

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/27/2025	
NAME OF PROVIDER OR SUPPLIER SHAWNEE GARDENS HEALTHCARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6416 LONG STREET , SHAWNEE, Kansas, 66216			
(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	
F0000	INITIAL COMMENTS The following citation represents the findings of complaint investigations 2599311, 2596718, and 2575819. The 2567 was sent electronically on 09/09/25.		F0000				
F0602 SS = E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 114 residents. The sample included eight residents, with seven residents reviewed for misappropriation of medications. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1, R2, R3, R4, R5, R6, and R7 remained free from misappropriation of medications. This deficient practice had the risk of missed medications and further misappropriation of medications for the affected residents. Findings included: - R1's Electronic Medical Record (EMR) documented an order with a start date of 07/24/25 for morphine sulfate (narcotic pain medication) solution 20 milligrams (mg)/milliliters (mL) with instructions to give 0.5 mL by mouth every four hours as needed for shortness of breath (SOB) or pain. R2's EMR documented an order with a start date of 06/18/25 for morphine sulfate solution 20 mg/mL with instructions to give 0.25 mL by mouth every hour as needed for pain/SOB.		F0602	"Past Noncompliance - no plan of correction required"			

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0602 SS = E	Continued from page 1 R3's clinical record documented an order with a start date of 10/03/24 for morphine 20 mg/mL with instructions to give 0.25 mL orally every four hours as needed for pain/SOB. R4's EMR documented an order with a start date of 03/29/25 and a discontinued date of 04/06/25 for morphine solution 20 mg/mL with instructions to give 0.5 mL sublingually (under the tongue) every four hours as needed for pain/SOB. R5's EMR documented an order with a start date of 05/14/25 and a discontinued date of 07/22/25 for morphine sulfate solution 20 mg/mL with instructions to give 0.5 mL sublingually every four hours as needed for moderate pain. R5's EMR documented an order with a start date of 05/14/25 and a discontinued date of 07/22/25 for morphine sulfate solution 20 mg/mL with instructions to give 0.25 mL sublingually every four hours as needed for pain or SOB. R6's EMR documented an order with a start date of 09/30/24 for morphine sulfate solution 20 mg/mL with instructions to give 0.25 mL by mouth every four hours as needed for pain or SOB. R7's EMR documented an order with a start date of 04/22/25 and a discontinued date of 08/24/25 for morphine sulfate solution 20 mg/mL with instructions to give 0.25 mL orally every four hours as needed for pain/air hunger (a form of respiratory distress characterized by gasping and labored breathing). The facility's "Investigation" dated 08/27/25, documented on 08/20/25, Licensed Nurse (LN) G reported to Administrative Nurse D and Administrative Staff A a noted color discrepancy for several liquid narcotics. The facility immediately started investigating, and staff assessed residents on liquid narcotics for pain and gave medication as needed. The facility audited liquid narcotics with no other discrepancies noted. The facility notified the provider and affected residents' representatives. The facility reported the discrepancies to the police. The facility suspended LN I on 08/20/25 pending the investigation, as she worked on both units during the timeframe. The facility contacted the pharmacy, and Consultant GG went to the facility to investigate. Consultant GG discovered R1, R2, R3, R4, R5, R6, and R7 had liquid morphine that appeared to be different in color or smell. Consultant GG destroyed the tampered medications per protocol. The facility reviewed camera footage and was unable to identify any suspicious activity of diversion. The facility identified multiple staff members who had	F0602					

