STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00183516. The revised 2567 was sent electronically on 05/30/24	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.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/30/2024

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
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

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F 550	Continued From page 1	F 550		

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 56 residents. The sample included 15 residents. Based on observation and interview, the facility failed to ensure residents' rights and dignity were respected by staff when staff failed to honor Resident (R) 37's request during dining. The facility further failed to ensure R46's dignity was maintained during care provided in the common area. This placed the residents at risk for decreased self-esteem and decreased self-worth.

Findings included:

- On 05/14/24 at 08:19 AM R37 sat in his wheelchair at the dining table with other residents and was a given chocolate shake.

On 05/14/24 at 08:21 AM R37 sat in his wheelchair in the dining room. R37 asked staff if he could go into the TV room to eat. R37 asked staff repeatedly to take him to the TV room. Licensed Nurse (LN) H, Certified Nurse Aide (CNA) N, and Certified Medication Aide (CMA) R continued to stay seated assisting other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 550	Continued From page 2	F 550		

On 05/14/24 at 08:26 AM, CNA N gave R37 some apricots. R37 asked staff if he could go to the TV room. The staff did not respond to R37. R37 stated he was not able to move his wheelchair. Observation revealed the wheelchair was locked. The staff did not assist him in moving his wheelchair.

On 05/14/24 at 08:30 AM, R37 continued to ask staff if he could go into the TV room. Staff told R37 that he needed to wait for his breakfast to be served.

On 05/14/24 at 08:41 AM, CNA N asked R37 if he wanted his coffee warmed. CNA N got up from assisting another resident and warmed up R37's coffee.

On 05/14/24 at 08:46 AM R37 asked staff again if he could go to the TV room. Staff ignored R37's request and did not reply.

On 05/14/24 at 08:47 AM R37 pointed at CMA R and asked the CMA if he could go over to the recliner and pointed at the recliner. CMA R did not answer R37.

On 05/14/24 at 08:48 AM LN H N served R37 bacon and eggs.

On 05/14/24 at 08:53 AM R37 took his napkin and wiped food from the table onto the floor.

On 05/14/24 at 08:51 AM R37 asked twice for some water. CNA N came to get R37's water cut and filled it for him.

On 05/14/24 at 08:54 AM R37 began to cough as he ate his bacon. R37 spit out his bacon. A male

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 550	Continued From page 3	F 550		

resident at another table asked if R37 was okay. R37 stated the staff didn't care.

On 05/14/24 at 08:55 AM R37 asked CNA N what her name was. CNA N told R37 her name. R37 continued to cough and LN H continued to sit and assist another resident to eat. CNA N told R37 to take a drink of water.

On 05/14/24 at 08:57 AM LN H approached R37 and stood next to him while he continued to cough.

On 05/14/24 at 08:59 AM LN H cleaned off R37's lap which was full of crumbs and then walked away. LN H made no vocal interaction with R37.

On 05/14/24 at 09:01 AM Social Services X started talking to R37 at the dining table. R37 told Social Services X he wanted to go to the TV room. Social Services X propelled R37 in his wheelchair to the TV room.

On 05/14/24 at 09:04 AM Social Services X asked R37 to talk about when he played in his band.

On 05/14/24 at 01:26 PM, CNA N stated staff should be interacting with the residents at meals and should respond when the resident speaks to them. CNA N stated that in the locked unit, staff was not always able to assist a resident right away if the staff was assisting another resident at that time.

On 05/15/24 at 08:17 AM LN H stated staff on the locked unit tried their best to interact at meals with the residents. LN H stated several residents required staff assistance with eating, so staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

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F 550	Continued From page 4	F 550		

would assist other residents as they were able to. LN H stated R37 was restless a lot and did not like to stay in one place very long.

On 05/15/24 at 12:45 PM Administrative Nurse D stated she expected staff to interact with the residents and try to accommodate a choice or request by a resident to go to another room. Administrative Nurse D stated staff tried not to overstimulate the residents in the locked unit but should still be conversing with them at meals and be attentive to a resident's request when voiced.

The "Resident Rights and Responsibilities" policy last revised on 11/16/21 documented that the community would ensure the residents' right to a dignified existence, self-determination, and person-centered care access to persons and services inside and outside the community. The community would protect and promote the rights of each resident. The community would treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his/her quality of life, recognizing each resident's individuality. The community would provide equal access to quality care regardless of diagnosis, severity, condition, or payment source. The community would support the resident in the exercise of his or her rights. The community would ensure a resident could exercise his/her rights without interference, coercion, discrimination, or reprisal.

The facility failed to ensure that R37's rights and dignity were respected when staff failed to acknowledge R37's request to go to another room. This placed the resident at risk for decreased self-esteem and decreased self-worth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 550	Continued From page 5	F 550		

- R46's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of 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), dementia (a progressive mental disorder characterized by failing memory, confusion), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Admission Minimum Data Set" (MDS) dated 02/20/24 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R46 required substantial to maximum staff assistance with chair-to-chair transfers and rolling left and right.

