STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175159	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place	8909 Parallel Pky Kansas City, KS 66112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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.

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

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 44 residents. The sample included 12 residents, with one reviewed for activities of daily living (ADL). Based on record review, interviews, and observations, the facility failed to ensure Resident (R) 17 received supportive care and services to promote and maintain his quality of life when the facility failed to provide him with his required adaptive utensils while eating his meals. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity. Findings Included:- R17's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of left sided hemiplegia (paralysis of one side of the body), cerebral infarction (stroke - 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), dysphagia (difficulty swallowing), muscle weakness, cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), reduced mobility, and muscle contractures (abnormal permanent fixation of a joint or muscle). R17's Quarterly Minimum Data Set (MDS) completed 06/20/25 revealed a Brief Interview for Mental Status (BIMS) score of ten, indicating mild cognitive impairments. The MDS noted he had upper-body extremity impairments on both sides that affected his range of motion. The MDS noted he required supervision or touch assistance during meals. R17's Functional Abilities Care Area Assessment (CAA) completed 03/17/25 indicated he was at risk for a decline in his ADLs related to his decreased mobility, fatigue, and medical diagnoses. The CAA noted he was at risk for nutritional impairment, skin breakdown, and falls. R17's Care Plan initiated 09/12/24 indicated he was at risk for an alteration of his ADLs related to his medical diagnoses. The plan indicated he required staff assistance for toileting, transfers, bed mobility, bathing, personal hygiene, and dressing. The plan noted he required meal set-up assistance. The plan indicated he needed to build up silverware and a two-handled cup during meals. R17's EMR under Order indicated an active order dated 08/10/25. The order instructed staff to apply R17's left and right wrist orthosis (hand splints to treat contractures) during the day and remove them during the nighttime. R17's EMR under Order indicated an active order dated 09/17/24. The order indicated occupational therapy ordered built-up utensils during mealtimes to increase R17's independence with self-feeding. On 08/11/25 at 08:30 PM, R17 sat in the dining room for breakfast. R17 wore an orthosis on both wrists. R17 ate his lunch with normal silverware and a regular cup without handles. R17 was not offered the special utensils during his meals. On 08/11/25 at 12:05 PM, R17 sat in the dining room for lunch. R17 wore an orthosis on both wrists. R17 ate his lunch with normal silverware and a regular cup without handles. R17 had difficulty handling his utensils as he ate his lunch. R17 was not offered the special utensils during his meals.On 08/12/25 at 09:11 AM, R17 ate his breakfast in the dining room. R17 was not offered the special utensils during his meals.On 08/12/25 at 10:42 AM, Certified Nurse's Aide (CNA) M stated that staff were expected to check the resident's dietary requirements and needs before serving the meals. She stated all staff had access to the care plans and would know if residents required special utensils for meals. On 08/12/25 at 11:20 AM, Administrative Nurse D stated staff were expected to review the planned interventions to ensure each resident's care needs were addressed. She stated the plans were reviewed by the interdisciplinary team weekly and updated. She stated the dietary needs of the residents would be listed in the care plan if they required special utensils and devices. The facility's Adaptive Equipment policy, revised 01/2025, indicated the facility was to ensure each resident was screened for the need of special adaptive equipment to improve the quality of care and independence for the identified resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 35 residents. The sample included 12 residents, with three residents reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to ensure staff assisted Resident (R) 23 with ensuring his fingernails were kept clean. This deficient practice placed R23 at risk for impaired dignity, comfort, and further decline in ADL. Findings Included: - R23's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hemiparesis (muscular weakness of one half of the body) following a cerebrovascular accident (CVA- stroke- 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) affecting the right dominant side, muscle weakness, need for assistance with personal care, hypertension (high blood pressure), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and sleep apnea (a disorder of sleep characterized by periods without respirations). