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F 000	INITIAL COMMENTS	F 000		

The following citations represent the findings of partial extended survey and complaint investigation #KS00188225.

On 06/03/24 at 03:15 PM Administrative Staff A, was provided the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R)1.

On 05/28/24 R1 complained of a burning sensation to her genital area and the staff took R1 to her room for assessment and discovered maggots in R1's genital area and vagina. R1 was sent to the hospital for evaluation of the infestation of her genital area. The facility's failure to identify risks associated with resident behaviors and implement interventions or strategies to mitigate risks as well as the failure to provide adequate hygiene and catheter care to prevent a maggot infestation placed R1 in Immediate Jeopardy.

The facility provided an acceptable immediacy removal plan on 06/03/24 at 04:41 PM which included the following corrective actions to be completed by 06/03/24 by 08:00 PM.
1. The staff cleaned the resident and the resident room completely on 05/28/24.
2. The facility in-serviced the nursing staff for notification of resident refusals, changes in resident preferences, refusal of resident cares, refusal of peri-care, residents who go outside without wearing a brief. The staff were signing that care was completed when the resident refused or did not want to come in from being outside. Staff were inserviced on what to do in the event a resident refused care and to notify the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/18/2024

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.

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nurse and then reattempt to go and render the care as necessary.
3. The facility would provide on-going nursing in-services to staff regarding documenting only the cares that are completed and charting refusals as refusals. The facility will in-service on thorough and complete catheter and peri-care for all nursing staff. Inservice staff on how neglecting this practice is both harmful to the resident psychologically and physically and that it is neglectful treatment. All nursing staff will be inserviced now and any staff who come to work will be inserviced prior to starting their shift.
4. The Director of Nursing (DON) provided education to the resident on the importance of always wearing a brief. Especially the need to wear a brief is she was spending most of her day outside. Educated on necessity of sanitary care of peri area and catheter care given to resident.
5. The DON and ADON would complete frequent checks on the resident weekly to ensure care was provided and there was no reoccurrence of the issue.
6. The facility conducted an audit of all residents who were potentially affected to ensure appropriate peri-care and catheter care.
7. The facility will conduct ongoing audits on appropriate pericare, catheter care and monitoring for correct documentation by nursing staff, and complete nursing in-services recompleted quarterly to ensure correct peri care and catheter care per doctor's orders.
8. The facility would monitor to ensure on-going compliance by following up monthly in QAPI for three months, with review of all audits completed and changes made as needed. ED to ensure that ANE is discussed in the next three all staff meetings.

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F 000	Continued From page 2 The surveyor verified the corrective action while onsite on 06/04/24 at 11:30 AM. The deficient practice remained at a "G" scope and severity, following removal of the immediacy. The 2567 was sent electronically on 06/18/24.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. The sample included three residents reviewed for neglect. The facility failed to ensure Resident (R) 1 remained free from neglect when staff failed to ensure R1 received adequate care and services required to prevent harm or injury to her physical and psychosocial wellbeing. R1, who had a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body) and an indwelling urinary catheter (a flexible tube inserted through into the bladder to drain urine), was legally blind and dependent	F 600		

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on staff for hygiene was outside without staff for extended periods of time with no brief or underwear, and with urinary catheter tubing exposed. On 05/28/24 R1 complained of a burning sensation to her genital area and the staff took R1 to her room for assessment and discovered maggots in R1's genital area and vagina. R1 was sent to the hospital for evaluation of the infestation of her genital area. The facility's failure to identify risks associated with resident behaviors and activity and implement interventions or strategies to mitigate risks as well as the failure to provide adequate hygiene and catheter care to prevent a maggot infestation placed R1 in Immediate Jeopardy.

Findings included:

- R1's Electric Medical Record (EMR), under the "Diagnosis" tab documented diagnoses of neuromuscular dysfunction of bladder (a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition), weakness, muscle weakness, colostomy, bilateral amputations of the right and left legs, type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) without complications, and dependence on wheelchair.

The "Annual Minimum Data Set" (MDS) dated 01/14/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required substantial to maximal assistance from staff where staff provided more than half the effort for toileting hygiene, shower and or bathing self, upper body dressing, lower body dressing, and personal hygiene. R1 had a colostomy and an indwelling catheter. R1's vision

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is severely impaired with no vision or sees only light colors or shapes; R1's eyes did not appear to follow objects.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 01/14/24 documented R1 had alteration in selfcare related to a Foley catheter (tube inserted into the bladder to drain urine into a collection bag), colostomy, and required assistance with ADLs.