R46's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 02/22/24 documented she had a diagnosis of dementia and she could make some of her needs known to the staff; staff would anticipate her other needs.

On 05/13/24 at 09:26 AM R46 sat in her wheelchair in the common TV area, Licensed Nurse (LN) G placed a gait belt around R46's abdomen. LN G stood in front of R46 and asked her to stand. R46's knees were bent and her heels were off the floor with only the tips of her toes touching the floor. LN G lifted R46 from the wheelchair and the gait belt slid upward, which raised R46's shirt upward and exposed R46's skin from her waist to her breast area during the transfer. No pivot disc or walker was used during the transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 550	Continued From page 6	F 550		

On 05/14/24 at 09:29 AM LN G pushed R46 in her wheelchair from the dining room area to the TV common area. LN G placed a gait belt around R46's abdomen and asked R46 to stand. LN G lifted R46 with the gait belt. R46 did not bear weight as LN G transferred her from the wheelchair. During the transfer from the wheelchair to the recliner the gait belt slid upward pulling R46's shirt up and exposing her back from the waist to her shoulders. No pivot disc or walker was used during the transfer.

On 05/15/24 at 10:00 AM, Certified Nurse Aide (CNA) M stated a resident should never be exposed in a common area. CNA M stated they should be covered to ensure their dignity.

On 05/15/24 at 10:15 AM, Licensed Nurse (LN) G stated never should a resident be exposed in a common area. LN G stated he had realized she had become exposed during the transfer and that should have not happened.

On 05/15/24 at 12:45 PM, Administrative Nurse D stated never should any resident be exposed in a common area.

The facility's "Resident Rights and Responsibilities" policy last revised on 11/16/21 documented that the community would ensure the residents' right to a dignified existence, self-determination, and person- centered care with access to persons and services inside and outside the community. The community would protect and promote the rights of each resident. The community would 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/her quality of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

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F 550	Continued From page 7 life, recognizing each resident's individuality. The community would provide equal access to quality care regardless of diagnosis, severity, condition, or payment source. The community would support the resident in the exercise of his or her rights. The community would ensure residents can exercise his/her rights without interference, coercion, discrimination, or reprisal. The facility failed to ensure R46 was treated with respect and dignity. This deficient practice placed R46 at risk for negative psychosocial outcomes and decreased autonomy and dignity.	F 550		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §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: §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 ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 8	F 676		

grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and 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 56 residents. The sample included 15 residents with four residents reviewed for activities of daily living (ADL). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 46 received the necessary assistive services for transfers. This deficient practice placed R46 at risk for loss of independence, decreased self-esteem, and impaired dignity.

Findings included:

- R46's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of 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), dementia (a progressive mental disorder characterized by failing memory, confusion), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 9	F 676		

The "Admission Minimum Data Set" (MDS) dated 02/20/24 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R46 required substantial to maximum staff assistance with chair-to-chair transfers and rolling left and right.

R46's "Fall Care Area Assessment" (CAA) dated 02/22/24 documented she had right-sided weakness related to a past stroke. R46's diagnosis of dementia placed her at a higher risk for falls.

R46's "Care Plan" dated 03/05/24 documented R46 used a pivot disc and walker for transfers.

On 05/13/24 at 09:26 AM R46 sat in her wheelchair in the common TV area, Licensed Nurse (LN) G placed a gait belt around R46's abdomen. LN G stood in front of R46 and asked her to stand. R46's knees were bent and her heels were off the floor with only the tips of her toes touching the floor. LN G lifted R46 from the wheelchair and the gait belt slid upward, which raised R46's shirt upward and exposed R46's skin from her waist to her breast area during the transfer. No pivot disc or walker was used during the transfer.

On 05/14/24 at 09:29 AM LN G pushed R46 in her wheelchair from the dining room area to the TV common area. LN G placed a gait belt around R46's abdomen and asked R46 to stand. LN G lifted R46 with the gait belt. R46 did not bear weight as LN G transferred her from the wheelchair. During the transfer from the wheelchair to the recliner the gait belt slid upward pulling R46's shirt up and exposing her back from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 10	F 676		

the waist to her shoulders. No pivot disc or walker was used during the transfer.

On 05/15/24 at 10:00 AM, Certified Nurse Aide (CNA) M stated the staff would know how a resident was to be transferred from the care plan. CNA M stated R46 was transferred with the assistance of a gait belt and one staff person. CNA M stated R46 had declined; she may have used a pivot disc and walker before her decline but she had not used a pivot disc or walker for a long time.

On 05/15/24 at 10:15 AM, Licensed Nurse (LN) G stated R46 was transferred with the assistance of a gait belt and one staff assistance. LN G stated he was unsure if therapy was working with R46 for transfer training using a pivot disc and walker. LN G stated R46 had difficulty with transfers.