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R23 was dependent on staff for oral hygiene, toileting, dressing, and showers, and needed setup or cleanup for eating. R23's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/17/25 for R23 documented the CAA triggered due to a BIMS score of two. The CAA documented R23 was pleasantly confused, and his cognition varied throughout the day; R23 was at risk for not getting his needs met. R23's Care Plan dated 05/27/21 documented R23 had an alteration in self-care related to diagnoses of Parkinson's disease, right hemiplegia, and dementia. The plan of care for R23 documented he was dependent on staff for bathing, toileting, and required setup for oral hygiene.On 08/10/25 at 08:24 AM, R2 sat in his wheelchair in front of the birds. R23's fingernails had a dark brown substance under his thumb nails. On 08/11/25 at 7:22 AM, R23 sat in the dining room while staff were assisting him with his breakfast order. R23's fingernails had a dark substance under them.On 08/12/25 at 10:42 AM, Certified Nurse Aide (CNA) M stated that if the resident was a diabetic, the nurses usually cut the fingernails or the activity director. CNA M stated when baths are given, the CNAs have a brush that CNAs clean residents' nails with. On 08/12/25 at 10:50 AM, Licensed Nurse (LN) G stated that residents got a bed bath twice a week. LN G stated CNAs clean fingernails on shower days. She stated that all staff should be looking at fingernails to ensure they are clean. On 08/12/25 at 11:07 AM, Administrative Nurse D stated it was all staff's responsibility to ensure residents do not have dirty fingernails. She stated the CNAs clean fingernails in the shower, and the activities director encourages all residents to get nail care on fingernail day. The facility's Bath/Shower policy dated 01/25 documented it was the policy of this facility to promote cleanliness, stimulate circulation, and assist in relaxation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The sample included 16, with three reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area and out of reach of eight cognitively impaired, independently mobile residents. The facility additionally failed to safely transfer Resident (R) 37, resulting in a non-injury fall, and ensure R9's fall interventions were followed. This placed the affected residents at risk for preventable accidents.Findings Included:- On 08/10/25 at 10:10 AM, an initial walkthrough of the facility was completed. An inspection of the 300 Hall revealed an unsecured cabinet across from the vending machine that contained disinfectant bleach wipes and a Clorox spray bottle. Both containers contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed. On 08/12/25 at 10:00 AM, a Certified Nurse’s Aide (CNA) M stated that cleaning chemicals were to be stored in a locked closet or drawer. On 08/12/25 at 10:30 AM, Licensed Nurse (LN) G stated all cleaning products were to be secured in a locked area away from the residents. On 08/12/25 at 11:30 AM, Administrative Nurse D stated that staff were expected to ensure chemical products were locked up after use. The facility’s “Chemical Storage” policy, revised 02/2023, indicated the facility will ensure an environment free from potentially hazardous materials, chemicals, and equipment. - R37’s Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of chronic kidney disease, emphysema (long-term, progressive disease of the lungs characterized by shortness of breath), muscle weakness, need for assistance with personal cares, reduced mobility, and seizures (violent involuntary series of contractions of a group of muscles). R37’s “Quarterly Minimum Data Set (MDS) completed 05/24/25 revealed a Brief Interview for Mental Status (BIMS) noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted she required partial to moderate assistance with bathing, transfers, bed mobility, dressing, toileting, and personal hygiene. The MDs noted she had no lower or upper extremity impairments. The MDS noted she used a wheelchair for mobility. The MDS noted she had one non-injury fall since her last assessment. R37’s “Falls Care Area Assessment (CAA)” completed 03/17/25 indicated she was at risk for a decline in her activities of daily living (ADL) related to her decreased mobility, fatigue, and cognitive impairment. The CAA noted she had a history of falls. The CAA noted that a care plan was implemented to minimize the risks related to her fall history. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37’s “Care Plan” initiated 09/19/24 indicated she was at risk of falls and altered activities of daily living related to her medical diagnoses. The plan noted she required staff assistance for toileting, transfers, bed mobility, personal hygiene, dressing, and bathing. The plan instructed staff to keep needed items within reach and encourage her to use her call light. The plan noted she had a fall on 07/09/25. The plan noted that the facility provided staff education to ensure the wheelchair brakes were locked before providing transfers. R37’s EMR under “Progress Notes” revealed a “Nursing Note” completed on 07/09/25. The note revealed that direct care staff attempted to transfer R37 to her wheelchair but failed to lock the brakes. The note indicated the wheelchair moved as R17 was being transferred by staff. The note revealed R17 was assisted to the ground by staff and laid on her left side. The note revealed R17 was assessed with no injury reported or found. On 08/10/25 at 08:00 AM, R17 reported she had fallen during transfer but had no injuries. R17 lay in her bed. Her wheelchair had brake extenders and a Dycem (non-slip mat to prevent falls) mat under the cushion. On 08/12/25 at 10:42 AM, Certified Nurse’s Aide (CNA) M stated that staff always ensure the wheelchairs were positioned properly and in the locked position to prevent falls. On 08/12/25 at 11:20 AM, Administrative Nurse D stated staff were expected to lock the brakes before transferring the resident into and out of the wheelchairs. She stated that all