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F0602 SS = E	Continued from page 2 access to the medications in question and were unable to narrow down the exact date the medications may have been tampered with. The investigation included the "Individual Resident's Controlled Substance Record" sheets for the affected residents. The sheets revealed the following last doses of liquid morphine received for each affected resident: R1 on 08/20/25, R2 on 08/07/25, R3 on 03/01/25, R4 on 04/07/25, R5 on 07/22/25, R6 on 05/02/25, and R7 never received any doses. R5 passed away on 07/22/25. On 08/27/25 at 02:11 PM, R6 laid in bed with her eyes closed. R6 appeared comfortable and without signs of pain or discomfort. On 08/27/25 at 02:13 PM, R2 laid in bed with her eyes closed. R2 appeared comfortable and without signs of pain or discomfort. On 08/27/25 at 02:16 PM, R3 laid in bed on his left side facing the wall. R3 appeared comfortable and without signs of pain or discomfort. On 08/27/25 at 02:56 PM, R1 laid in her bed. R1 appeared comfortable and without signs of pain or discomfort. On 08/27/25 at 02:58 PM, R4 laid in bed. R4 appeared comfortable and without signs of pain or discomfort. On 08/27/25 at 03:00 PM, R7 sat in her wheelchair near the nurses' station and talked to staff. R7 appeared comfortable and without signs of pain or discomfort. On 08/27/25 at 03:34 PM, LN H stated she prevented misappropriation of narcotics by performing a count with the oncoming nurse or with the off-going nurse during shift change. She stated the nurses counted the number of cards and bottles and compared them to the narcotic log. LN H stated the off-going nurse read the count book and the oncoming nurse counted the amount in the cards/bottles. LN H stated the nurse verified the resident's name, medication name, and count number. She stated if the nurse received new medications or removed a medication, the card count was reflected on the log. On 08/27/25 at 04:01 PM, Administrative Nurse D stated on 08/20/25, LN G completed count at the beginning of her shift and noticed some of the bottles of morphine were questionable as far as color and consistency. LN G notified Administrative Nurse D of the problem, and the facility pulled out all of the morphine bottles to	F0602					

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F0602 SS = E	Continued from page 3 compare with the count sheets. Administrative Nurse D stated the facility started an investigation and immediately suspended the last nurse who worked the cart. She stated the facility had notified the police and the pharmacy. She stated Consultant GG went to the facility and completed an assessment, then talked to her boss, before giving the facility the findings. Administrative Nurse D stated she and Consultant GG destroyed the liquid narcotics together. She stated the facility had the pharmacy initially only refill R1's morphine as she was the only one actively using it. Administrative Nurse D stated the facility collected evidence and educated nurses on proper narcotic counts and being precise with dosages. She stated the facility pulled the schedules and suspected the upstairs nurse, but throughout the investigation, the facility could not officially put it on LN I. Administrative Nurse D stated the facility investigated every nurse that touched the narcotic carts, and after the investigation was unsubstantiated, the facility allowed LN I to return to work. She stated LN I never appeared altered under the influence, and the facility policy did not drug test unless the staff member appeared altered. On 08/27/25 at 04:31 PM, Administrative Nurse D stated that staff prevented misappropriation of narcotics by conducting a narcotic count. She stated the oncoming nurse counted the cards while the off-going nurse read the narcotic sheet in the book. Administrative Nurse D stated the nurses counted all the medications in total and made sure the total count was correct, then they went one-by-one and compared. She stated that when the nurse got to the liquid narcotics, they placed the bottle on a flat surface to read the amount and made sure the color looked appropriate. Administrative Nurse D stated she expected that even if the medication had not been given recently, the staff would remove it from the box and view it with their own eyes. She stated if staff found a discrepancy, she expected them to report to her immediately, and she expected staff not to take someone's medications. The facility's "Abuse, Neglect, and Exploitation" policy, not dated, directed the facility provided protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation, and misappropriation of resident property. The facility's "Controlled Substance Administration and Accountability" policy, dated 01/01/20, directed two licensed nurses to account for all controlled substances and access keys at the end of each shift.		F0602				

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F0602 SS = E	Continued from page 4 The facility put the following corrective actions into place prior to the onsite visit with a compliance date of 08/20/25: The facility reported the liquid morphine discrepancies to the police on 08/20/25. The facility notified the liquid morphine discrepancies to the pharmacy on 08/20/25. Consultant GG inspected the seven bottles of morphine for signs of tampering and reported her findings to the facility. Administrative Nurse D and Consultant GG destroyed the tampered morphine bottles on 08/20/25. The facility replaced R1's morphine as she was the only one actively using it on 08/20/25. The pharmacy planned to bill the facility for the diverted morphine bottles that the residents paid for on 08/20/25. The facility conducted an Ad-Hoc Quality Assurance and Performance Improvement (QAPI) meeting on 08/20/25. The facility educated Licensed Nurses and Certified Medication Aides (CMA) on Controlled Substances and The Elder Justice Act on 08/20/25. This deficient practice was cited at past noncompliance. The scope and severity remain an "E".			F0602			