On 05/15/24 at 12:45 PM, Administrative Nurse D stated staff would find how much assistance and how each resident was to be transferred from the "Care Guide" (a nursing tool that gives a brief overview of the care needs of each resident) which contained information from the care plan. Administrative Nurse D stated staff should follow the guide when care is provided. Administrative Nurse D stated if a resident's status had changed nursing staff should notify her to ensure the resident was evaluated for a significant change.

The facility's "Resident Rights and Responsibilities" policy last revised on 11/16/21 documented that the community would ensure the residents' right to a dignified existence, self-determination, and person- centered care with access to persons and services inside and outside the community. The community would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 protect and promote the rights of each resident. The community would 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/her quality of life, recognizing each resident's individuality. The community would provide equal access to quality care regardless of diagnosis, severity, condition, or payment source. The community would support the resident in the exercise of his or her rights. The community would ensure residents can exercise his/her rights without interference, coercion, discrimination, or reprisal. The facility failed to ensure R46 was provided with the necessary assistive devices for transfers. This deficient practice placed R46 at risk for loss of independence, decreased self-esteem, and impaired dignity.	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 12	F 686		

The facility identified a census of 56 residents. The sample included 15 residents with four reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R)47's pressure-reducing interventions were implemented correctly when the low air-loss mattress pump was set at an inaccurate weight for the resident. The facility additionally failed to complete weekly wound assessments on R37. This deficient practice placed all affected residents at risk for complications related to skin breakdown and pressure ulcers.

Findings Included:

- The "Medical Diagnosis" section within R47's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder), pressure ulcer, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and insomnia (difficulty sleeping).

R47's "Significant Change Minimum Data Set (MDS)" completed 04/02/24 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS noted she required substantial to maximal assistance for bed mobility, transfers, personal hygiene, dressing, bathing, and toileting. The CAA indicated she had a Stage 3 pressure ulcer (full-thickness pressure injury extending through the skin into the tissue below). The MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 13	F 686		

indicated she had pressure-reducing devices for her bed and wheelchair. The MDS indicated no restraint in use. The MDS indicated she received hospice services (end-of-life comfort care).

R47's "Pressure Ulcer Care Area Assessment (CAA)" completed 04/03/24 noted R47 received hospice services and had a Stage 3 pressure ulcer on her coccyx (area at the base of the spine). The CAA indicated hospice provided a low air-loss mattress for her bed and a pressure-reducing cushion for her wheelchair. The CAA indicated the care plan will include wound management interventions.

R47's "Care Plan" dated 03/07/24 indicated she was at risk for impaired nutrition, falls, activities of daily living (ADL) decline, and pressure ulcers. The plan indicated she required staff assistance with grooming, dressing, toileting, bathing, transferring, and locomotion. The plan indicated she required the use of bilateral transfer bars on her bed for repositioning, transfers, and bed mobility. The plan indicated R47's hospice service provided a low air-loss mattress to reduce pressure on her body. The plan instructed staff to check her bed function and settings each shift. The plan indicated she had a bolstered overlay on her low air-loss mattress to help R47 distinguish the perimeter of her mattress.

R47's EMR indicated she weighed 107 pounds (lbs.) on 05/08/24.

R47's EMR under "Physician Orders" revealed an order dated 02/19/24. The order instructed staff to check the functioning of her low air-loss mattress and ensure it was suitably set and adjusted based on her weight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 14	F 686		

A review of the low air-loss mattress manufacturer's operation guide (ProActive Protekt Aire 6000) indicated the pump and mattress were intended to reduce the incidence of pressure ulcers while optimizing comfort. The guide indicated that firmness can be adjusted based on the recommendations of the health care professional and the patient's weight.

On 05/13/24 at 07:03 AM R47 slept in her bed. R47's low air-loss mattress was set to 280 lbs. The mattress pump had fixed weight settings of 80lbs, 120lbs, 160lbs, 200lbs, 240lbs, 280lbs, 320lbs. and 350lbs. R47's bed had bilateral transfer bars installed on both sides of her bed and bolstered mats loosely next to the assist bars.

On 05/14/24 at 2:03 PM, R47 slept in her bed. Her low air-loss mattress remained set at 280lbs.

On 05/15/24 at 09:20 AM R47's low air-loss mattress was set to 280lbs. Licensed Nurse (LN) I stated the low air-loss mattresses were set by the resident's current weight. She stated nurses were expected to check the pump settings each shift. She stated R47's bed should be set at 120 lbs. per her current weight.

On 05/15/24 at 12:46 PM Administrative Nurse D stated staff were expected to set the low air-loss mattress pumps to the closest weight range. She stated the pump should be set by R47's current weight.

The facility's "Skin Integrity: Pressure Ulcers/Injury Prevention" policy revised 10/2022 indicated the facility will utilize therapeutic support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

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F 686	Continued From page 15	F 686		

surfaces along with nutrition, repositioning, and clinically proven treatment regimens to manage wounds. The policy indicated the facility was to ensure the appropriate usage of pressure redistribution support surfaces per the manufacturer's guidelines and the medical provider's intended orders.