The "Urinary Incontinence and Indwelling Catheter CAA" dated 01/14/24 documented R1 had an indwelling Foley catheter and colostomy bag and required assistance with ADLs and was at risk for complications related to her neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

The "Pressure Ulcer CAA" dated 01/14/24 documented R1 was at risk for skin and or pressure injury related to her Foley catheter, colostomy and required assistance with ADLs and was at risk for complications related to decreased functional mobility, alteration in vision, right below the knee amputation, and left above the knee amputation.

The "Quarterly MDS" dated 04/15/24 documented a BIMS score of 15, which indicated intact cognition. R1 required substantial to maximal assistance from staff where staff provided more than half the effort for toileting hygiene, shower and or bathing self, upper body dressing, lower body dressing, and personal hygiene. R1 had a colostomy and an indwelling catheter. R1's vision is severely impaired with no vision or sees only light colors or shapes; R1's eyes did not appear to follow objects.

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R1's "Care Plan" revised 10/12/23 documented R1 had the potential for injury related to smoking and was at risk for complications as she was legally blind. The plan directed staff that R1 was alert and oriented knew the risks versus benefits related to smoking. R1 was able to smoke without being supervised. An intervention dated 09/16/23 directed staff to report non-compliance or unsafe smoking habits to R1's physician and responsible party.

R1's "Care Plan" initiated on 01/07/23 directed staff to monitor, record, and report to the medical director signs and symptoms of a urinary tract infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, four smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns.

R1's "Care Plan" revised on 01/13/23 directed staff that R1 had an indwelling catheter and staff were to provide catheter care every shift and as needed. R1's revised interventions dated 03/30/24 directed staff that R1 required substantial to maximal assistance with toileting hygiene.

R1's "Care Plan" dated 04/28/24 documented R1 was at risk for complications because she often refused wound care and would rather sit outside and vape or smoke. The plan directed staff to negotiate a time for ADL so that the resident could participate in the decision-making process, staff were to return at the agreed upon time. The plan directed staff if the resident resisted with ADL, to reassure the resident, leave and return

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five to 10 minutes later to try again.

R1's "Care Plan" lacked any interventions relating to R1 refusing to allow care to be provided related to her changing her clothing, preference to not wear a brief or underwear, or refusal of catheter and perineal care specifically.

R1's "Weekly Skin Evaluation" located under the "Assessments" tab, dated 05/20/24 at 09:22 AM documented R1 continued Skin-prep (liquid skin protectant) treatments to sacrum (large triangular bone/area between the two hip bones) and left buttock. R1 continued to have bruising and scabbing to her bilateral upper extremities, bruising to abdominal area. The assessment recorded redness and irritation noted to R1's vaginal area.

R1's "Weekly Skin Evaluation" located under the "Assessments" tab, dated 05/27/24 at 09:39 AM documented no edema was noted. Staff applied Skin-prep. R1 continued with wound care to her sacrum and under the left buttock. R1 had redness under her right buttock and continued to have bruising and scabbing noted to her bilateral upper extremities.

R1's "Document Survey Report" documented R1 had a shower on 05/14/24, 05/17/24, 05/21/24 and 05/24/24; she was not available for a shower on 05/28/24. Review of the report revealed R1 did not have documented bathing refusals.

R1's "30 Day Lookback Period" lacked documentation for behavior symptoms.

Review of "Lab Results" collected 05/27/24 for a urinalysis documented greater than three

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organisms isolated which indicated probable contamination. The lab recommended a recollection and reorder if clinically indicated.

The "Nursing Note" dated 05/28/24 at 01:26 PM documented R1 returned from dialysis very upset and crying. R1 stated that she was "hurting" in the peri area and felt like she had a urinary tract infection. R1 had already had a urinalysis obtained and awaiting results. Unidentified Certified Nurse Aides (CNA) reported R1 refused peri care, to lay down throughout the day and to change clothing. Administrative Nurse F aware of complaints and aware of the refusals of care. Licensed Nurse (LN) H discussed this with R1 and R1 agreed to allow cares and to get on a routine that would allow rest, and cleaning and changing of clothes as needed and on a routine basis.