staff were educated on proper transfer techniques. The facility’s “Fall Management System” policy, revised 10/2023, stated the facility would ensure a safe environment for all residents. The policy indicated staff would assess each resident’s potential risks, including functional abilities, potential falls, assistive devices, and environment, to ensure resident safety. The policy noted that interventions were implemented based on each resident’s needs to minimize complications. - R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), renal failure (inability of the kidneys to excrete wastes, concentrate urine, and conserve electrolytes), symptoms and signs involving cognitive function and awareness, and atrial fibrillation (rapid, irregular heartbeat). The “admission Minimum Data Set (MDS)” dated 03/10/25 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R9 used a wheelchair for mobility during the observation period. The MDS documented R9 required substantial to maximum assistance with transfers and dressing. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R9 used a wheelchair for mobility during the observation period. The MDS documented R9 was dependent on staff assistance for bathing. The MDS documented R9 require substantial to maximum assistance with transfers and dressing. R9's Falls Care Area Assessment (CAA)” dated 04/16/25 documented he was at risk for falls related to his decreased mobility and history of falls prior to admission to the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's “Care Plan” dated 03/05/25 documented staff would ensure his call light was in reach and encourage him to call for assistance as needed. The plan of care documented staff would ensure R9 was wearing appropriate footwear when ambulating or wheeling in the wheelchair. The plan of care documented the staff would keep R9’s needed items, water, and other items of choice in reach. The plan of care dated 03/27/25 documented on 03/27/25 therapy would evaluate for recliner safety. The plan of care dated 07/09/25 documented on 01/17/25 nursing staff educated him to call for staff assistance to retrieve any items which are out of reach. The plan of care documented on 03/29/25 non-skid strips were placed on the floor in front of R9’s recliner. The plan of care documented on 04/11/25 staff placed a “Call Before Fall” sign on the wall behind his recliner. On 8/12/25 at 08:51 AM R9 sat in his recliner as he watched TV. R9’s feet were elevated in the recliner. R9’s call light was pinned to the bed out of reach behind his wheelchair. R9’s bedside table with his water and other items was out of reach by the room door. On 08/12/25 at 10:42 AM, Certified Nurse Aide (CNA) M stated everyone had access to all the resident’s care plan and the Kardex (nursing tool that gives a brief overview of the care needs of each resident) that has all their information. CNA M stated it was everyone’s responsibility to ensure the resident’s fall intervention were in place. CNA M stated the new intervention would be on the Kardex and if there were any new interventions added that information would be passed on during shift change report. On 08/12/25 at 10:50 AM, Licensed Nurse (LN) G stated everyone had access to the resident’s care plan and to the Kardex. LN G stated it was everyone’s responsibility to ensure every resident’s fall intervention were in place as care planned. LN G stated if any new interventions had been added to the resident’s care plan after a fall, that information was passed on during the shift change report. On 08/23/25 at 11:10 AM, Administrative Nurse D stated she would expect the charge nurse to add a new intervention on the resident’s care plan after a fall. Administrative Nurse D stated the interdisciplinary team (IDT) would review the new intervention and determine if that was to root cause of the fall. Administrative Nurse D stated everyone had access to the care plan or the Kardex and it was everyone’s responsibility to ensure the fall interventions were in place as care planned. The facility’s “Quality of Care” policy dated 12/2023 documented it was the policy of the facility to provide an environment that remains as free of accident hazards as possible. It was also the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 35 residents. The sample included 12 residents, with two residents reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to consistently communicate Resident (R) 51 medical condition with a pre- and post-dialysis communication prior to and post-hemodialysis. This deficient practice placed R51 at risk of potential adverse outcomes and physical complications related to dialysis. Findings included:- R51's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of end-stage renal disease (ESRD- a terminal disease of the kidneys) with dialysis (procedure where impurities or wastes were removed from the blood), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), acquired absence of left leg above knee, , peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), muscle weakness, and need for assistance with personal care. The admission Minimum Data Set (MDS) for R51, dated 06/12/25, recorded a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R51 required hemodialysis during the observation period. R51's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 06/12/25 documented R51 has an alteration in functional abilities related to decreased mobility and pain. The CAA documented R51 had recently fallen and had a fractured cervical spine, and always had a hard neck collar. R51's Care