The facility failed to ensure that R47's low air-loss mattress pump was appropriately set to her current weight. This deficient practice placed R47 at risk for complications related to skin breakdown and pressure ulcers.

- The electronic medical record (EMR) for R37 documented diagnoses of 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), early onset Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), psychosis (any major mental disorder characterized by gross impairment in reality perception), and hemiplegia (weakness and paralysis on one side of the body).

R37's "Significant Change Minimum Data Set (MDS)" dated 01/04/24 documented R37 had a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. R37 required maximal assistance from staff for upper body dressing. R37 was dependent on staff for activities of daily living (ADLs). R37 was at risk of developing pressure ulcers. A formal and clinical assessment had been completed for R37. R37 had a pressure-reducing device for his chair and his bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 16	F 686		

R37's "Quarterly MDS" dated 04/03/24 documented a BIMS score of eight which indicated moderately impaired cognition. R37 was dependent on staff for his ADLS. R37 was at risk for pressure ulcers and had one unhealed Stage 2 pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters). R37 used a pressure-reducing device for his chair and bed. R37 received pressure ulcer care and the application of ointments or medications.

R37's "Pressure Ulcer Care Area Assessment (CAA)" dated 01/11/24 documented R37 was at risk for skin breakdown and pressure injury related to incontinence and his decreased mobility. R37 had a pressure-reducing mattress and pressure-reducing cushion in his wheelchair. Staff was to toilet R37 before and/or after meals and activities. R37 was working with skilled therapies on functional ADLs and increased mobility.

R37's "Pressure Ulcer Care Plan" last updated 05/01/24 directed staff to ensure he had a cushion in his wheelchair and switch it to the recliner and dining room chair with transfers. Staff was to assist R37 with repositioning hourly when in a wheelchair or recliner and every two hours when in bed. Staff was to apply Magic Butt Paste (a medicated cream used to treat skin issues) twice daily to buttocks. The care plan lacked staff direction for weekly skin or wound assessments.

R37 "Physician Orders" documented an order dated 12/29/23 that directed staff may use skin and wound care treatment guidelines and an order dated 04/30/24 to apply Magic Butt Paste to bilateral buttocks twice daily for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

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F 686	Continued From page 17	F 686		

redness/excoriation until healed.

R37's "Braden Scale for Predicting Pressure Sore Risk" Assessment dated 01/03/24 documented a score of 13, which indicated a moderate risk for pressure ulcer development.

A "Skin Evaluation Form" dated 03/05/24 for R37 documented a full-thickness pressure wound to the right buttock. The evaluation lacked measurements for the wound.

R37's EMR lacked evidence of further wound assessment from 03/05/24 until 03/19/24, 14 days later.

A "Skin Evaluation Form" dated 03/19/24 for R37 documented a circular-shaped superficial wound. The wound bed had 100 percent (%) red granulation tissue (new tissue formed during wound healing). Wound measurements were one centimeter (cm) in length and one cm in width. The wound was a stage two wound. The treatment was an Aquacel foam dressing (a medicated dressing used for wound healing).

R37's EMR lacked evidence of further wound assessment from 03/19/24 to 04/23/24, 34 days later.

A "Skin Evaluation Form" dated 04/23/24 at 01:49 PM for R37 documented a partial thickness pressure wound. The resident returned from hospitalization with a superficial open area. The resident returned with an order for a topical cream/ointment. The resident's wife was updated on the wound's progress and treatment change. Wound measurements were 2.0 cm in length, 0.6 cm in width, and 0.1 cm in depth. The treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 18	F 686		

was to apply Magic Butt Paste twice daily.

R37's EMR lacked evidence of a weekly wound assessment from 04/24/24 through the review date of 05/13/24.

On 05/14/24 at 07:38 AM R37 sat in his wheelchair in the TV room. A cushion was present in the seat of the wheelchair.

On 05/14/24 at 09:33 AM R37 lay in bed resting. R37's call light was within reach; the bed was in a low position.

On 05/14/24 at 08:17 AM Licensed Nurse (LN) H stated that she typically was responsible to do the weekly skin assessments on the unit. LN H stated the wound care nurse should come around weekly to check R37's wound.

On 05/14/24 at 12:45 PM Administrative Nurse D stated that the unit charge nurse should be doing weekly skin checks on the residents. Administrative Nurse D stated the wound nurse should come weekly to assess any active wounds and document the findings appropriately. Administrative Nurse D stated that R37 was not always cooperative with his wound care and those missed assessments should have been documented. Administrative Nurse D stated she had inadvertently missed R37's assessment on 05/07/24.