The "Nursing Note" dated 05/28/24 at 03:22 PM documented an unidentified CNA reported to LN I that R1 needed her colostomy bag changed which nurse changed and reported that R1 was crying since R1 had returned from dialysis. LN I checked on R1 and R1 stated that her bottom and peri area was hurting and R1 felt a burning sensation. R1 was getting ready to take a bath and or shower and after R1 transferred into bed, an unidentified CNA reported to LN I that R1 appeared to have maggots in her pants, around her buttock, and peri area. Administrative Nurse F and Administrative Nurse D were notified and R1 was sent to the hospital.

The "Nursing Note" dated 05/28/24 at 07:35 PM documented LN J was notified by an unidentified CNA that R1 complained of a burning sensation to her vaginal area. R1 was taken to her room

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and assessed. Upon assessment, R1 appeared to have maggots in her vaginal area. The staff cleaned R1's peri area and removed her catheter. The staff contacted the physician and the physician ordered R1 to be sent to the hospital. LN J received a call LN K and was informed R1 was cleaned up while in the emergency room, and maggots were removed from R1's vagina. LN K reported R1 was stable and being sent back. LN K reported R1 needed to be washed with soap and water.

The "Nursing Note" dated 05/28/24 at 08:03 PM documented R1 returned to the facility at 07:50 PM and was taken to R1's room and transferred into bed. R1 was informed she would be showered to which R1 agreed to and received a shower immediately upon arrival back to the facility. The staff washed R1 with soap and water, provided peri care, applied barrier cream to R1's peri area, and applied a brief to R1. R1's room was cleaned and disinfected.

The "Progress Notes" from 03/01/24 through 05/27/24 lacked documentation that R1 refused catheter and/or perineal cares.

R1's "Treatment Administration Record" for May 2024 documented an order for indwelling catheter care every shift, dated 10/23/23. The TAR was signed to indicate staff provided catheter care three times each day including all three shifts on 05/27/24, and the morning shift of 05/28/24. There were no refusals prior to 05/28/24 documented on the TAR.

Review of the hospital's "ED Provider Notes" documented the resident presented to the emergency department after her nursing home

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found maggots in her vaginal area. The resident reported she had itchiness in the area the last couple days and had ben treated for a yeast infection recently. The resident reported she felt safe and wanted to return to the facility. The note documented a diagnosis of maggot infestation and directed the facility to keep the area clean and dry. The note recorded a report would be made regarding the facility due to concerns for cleanliness.

During an observation on 06/03/24 at 12:35 PM R1 was seated in her high back wheelchair with clean clothing on and appeared well groomed. R1 stated staff had started to provide peri care and catheter care since R1 had went out to the hospital after "They" (indicating maggots) were found. R1 stated that prior to this happening she received no peri care and no catheter care. R1 stated her genitals had hurt for so long and R1 had thought it was another urinary tract infection. R1 revealed staff finally got a urinalysis collected the day before staff found the maggots. R1 stated when staff collected the urinalysis it was performed by clamping off her catheter tubing and drawing the urine from the port access. R1 stated her pants were never removed and she was not assessed related to the discomfort she felt in her genital area. R1 stated when the staff found the maggots R1 was embarrassed at first, but now R1 stated she is just in pain. R1 described the pain in her genital area as burning and kind of itchy, but the burning was what hurt the most. R1 stated she never refused cares. R1 revealed she may have refused to change her clothes but if staff had informed R1 that R1 had clothing on for more than a day or two and staff wanted to help her change and provide cares, R1 would have absolutely allowed that. R1 rocked

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back and forth on her bottom during the interview. R1 revealed that she rocked to help with the burning and itching in her private area.

During an interview on 06/03/24 at 10:53 AM, Administrative Nurse D stated R1 liked to sit outside. Administrative Nurse D stated R1 would not put any underwear, brief, or anything on other than pants or shorts. Administrative Nurse D stated that R1 continued to refuse cares. Administrative Nurse D stated she had recently gone through and done training that staff needed to be providing catheter cares and peri care.

During an interview on 06/03/24 at 12:33 PM, Certified Medication Aide (CMA) R stated R1 allowed staff to provide peri care and catheter care and rarely refused. CMA R stated if R1 refused CMA R reported it to the charge nurse and documented the refusal into point of care charting. CMA R stated she provided R1 cares but not that often. CMA R stated it had been quite a while since she had received catheter care training and stated it was roughly a year.

