidentified needs.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). 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	F 657		

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resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 151 residents. The sample included 31 residents. Based on observation, record review, and interview, the facility failed to revise the care plan with trauma triggers and coping strategies for Resident (R)50 who had post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) which placed the resident at risk for impaired care due to uncommunicated care needs.

Findings included:

- Resident (R) 50's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), 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 (a language disorder that affects ability to communicate), post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress),

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major depressive disorder (major mood disorder which causes persistent feelings of sadness), Wernicke's encephalopathy (impaired coordination movement and eye dilated veins).

R50's "Quarterly Minimum Data Set" (MDS), dated 01/21/24, documented that staff assessed R50's cognition as moderately impaired. R50 rejected care one to three days of the look-back period. R50 received an antidepressant (medication used to treat mood disorders) and was independent with most activities of daily living.

The "Behavioral Symptoms Care Area Assessment" (CAA), dated 08/21/23, documented R50 had multiple episodes of refusing care such as showers. R50's family was very involved and encouraged R50 to participate.

R50's "Care Plan," dated 02/27/24, documented R50 had problems with short-term memory due to the diagnosis of dementia. The care plan directed staff always to tell R50 what staff were going to do before initiating nursing care and to encourage R50 to talk about her life, past experiences, career, and family.

R50's admission information documented R50 had a 70 percent (%) disability through the Veteran Administration (VA).

The facility's "Social Service Quarterly Long-Term Observation", dated 11/17/22, documented a trauma screening which recorded R50 answered "No" when asked about a history of traumatic events.

The "Progress Note" dated 12/27/23 at 01:49 PM,

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documented R50's family called the facility regarding R50 being upset. R50 indicated that someone had spoken mean to her, and she wanted someone to pick her up from the facility. The note further documented R50's roommate had been using profanities toward staff and R50's family inquired about a private room.

On 03/26/24 at 08:17 AM, observation revealed R50 remained in bed, covered with several blankets. She had a breakfast tray sitting on her overbed table.

On 03/26/24 at 02:20 PM, Social Service X stated most of the facility's residents were admitted from Veteran Administration (VA) referrals and usually had PTSD. Social Service X had not assessed or gathered information related to R50's triggers of past trauma nor had she spoken to R50's family about possible triggers to prevent re-traumatization.

On 03/26/24 at 02:20 PM, Administrative Staff Nurse E verified that R50's "Care Plan" had behaviors of obsessive cleaning noted but did not specifically address R50's trauma issues.

On 03/26/24 at 04:29 PM, Administrative Nurse D stated residents with a diagnosis of PTSD were not assessed for triggers on admission, only when the residents showed some sort of symptoms such as depression, flashbacks, or anxiety. Administrative Nurse D said if those symptoms occurred, she expected her staff to conduct a PTSD assessment.

The facility's "Trauma Informed Care and Behavioral Health Management" policy, dated 09/2019, documented it is the philosophy of the

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F 657	Continued From page 26 facility to assist in the early identification of residents' past traumatic events/behaviors and to develop and implement interventions to manage or de-escalate those behaviors. Any actual or potential areas of concern identified by the social worker based on the interview will be documented and communicated with the nurse, nursing administration, behavior management committee, and care planned. Care Plans will be communicated to all direct caregivers to avoid triggers for the residents and promote their mental and psychological well-being. The facility failed to identify and implement interventions for R50's diagnosed PTSD, which placed the resident at risk of uncommunicated care needs.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §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 §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. §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.	F 688		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 151 residents. The sample included 31 residents, of which one was reviewed for mobility and positioning. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 53 received appropriate treatment and services to maintain and prevent a decline in mobility and ambulation. This placed the resident at risk for a decline in mobility and impaired independence.

Findings included:

- R53's Electronic Health Record (EHR), recorded the diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

R53's "Admission Minimum Data Set" (MDS), dated 12/12/23, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment revealed the resident required partial to moderate assistance with activities of daily living (ADLs) and supervision to walk 50 to 150 feet.

R53's "Care Plan," dated 12/07/23, directed staff to assist the resident with dressing but lacked any direction for therapy or restorative assistance.

R53's "Restorative Therapy Plan of Care," dated 03/09/24, documented the restorative aide would

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	175122	A. BUILDING _____ B. WING _____	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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assist the resident to walk two to three times a week using the platform walker in the therapy gym with a gait belt for 100 feet, twice with stand-by assistance.

A review of the "Restorative Flowsheet" documentation revealed the resident refused to walk on 03/26/24 and lacked documentation the resident was provided or asked to participate in ambulation from 03/09/24 until 03/26/24.