The "Skin Integrity: Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment" policy last revised on 10/28/22 documented that skin integrity and tissue tolerance would be evaluated. Staff was to identify residents at risk for pressure ulcer/injury

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 19 development. Staff would implement pressure ulcer/injury preventative measures to maintain intact skin. Staff would initiate and implement wound treatment orders when pressure ulcers/injuries and/or wounds were present or acquired. Staff was to do a full skin evaluation on admission and weekly by a licensed nurse. The facility failed to ensure staff appropriately assessed and monitored R37's pressure injury at least weekly. This placed R37 at risk for complications related to skin breakdown and pressure ulcers.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 690	Continued From page 20	F 690		

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 56 residents. The sample included 15 residents with three residents reviewed for catheters (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and urinary tract infection (UTI infection in any part of the urinary system). Based on observation, record review, and interviews, the facility failed to provide appropriate treatment for Resident (R) 31 with an indwelling catheter (a tube inserted into the bladder to drain urine into a collection bag) when the facility failed to prevent the drainage bag from resting on the floor. This deficient practice placed R31 at risk for catheter complications including infection.

Findings included:

- R31's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of bladder cancer, dementia (a progressive mental disorder characterized by failing memory, and confusion), and urinary retention (lack of ability to urinate and empty the bladder).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 690	Continued From page 21	F 690		

The "Annual Minimum Data Set" (MDS) dated 07/11/23 documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R31 had an indwelling catheter during the observation period.

The "Quarterly MDS" dated 04/09/24 documented a BIMS score of three which indicated severely impaired cognition. The MDS documented that R31 had an indwelling catheter during the observation period.

R31's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 07/25/23 documented R31 required an indwelling catheter related to his diagnosis. R31 required assistance from staff for proper hygiene related to the care of his indwelling catheter. R31 had a recent hospitalization related to a UTI.

R31's "Care Plan" dated 01/19/24 documented staff would provide R31 with catheter care per facility policy.

R31's EMR under the "Orders" tab revealed the following physician orders:
Catheter care per facility policy every shift for urinary retention dated 06/20/23.

R31's EMR under the "Medication Administration Record" (MAR) reviewed from 04/01/23 to 05/13/24 revealed the following physician orders:
Macrobid (antibiotic) 100 milligrams (mg) capsule, give one capsule by mouth two times daily for five days for UTI dated 04/10/23.
Macrobid 100 mg capsule give one capsule by mouth daily for 60 days for UTI prophylaxis (preventative in nature) dated 04/15/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 690	Continued From page 22	F 690		

Cefuroxime axetil (antibiotic) 250 mg tablet give one tablet by mouth every 12 hours for 10 days for UTI dated 06/21/23.
Cipro (antibiotic) 250mg give one tablet by mouth two times a day times seven days for UTI dated 09/28/23 and discontinued on 09/29/23.
Cipro 250mg give one tablet by mouth two times a day times seven days for UTI dated 01/16/24.
Doxycycline hyclate 100mg capsule give one capsule by mouth two times daily times 10 days for UTI dated 01/17/24.
Doxycycline hyclate 100mg capsule give one capsule by mouth two times daily times seven days for UTI dated 02/13/24.
Doxycycline hyclate 100mg capsule give one capsule by mouth two times daily times seven days for UTI dated 03/12/24.
Doxycycline hyclate 100mg capsule give one capsule by mouth two times daily times seven days for UTI and pneumonia (inflammation of the lungs) dated 05/05/24.

On 05/15/24 at 06:57 AM R31 lay on his bed. His urinary catheter bag contained dark amber urine. The bad lay directly on the floor at the foot of R31's bed.

On 05/15/24 at 07:10 AM, Certified Nurse Aide (CNA) M stated R31's catheter drainage bag should never be placed on the floor. CNA M stated the catheter bag should be placed in a dignity bag and attached to the bed not touching the floor.

On 05/15/24 at 10:15 AM, Licensed Nurse (LN) G stated R31's catheter drainage bag should never be stored on the floor. LN G stated the catheter drainage bag should be placed on the bed off the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 690	Continued From page 23 On 05/15/24 at 12:45 PM, Administrative Nurse D stated to prevent infections, R31's catheter drainage bag should never be placed on the floor. The facility's "Catheter Care-Urinary Foley "policy last reviewed on 10/08/21 documented catheter care is performed appropriately by qualified nursing staff to prevent complications caused by the presence of an indwelling urethral catheter. The facility failed to prevent the catheter drainage bag from touching the floor for R31 who had frequent UTIs. This deficient practice placed R31 at risk of catheter-related complications and further UTIs.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. 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. This REQUIREMENT is not met as evidenced by: The facility identified a census of 56 residents. The sample included 15 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 5's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 24	F 695		

sleep) mask was stored in a sanitary manner. This placed R5 at an increased risk for respiratory infection and complications.

Findings included:

- R5's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (HTN-elevated blood pressure), kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), obstructive sleep apnea (an open airway during typical breathing during sleep and a blocked airway), and glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow).

The "Quarterly Minimum Data Set" (MDS) dated 03/26/24 documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented R5 was dependent on staff for all activities of daily living (ADLs).