On 06/03/24 at 12:52 PM LN G stated that the CNAs knew to do catheter cares for the residents because it was a required task. LN G stated that R1 did not like having her clothes changed and she would not let the staff change her clothes. LN G stated that R1 sometimes refused to allow catheter care and when R1 refused, LN G made a progress note of R1's refusal.

On 06/03/24 at 12:41 PM Administrative Nurse E stated that catheter cares did not show up on point of care charting for the CNAs but it was on the nurses "Treatment Administration Record"

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(TAR).

On 06/03/24 at 03:29 PM CNA M stated he had not received training for catheter or perineal care since starting work at the facility.

On 06/03/24 at 04:10 PM CNA N stated she could not recall the last time she had received catheter and perineal care training.

The facility's "Indwelling Urinary Catheter Care: Quality of Care" policy revised December 2023 documented it was the policy of the facility that each resident with an indwelling catheter would receive catheter care daily and as needed to promote hygiene, comfort, and decrease the risk of infection.

The facility's "Abuse: Prevention and Prohibition Against: Freedom From Abuse, Neglect Exploitation" revised December 2023 documented the facility would provide oversight and monitoring to ensure that its staff, who are agents of the Facility, delivered care and services in a way that promoted and respected the rights of the residents to be from abuse, neglect, misappropriation of resident property, exploitation, or use of technology that would infringe on the resident's right to personal privacy. Neglect is documented as the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurred when the facility is aware of, or should have been aware of, goods or services that a resident(s) required but the facility failed to provide them to the resident(s), that resulted in or may have resulted in physical harm, pain, mental anguish,

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or emotional distress. Neglect included cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress.

On 06/03/24 at 03:15 PM Administrative Staff A, Administrative Nurse D, Administrative Nurse E, and Consultant GG were provided the IJ template and notified the facility failed to ensure staff provided the necessary cares and services to ensure R1 remained free from harm or injury and failed to provide adequate care to prevent a maggot infestation. Other psychosocial considerations include the likelihood for fear and humiliation due to R1 having maggots in her genital area.

The facility provided an acceptable immediacy removal plan on 06/03/24 at 04:41 PM which included the following corrective actions to be completed by 06/03/24 by 08:00 PM.
1. The staff cleaned the resident and the resident room completely on 05/28/24.
2. The facility in-serviced the nursing staff for notification of resident refusals, changes in resident preferences, refusal of resident cares, refusal of peri-care, residents who go outside without wearing a brief. The staff were signing that care was completed when the resident refused or did not want to come in from being outside. Staff were inserviced on what to do in the event a resident refused care and to notify the nurse and then reattempt to go and render the care as necessary.
3. The facility would provide on-going nursing in-services to staff regarding documenting only the cares that are completed and charting refusals as refusals. The facility will in-service on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND POST ACUTE REHABILITATION	7850 FREEMAN AVENUE KANSAS CITY, KS 66112

(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 600	Continued From page 13	F 600		

thorough and complete catheter and peri-care for all nursing staff. Inservice staff on how neglecting this practice is both harmful to the resident psychologically and physically and that it is neglectful treatment. All nursing staff will be inserviced now and any staff who come to work will be inserviced prior to starting their shift.
4. The Director of Nursing (DON) provided education to the resident on the importance of always wearing a brief. Especially the need to wear a brief is she was spending most of her day outside. Educated on necessity of sanitary care of peri area and catheter care given to resident.
5. The DON and ADON would complete frequent checks on the resident weekly to ensure care was provided and there was no reoccurrence of the issue.
6. The facility conducted an audit of all residents who were potentially affected to ensure appropriate peri-care and catheter care.
7. The facility will conduct ongoing audits on appropriate pericare, catheter care and monitoring for correct documentation by nursing staff, and complete nursing in-services recompleted quarterly to ensure correct peri care and catheter care per doctor's orders.
8. The facility would monitor to ensure on-going compliance by following up monthly in QAPI for three months, with review of all audits completed and changes made as needed. ED to ensure that ANE is discussed in the next three all staff meetings.

The surveyor verified the corrective action while onsite on 06/04/24 at 11:30 AM. The deficient practice remained at a "G" scope and severity, following removal of the immediacy.