On 03/25/24 at 11:00 AM, observation revealed the resident sat in a recliner in her room. She was dressed in street clothes and had her feet elevated.

On 03/26/24 at 07:30 AM, Physical Therapist (PT) HH stated the resident received physical therapy from admission 12/05/23 until 03/09/24. PT HH stated the therapists developed a restorative program for R53 on 03/09/24 and the restorative aide would continue the resident's restorative program 2-3 times a week. PT HH stated the facility had one restorative aide to complete restorative on all the residents in the facility who required restorative services.

On 03/26/24 at 02:10 PM, Administrative Nurse E verified the physical therapists completed the resident's therapy and then the therapist developed a restorative program. Administrative Nurse E stated the restorative aide would document the restorative services in the EHR. Administrative Nurse E verified the resident had not received any of the directed restorative services since 03/09/24 when the therapist developed the restorative program for the resident.

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The facility's "Restorative Therapy Program" policy, dated May 2021, documented the facility would assist each resident to attain and or maintain their individual highest most practicable functional level of independence and well-being, in accordance with State and Federal regulations. Each resident would be screened and evaluated by the nurse or therapist designated to oversee the restorative nursing process for inclusion into the appropriate facility restorative nursing program when it has been identified by the interdisciplinary team that the resident is in need or may benefit from such program. The facility's restorative nursing program would include, but not be limited to hygiene, mobility including ambulation, dining, and communication. The restorative program would be documented on the facility-designated restorative care form and tools in the resident's electronic medical record. The designated nurse would be responsible for obtaining orders for the resident's restorative program and documentation every month. The therapist would be responsible for initiating and updating restorative care plans and the designated nurse or therapist would continue to monitor the resident's progress. The designated nurse would evaluate the restorative documentation monthly to determine if there are any changes needed to the existing program and make a monthly progress note, in the resident's electronic medical record. The policy documented some residents may not wish to participate in restorative care programming which will be respected as an election of choice and documented accordingly.

The facility failed to ensure R53 received appropriate restorative treatment and services to increase or prevent further deterioration for the

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F 688	Continued From page 30 resident. This placed the resident at risk for a decline in mobility and impaired independence.	F 688		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 151 residents. The sample included 31 residents. The facility had six medication carts. Based on observation, interview, and record review, the facility failed to date Resident (R)53's insulin (a hormone which allows cells throughout the body to uptake	F 761		

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glucose) flex pen when opened and failed to discard R15 and R346's insulin flex pen and R01's insulin vial when outdated. The facility further failed to discard expired stock medications. This deficient practice placed the affected residents at risk for ineffective medications.

Findings included:

- On 03/25/24 at 08:15 AM, observation of the facility's 500 Nurse medication cart revealed the following:
R53's Lantus (long-acting insulin) flex pen lacked an open date and discard date.
R15 s Lantus flex pen opened date of 02/25/24 and discard date of 03/23/24.

On 03/25/24 at 08:20 AM, observation of the facility's 600 Nurse medication cart revealed the following:
R346's Levemir (long-acting insulin) flex pen lacked an open and discard date.
R01's Lantus vial had an opened date of 02/14/24, and a discard date of 03/12/24.

On 03/25/24 at 08:25 AM, observation of the facility's 600 medication cart revealed the following:
Gerri-Tussin DM (cold and cough medication) 16 fluid ounces expired April 2022.

On 03/26/24 at 10:30 AM, Administrative Nurse E verified the nurses were to date the insulin when opened and discard the outdated insulin, Administrative Nurse E said staff were to discard expired stock medications.

Medlineplus.gov directs open, unrefrigerated

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Levemir vials and pens that can be used within 42 days, but after that time they must be discarded. Unrefrigerated vials or pens of Lantus can be used within 28 days but after that time they must be discarded.

The facility's "Insulin Administration" policy dated May 2021, documented the staff would administer insulin via pen device according to the physician's orders and the facility's policy and procedures. Insulin pens should be clearly labeled with the person's name. The label on the pen and make sure it is the correct ordered insulin for the resident, check the expiration date, if the pen is being used for the first time, date the on the label. Refer to the chart for pen expiration dates. Verify the insulin is being given at the correct time in relation to meals.

The facility's "Storage of Drugs" policy, dated December 2021, documented the facility would store in the original container in which they were received. The refrigerator, freezer, and control room would be available in the pharmacy medications requiring specific storage. No discontinued, outdated, or deteriorated drugs or medications are stored in the facility over thirty (30) days.

The facility failed to date R53's flex pen insulin with the date opened and discard date, and failed to discard R01's, R15's, and R346's outdated insulin vial. The facility also failed to discard expired stock medications placing the residents at risk for ineffective medication.