R5's "Functional Abilities Care Area Assessment" (CAA) dated 09/29/23 documented R5 required moderate to extensive assistance for all ADLs with the assistance of one to two staff members. R5 worked well with skilled therapy to improve her functional abilities. R5 had edema to the left lower extremity and an ace wrap was applied for edema; the left lower extremity was elevated on a pillow. R5 was able to feed herself after setup. R5 was not ambulatory with nursing and was wheelchair-bound. She required staff assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 25	F 695		

to propel her wheelchair.

R5's "Care Plan" lacked staff direction for the care of R5's CPAP mask.

R5's EMR dated 09/25/24 under the "Orders" tab revealed the following physician orders: Apply CPAP at bedtime; staff to take off the mask in the morning.

On 05/13/24 at 01:58 PM, R5 sat in the commons area in her wheelchair watching TV. R5's CPAP mask was laid directly on her bedside table without containment.

On 05/14/24 at 07:08 AM R5 laid in her bed, with the head of the bed elevated. R5's CPAP mask was laid directly on the bedside table without containment.

On 05/15/24 at 06:47 AM Certified Nurse's Aide (CNA) P stated staff removed R5's CPAP mask in the mornings and placed it on the bedside table. CNA P stated she had never seen the mask stored any other way.

On 05/15/24 at 09:20 AM Licensed Nurse (LN) I stated that CPAP masks were to be stored in a dated plastic bag, not laid on the bedside table.

On 05/15/24 at 12:44 PM, Administrative Nurse D stated CPAP masks should be stored in a bag and dated; the mask should not be laid over the bedside table. She stated the masks were cleaned by the house staff.

The facility's "Oxygen Therapy" policy revised on 10/08/21 documented that when the device is not in use, stored in plastic or other bag to keep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 26 tubing and the device off the floor. The facility failed to ensure R5's CPAP was stored in a sanitary manner. This placed R5 at increased risk for respiratory infection and complications.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: The facility identified a census of 56 residents. The sample included 15 residents with four reviewed for siderails. Based on observations, record review, and interviews, the facility failed to identify Resident (R)47's low air-loss mattress	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 700	Continued From page 27	F 700		

and bolstered overlay as possible risks on R47's side rail assessment. This deficient practice placed R47 at risk for inadequate care due to unidentified care needs.

Findings Included:

- The "Medical Diagnosis" section within R47's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder), pressure ulcer, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and insomnia (difficulty sleeping).

R47's "Significant Change Minimum Data Set (MDS)" completed 04/02/24 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS noted she required substantial to maximal assistance for bed mobility, transfers, personal hygiene, dressing, bathing, and toileting. The CAA indicated she had a Stage 3 pressure ulcer (full-thickness pressure injury extending through the skin into the tissue below). The MDS indicated she had pressure-reducing devices for her bed and wheelchair. The MDS indicated no restraints were in use. The MDS indicated she received hospice services (end-of-life comfort care).

R47's "Pressure Ulcer Care Area Assessment (CAA)" completed 04/03/24 noted R47 received hospice services and had a stage three pressure ulcer on her coccyx (area at the base of the spine). The CAA indicated hospice provided a low air-loss mattress for her bed and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 700	Continued From page 28	F 700		

pressure-reducing cushion for her wheelchair. The CAA indicated the care plan will include wound management interventions.

R47's "Fall CAA" completed 04/03/24 indicated she had a history of falls related to her impaired safety awareness and attempts to self-transfer without assistance. The CAA indicated she had a bolstered overlay mat placed on her low air-loss mattress to assist with positional awareness in her bed.

R47's "Care Plan" dated 03/07/24 indicated she was at risk for impaired nutrition, falls, activity of daily living (ADLs) decline, and pressure ulcers. The plan indicated she required staff assistance with grooming, dressing, toileting, bathing, transferring, and locomotion. The plan indicated R47's hospice service provided a low air-loss mattress to reduce pressure on her body. The plan indicated she had a bolstered overlay on her low air-loss mattress to help R47 distinguish the perimeter of her mattress. The plan indicated she required the use of bilateral transfer bars on her bed for repositioning, transfers, and bed mobility.

R47's EMR under "Physician Orders" revealed an order dated 02/19/24. The order instructed staff to check the functioning of her low air-loss mattress and ensure it was suitably set and adjusted based on her weight.

R47's EMR under "Physician Orders" revealed an order dated 02/19/24. The order indicated she had bilateral transfer assist bars placed on her bed to assist with mobility and transfers.

R47's EMR under "Forms" revealed an "Assistive Device for Bed Screening" completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 700	Continued From page 29	F 700		

02/19/24. The form indicated she had a history of falls and difficulty with balance. The form indicated she required repeated use of the bed rails during transfers. The form indicated the device was in working condition and she had a high/low bed. The form did not identify the low air-loss mattress or bolstered mattress overlay on her bed as a risk. No other device screenings were completed for R47.

On 05/13/24 at 07:03 AM R47 slept in her bed. R47's low air-loss mattress was set to 280 lbs. R47's bed had bilateral transfer bars installed on both sides of her bed and bolstered mats positioned next to the assist bars.