Plan dated 06/23/25 documented R51 had ESRD and required hemodialysis. R51's plan of care documented nursing was to check arteriovenous (AV) fistula (an abnormal connection between an artery and a vein) every day for bruit (blowing or swishing sound heard when blood flows through a shunt) and thrill (a fine vibration felt that reflects the blood flow by a dialysis resident's shunt). The plan of care documented R51's AV fistula was located in the left upper extremity, and staff were to encourage R51 to go to scheduled dialysis appointments on Monday, Wednesday, and Friday.R51's EMR under the Orders tab dated 08/04/23 revealed the following physician's order: Dialysis communication form completed and filed after dialysis every day shift, every Monday, Wednesday, and Friday, dated 06/06/25.Assess and document assessment of AV shunt/fistula for Brit and Thrill every shift and as needed, dated 06/06/25. Assess dialysis site to ensure proper dressing was in place upon return from dialysis every shift, every Monday, Wednesday, and Friday, dated 06/06/25. Review of R51's EMR under Misc tab, documented the facility dialysis communication forms lacked evidence of pre- and post-hemodialysis assessment for the following dates: 06/18/25, 06/2025, 06/23/25, 07/11/25, 07/14/25, 07/18/25, and 07/21/25. On 08/12/25 at 10:50 AM, Licensed Nurse (LN) G stated that the process for dialysis communications sheets was when the resident returned from dialysis, the sheet was filled out, and placed in his binder. If the communication sheet was not in the binder, nursing was to call the dialysis center and get report. LN G said staff placed the completed sheet in the folder to be scanned into the resident's chart. On 08/12/25 at 11:09 AM, Administrative Nurse D stated that the facility was to ensure the communication reports were filled out before the resident left for dialysis. The nurse on duty would ensure the forms were returned or call the dialysis center and have the dialysis center return the sheet. Administrative Nurse D stated the facility had been having problems getting the communication sheets back from the dialysis center. She stated the facility started sending the sheets in a binder in hopes the sheets were returned. The facility's Dialysis Pre and Post Care policy dated 12/23 documented it was the policy of this facility to: assist residents in maintaining homeostasis pre- and post-renal dialysis; assess and maintain patency of renal dialysis access; assess resident daily for function related to renal dialysis; and participate in ongoing communication; and collaboration with the dialysis facility regarding dialysis care and services.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. The facility identified a census of 35 residents. The sample included 12 residents, with four residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R) 4 had a documented risk assessment that included alternatives that had been tried and failed. This placed the R4 at risk for uninformed decisions and impaired safety related to the risks associated with the use of siderails.Findings included:- R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and cerebrovascular accident (CVA- stroke- 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). The admission Minimum Data Set (MDS) dated 05/08/25 documented a Brief Interview of Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R4 required substantial to maximum staff assistance with bed mobility, dressing, transfers, and bathing. R4's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/30/25 documented she had decreased mobility, was blind, and had a diagnosis of dementia. R4's Care Plan dated 05/04/25 documented she had bilateral upper quarter bedrails to assist with bed mobility. The facility provided a Bed Rail Safety Assessment dated 05/05/'25 that documented R4's representative had given verbal consent for the side rails. The assessment documented the interdisciplinary team (IDT) justification was all the beds at the facility had the functions on the rails to operate the bed. The bed rails were used for positioning and promoting independence with bed mobility. The assessment lacked the alternatives that had been tried and failed prior to bed rails. The assessment lacked the drug classification that would place a resident at risk for entrapment. On 08/12/25 at 7:19 AM, R4 laid in bed asleep on her right side. R4's bilateral upper bed rails were pulled up and locked into place. On 08/12/25 at 10:45 AM, Certified Nurse Aide (CNA) M stated she had not seen any siderails up on any of the residents. CNA M stated the lower siderails on the beds are secured down. On 08/12/25 at 10:50 AM, Licensed Nurse (LN) G stated side rail assessment was completed at the time of admission, quarterly, annually, and when there was a significant change. LN G stated that the factors that would make siderails unsafe would be their cognitive status, mobility, and history of falls, which would place the resident at risk of entrapment. On 08/23/25 at 11:10 AM, Administrative Nurse D stated a siderail assessment was completed at the time of admission, quarterly, annually, and when there was a significant change. Administrative Nurse D stated the IDT made the final decision if a resident was safe to use siderails. Administrative Nurse D stated R4 held the siderail when staff would provide assistance with bed mobility. Administrative Nurse D stated the IDT would review the resident's medication, mobility, mental status, safety awareness, and history of falls. The facility's Quality of Care policy dated 12/2023 documented it is the policy of this facility to 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.