On 05/15/24 at 09:20 AM Licensed Nurse (LN) I stated the bed's side rails and attachments were assessed upon R47's admission to the facility. She stated she was not sure if the risk assessments differentiated between mattress types and overlays.

On 05/15/24 at 12:46 PM Administrative Nurse D stated the charge nurse completed the risk assessments on the bed rails. She stated the assessment should identify the type of mattress and adaptive equipment used on the bed. She stated the assessment should be used to identify possible risks related to gaps between the rail and bed, possible strangulation hazards, and the effectiveness of the assist rails.

The facility's "Assistive Devices Used for Bed" policy dated 06/2023 indicated the facility would provide continual assessment for assistive devices attached to beds to ensure safety and the need for use. The policy indicated the evaluation would include environmental hazards to identify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 700	Continued From page 30 potential risks to the resident's implemented interventions, and goals to improve mobility. The facility failed to identify R47's low air-loss mattress and bolstered overlay as possible risks on R47's side rail assessment. This deficient practice placed R47 at risk for inadequate care due to unidentified care needs.	F 700		
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:	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 761	Continued From page 31	F 761		

The facility reported a census of 56 residents. The facility identified one medication room and four medication carts. Based on observations, record review, and interviews, the facility failed to store medications and biologicals appropriately when the facility failed to lock the medication room and additionally failed to appropriately label Resident (R)31's insulin (a hormone that lowers the level of glucose in the blood) medication once opened. This deficient practice placed the residents at risk for unnecessary medication and administration errors.

Findings Included:

-On 05/13/24 at 08:15 AM a walkthrough of the facility's second floor was completed. An inspection of the medication room revealed the entry door was not locked. The room contained a secured digital medication storage system for the facility's prescription medications, a locked medication refrigerator, and a shelf with unsecured stock (over-the-counter medications) medications. The room was secured by Licensed Nurse (LN) J upon completion of the medication room inspection.

On 05/14/24 at 08:47 AM an inspection of Northgate hallway's medication cart was completed with LN G. An inspection of R31's insulin (hormone that lowers the level of glucose in the blood) revealed one opened Basaglar (long-acting insulin) pen and one opened Novolog (fast-acting insulin) pen were not dated when opened. LN G immediately removed the unlabeled insulin pens from the medication carts.

On 05/13/24 at 08:20 AM LN J stated staff were expected to pull the medication room door fully

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 761	Continued From page 32	F 761		

shut and ensure it was always locked. She stated residents should never have access to medications and nursing equipment stored within the medication room.

On 05/14/24 at 08:47 AM LN G stated insulin pens should be labeled with the open date once opened and discarded within 28 days after being opened.

On 05/15/24 at 12:26 PM Administrative Nurse D stated the medication rooms were expected to be locked at all times. She stated staff were expected to ensure the doors closed properly upon exiting the rooms. She stated insulin pens were to be labeled with an open date once opened and stored in the medication carts.

The facility's "Medication Storage" policy revised 05/2021 indicated all medications and biologicals were to be stored safely following the manufacturer's storage recommendations. The policy indicated medications should be properly labeled with the recommended expiration dates and stored in a manner appropriate for the specific medication.

Medlineplus.gov documents opened, unrefrigerated vials or pens of Basaglar and novolog insulin can be used within 28 days; after that time they must be discarded.

The facility failed to store medications and biologicals appropriately when the facility failed to lock the medication room and additionally failed to appropriately label R31's insulin medication once opened. This deficient practice placed the residents at risk for unnecessary medication and administration errors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 56 residents, one kitchen, four serving areas, and dining rooms. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to cleaning, food storage, equipment storage, and food preparation practices. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns. Findings include: - On 05/13/24 at 08:09 AM during the initial tour, observation revealed the following: Bowls were stored upright on the rack by the delivery doors instead of inverted.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 812	Continued From page 34	F 812		

Three refrigerator and four freezer temperature logs lacked evidence staff checked the temperature on Sunday, 05/12/24 in the main kitchen.
The walk-in freezer had breaded chicken breasts that were uncovered and not dated.
The commercial meat slicer was uncovered but not in use.
The dishwasher temperature logbook lacked evidence staff checked the water temperature on 05/09/24 and 05/11/24.
The cottage cheese and milk were open and not dated.

On 05/15/24 at 11:40 AM Dietary Staff (DS) CC prepared the pureed food. DS CC did not do hand hygiene before beginning the food preparation task. DS CC donned gloves and then touched unclean surfaces which included the preparation counter and the warmer handle as well as unclean utensils. Wearing the same gloves, DS CC grabbed the ham loaf directly from the pan with her gloved hand and placed it in the blender. DS CC then doffed her gloves and without performing hand hygiene, proceeded to wipe the counter and sink.

On 05/15/24 at 11:50 AM DS CC used her ungloved hand to get a spatula from the hanging rack by grabbing the spatula by the end that touched food.