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility identified a census of 35 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to act upon the Consultant Pharmacist (CP) recommendations for Resident (R) 4. This deficient practice placed R4 at risk for unnecessary medication use, side effects, and physical complications.Findings included:- R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and cerebrovascular accident (CVA- stroke- 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). The admission Minimum Data Set (MDS) dated 05/08/25 documented a Brief Interview of Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R4 required substantial to maximum staff assistance with activities of daily living (ADL). The MDS lacked indication a drug regimen review was completed during the observation period. R4's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/30/25 documented she was at risk of adverse side effects related to the medication she received. R4's Care Plan dated 06/25/25 documented nursing staff would administer medication as ordered by the physician.R4‘s EMR under the Orders tab revealed the following physician orders: Dulcolax (laxative) oral tablet delayed release (DR) five milligram (mg) (bisacodyl), give one tablet by mouth every 24 hours as needed for constipation, dated 05/02/25. The order lacked do not crush instructions. Review of the Monthly Medication Review (MMR) from August 2024 to July 2025 documented recommendations from 07/01/25 to add do not crush to Dulcolax DR order. Review of R4's August 2025 Medication Administration Record (MAR) lacked do not crush instructions for Dulcolax medication.On 08/11/2025 at 12:24 PM, R4 sat upright in a Broda chair (specialized wheelchair with the ability to tilt and recline) as the nursing staff assisted her with lunch. On 08/23/25 at 11:10 AM, Administrative Nurse D stated she expected the pharmacy reviews would be reviewed and acted upon within seven days of receiving the MRR's. The facility's Pharmacy Services policy dated 12/2023 documented it was the policy of the facility that the drug regimen of each resident would be reviewed at least once a month by a licensed pharmacist. A medication regimen review (MRR) includes a review of the resident's medical chart. Identified irregularities would be documented on a separate written report that included the resident's name, the relevant drug, and the irregularity identified. The report would be sent to the attending physician, the facility's Medical Director, and the Director of Nursing Services (DNS) to be acted upon.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175159	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place	8909 Parallel Pky Kansas City, KS 66112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility reported a census of 44 residents. The facility identified two medication rooms and four medication carts. Based on observations, record reviews, and interviews, the facility failed to secure one of two medication storage rooms. This deficient practice placed the residents at risk for unnecessary medication and administration errors.Findings Included:- On 08/10/25 at 10:05 AM, an initial walkthrough of the facility was completed. An inspection of the 100 Hall Team Office medication storage room revealed that the door was not secured. An inspection of the medication storage room revealed shelves of stock medication, enteral feeding solutions, and medical supplies. On 08/10/25 at 10:11 AM, Licensed Nurse (LN) G stated the door should be locked at all times due to the medications in the room. She stated that sometimes the doorknob would stick and not close properly. She stated staff were expected to ensure the room remained locked when exiting. LN G secured the room at 10:14 AM. On 08/12/25 at 10:30 AM, Administrative Nurse D stated staff were expected to ensure the medication rooms remained locked. The facility's Medication Storage policy (undated) indicated the facility was to secure all medication in a clean, locked, and organized manner to ensure safe handling and administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility identified a census of 35 residents. The facility had one main kitchen and one dining area. The facility failed to ensure that staff members properly tested the dishwashing sanitization chemicals. The facility also failed to ensure food items were labeled and dated when opened. These deficient practices placed residents at risk for contamination and foodborne illness.Findings included:- During the initial tour of the kitchen and dining room area on 08/10/25 at 10:05 AM, an open undated gallon of milk was in the refrigerator. During review of the dishwashing process, Dietary Staff BB stated the facility had not started using the dishwashing machine and washed the dishes by hand in the three-sink system. Dietary Staff BB stated that the facility washed the dishes in hot water and chemicals. Dietary Staff stated the facility did not have test strips at that time to test the water or have a log to review.On 08/12/25 at 10:11 AM, Dietary Staff BB stated that every item that was opened should be labeled and dated. Dietary Staff BB stated the facility had received the dishwasher test strips to test the dishwashing water to prevent foodborne illness.The facility's undated Sanitary Conditions for Food policy documented it was the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State, and/or local authorities.