On 05/15/24 at 11:51 AM DS BB stated staff were expected to ensure clean hygienic food preparation and use clean utensils while serving or preparing meals. DS BB stated staff were to store cooking utensils and plates and bowls with the eating surface downward. She stated staff were expected to check refrigerator and freezer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 812	Continued From page 35 temperatures every shift; dishwasher temperatures should be checked before each meal. DS BB stated she expected staff to do hand hygiene and wear gloves to protect residents from potential foodborne illnesses and cross-contamination. She said staff were expected to check stored food to ensure opened items were labeled and dated. A review of the facility's "Cura Hospitality Operations" policy and procedure dated 9/2022 indicated the facility would promote a system that identified proper service, cleaning, and food storage. The policy noted all surfaces within the dining room and kitchen were to be cleaned and sanitized per professional standards. The policy indicated food would be labeled/dated and stored safely. The policy noted all kitchen and dining equipment be stored in a manner that prevents soiling or contamination of clean items. A review of the facility's "Hand Hygiene" policy and procedure dated 10/07/22 indicated staff were to ensure safe food handling practices to prevent cross-contamination and food-borne illness. The policy indicated staff should complete hand hygiene in between touching surfaces related to direct food preparation, handling, and serving. The facility failed to follow sanitary dietary standards related to cleaning, food storage, equipment storage, and food preparation practices. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 36 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals 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:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 37	F 880		

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

§483.80(e) Linens.
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 56 residents. The facility identified six residents on enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care) and one resident on contact precautions (transmission-based precautions for infectious disease that may spread with direct or indirect contact). Based on record review, observations, and interviews, the facility failed to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 38	F 880		

adequate infection control standards related to following enhanced barrier precautions, wearing personal protective equipment (PPE), and indwelling catheter maintenance (tube placed in the bladder to drain urine into a collection bag). These deficient practices placed the residents at risk for infectious diseases.

Findings Included:

- On 05/13/24 at 08:11 AM an inspection of Resident (R)6's room revealed no enhanced barrier precaution signage or personal protective equipment was posted in or around his room for his wound care.

On 05/13/24 at 08:13 AM an inspection of R14's room revealed no enhanced barrier precaution signage or personal protective equipment was posted in or around his room for his indwelling urinary catheter.

On 05/13/24 at 08:14 AM an inspection of R24's room revealed no enhanced barrier precaution signage or personal protective equipment (PPE) was posted in or around his room for his indwelling urinary catheter.

On 05/13/24 at 08:16 AM an inspection of R31's room revealed no enhanced barrier precaution signage or personal protective equipment was posted in or around his room for his indwelling urinary catheter.

On 05/13/24 at 10:30 AM enhanced barrier precaution signage and PPE were placed outside R6, R14, R24, and R31's rooms.

On 05/14/24 at 01:45 PM, an inspection of R40's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 39	F 880		

room revealed a contact isolation sign and PPE posted outside her room. Certified Nurse Aide (M) entered the room at 01:45 PM and completed peri-cares without donning the required PPE to prevent exposure to R40's bacterial urinary infection.

On 05/13/24 at 10:35 AM Licensed Nurse (LN) L stated the enhanced barrier precautions signs indicated residents were at risk for infections and staff were expected to wear gloves and gowns while providing high contact care. She stated the signs and PPE should be placed in a room for residents on enhanced barrier precautions.

On 05/15/24 at 06:57 AM R31 slept on his bed. His urinary catheter bag contained dark amber urine and laid directly on the floor at the foot of R31's bed.

On 05/14/24 at 01:45 PM, CNA M acknowledged they should have donned PPE while entering R40's room and providing peri-cares to her. CNA M stated R40 had just been placed on contact precautions.

On 05/15/24 at 12:46 AM Administrative Staff B stated each room identified on enhanced barrier precautions should have the signage and personal protective equipment. She stated that PPE should be utilized when performing direct care for residents with open wounds, stomas (surgically made holes in the body), and catheters. She stated staff had an infection control related skills fair the previous month that covered enhanced barrier precautions, PPE, hand hygiene, and contact precautions. She stated staff were educated and should have been aware of the appropriate precautions. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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 40	F 880		

catheter bags should always be hung below the level of the bladder and never allowed to touch the floor.

The facility's "Infection Control" policy dated 04/2024 indicated facility will educate and ensure staff follow the facility's training related to providing, maintaining, and wearing the proper personal protective equipment for residents with special precautions. The policy indicated enhanced barrier precautions will be implemented on residents at risk for wound or indwelling medical device infections.

The facility's "Catheter Care-Urinary Foley "policy last reviewed on 10/08/21 documented that catheter care is performed appropriately by qualified nursing staff to prevent complications caused by the presence of an indwelling urethral catheter.

The facility failed to follow sanitary infection control standards related to enhanced barrier precautions, wearing PPE, and indwelling catheter maintenance. These deficient practices placed the residents at risk for infectious diseases.