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	175159	A. Building B. Wing	08/12/2025

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility reported a census of 36 residents. The sample included 12 residents. Based on record review and interviews, the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ - Staffing Data Report) when the facility failed to submit accurate weekend staffing coverage hours. This placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - A review of the facility's submitted PBJ data from 04/01/24 through 03/31/25 indicated the facility triggered for excessively low weekend staffing for Fiscal Year (FY) Quarter One 2024 (10/01/24 to 12/31/24) A review of the facility's working schedule, time sheets/punches, and posted staffing hours indicated no gaps or loss of hours. On 08/12/25 at 11:20 AM, Administrative Nurse D stated the facility used agency staff during the triggered period, and the time may not have been documented appropriately on the reporting. The facility's Payroll-Based Journaling policy, revised 10/2023, indicated staffing and census information will be reported electronically to the Centers for Medicare and Medicaid Services (CMS). The policy indicated that staffing information during the recorded time period shall be made available to residents, family members, and the public within 24 hours of a written or verbal request.

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	175159	A. Building B. Wing	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 35 residents. The facility identified seven residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to ensure trash was stored and contained properly. The facility further failed to ensure trash was not left on top of the Personal Protective Equipment (PPE) cart, and the clean linen door was not propped open. The facility further failed to ensure soap and paper towels were available in the same room, and gloves were available in the dirty laundry area, and all staff knew where the hand washing sink was in the laundry room. These deficient practices placed the residents at risk for infectious diseases. Findings included:- An initial walkthrough of the facility was completed on 08/10/25 at 07:05 AM. A clear bag of trash was left on top of a PPE cart in the 300 halls. A clean linen closet was propped open in the 300 halls. On 08/10/25 at 10:05 AM, a walk-through laundry accompanied by Housekeeping Staff V occurred. During the walk-through of the laundry room, no handwashing sink was seen, and no PPE was revealed. On 08/11/25 at 08:07 AM, Laundry Supervisor U showed me the laundry soaking sink in the laundry room, and stated that staff wash their hands here, they get soap from the dirty laundry area, come back to the laundry soaking sink, wash their hands, and then go back to the dirty laundry area to dry their hands. [NAME] Supervisor U stated there were gowns by the washing machines, but she had forgotten to get any gloves. On 08/12/25 at 10:42 AM, Certified Nurse's Aide (CNA) M stated that clean linen rooms should not have the door propped open, and it was the responsibility of all staff to ensure trash was picked up and disposed of properly. On 08/12/25 at 12:37 AM, Licensed Nurse (LN) G stated that trash should never be left on a PPE cart. She stated it was the responsibility of the person who left the trash to dispose of the trash. LN G stated that if any staff member sees trash where it was not supposed to be, that staff member should dispose of the trash. She stated linen closets should never be left open. On 08/12/25 at 11:07 AM, Administrative Nurse D stated that it was all staff's responsibility to ensure trash was disposed of properly. She stated linen closets should never be propped open. The facility's Infection Control Program policy dated 04/25 documented the infection prevention and control program was a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection prevention and control program consist of coordination/oversight, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The program would be carried out by the facility infection preventionist. It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards.