

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER McCrite Plaza Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1610 SW 37th Street Topeka, KS 66611	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037</p> <p>The facility identified a census of 57 residents. The sample included 15 residents with one resident reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 41's dignity was maintained. This deficient practice placed R41 at risk for impaired dignity and decreased psychosocial well-being.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R41's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). <p>The Significant Change Minimum Data Set (MDS) dated [DATE] documented R41 had severely impaired cognition. The MDS documented R41 was dependent on staff assistance for activities of daily living (ADLs). The MDS documented R41 had bilateral lower extremity impairment of range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension).</p> <p>R41's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/15/24 documented R41 had a diagnosis of dementia. R41 had memory loss and disorganized thinking.</p> <p>R41's Care Plan dated 03/11/24 documented he preferred his shower twice weekly in the evening. The plan of care documented that staff would break down the tasks into segments for R41 to be more manageable. The plan of care for R41 documented that staff would establish and maintain a routine and would reorient and reassure him as needed. The plan of care also documented staff would support and assist him with problem-solving.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/05/24 at 09:09 AM R41 was transferred from his bed to a shower chair with the assistance of Certified Nurse Aide (CNA) O and CNA P with a Hoyer lift (total body mechanical lift). R41 was dressed in a gown that was open in the back, he was unable to sit upright on the shower chair. CNA O placed a small blanket from R41's bed around his waist to his knees. CNA O and CNA P attempted to reposition him on the shower chair by lifting him under his arms and legs. CNA O stated R41 was unable to sit upright on the shower chair, and he usually was given a shower on the bath bed, but another unit was using it at that time. CNA O stated she would have to pull R41 down the hallway backward because R41's feet would get caught under the shower chair or drag on the floor. CNA O pulled R41 down the hallway to the shower room backwards with CNA P attempting to hold R41's feet from dragging on the floor.</p> <p>On 08/07/24 at 09:07 AM, CNA N stated should never be pulled backward down the hallway on a shower chair. CNA N stated a resident should be covered when in the hallways.</p> <p>On 08/07/24 at 09:12 AM, Licensed Nurse (LN) H stated a resident should never be pulled backward, if a person's legs are too long, they should have been put in a reclining shower chair. LN H said residents should be covered appropriately.</p> <p>On 08/07/24 at 10:43 AM, Administrative Nurse D stated if a resident was unable to be pushed forward in the shower chair then it would be safer to pull the resident backward Administrative Nurse D stated she expected the staff to follow the residents' care plan.</p> <p>The facility's Right to Dignity policy dated 11/29/19 documented the facility would promote care for residents of the facility in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of the resident's individuality. All staff would provide dignity to each resident by maintaining the resident's privacy of body which included. Keeping the resident covered while transporting the resident outside the resident's room. The residents would be undressed and dressed inside the bathing room rather than being transported without full clothing unless otherwise care planned, and a resident has requested it.</p> <p>The facility failed to ensure R41's right to be treated with respect, and dignity when pulled in the hallway backward on a shower chair. This deficient practice placed R41 at risk for negative psychosocial outcomes and decreased dignity.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037</p> <p>The facility identified a census of 57 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to ensure the oxygen tubing was stored in a sanitary manner to decrease exposure and contamination for Resident (R)41. This deficient practice placed R41 at increased risk for respiratory infection and complications.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R41's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). <p>The Significant Change Minimum Data Set (MDS) dated [DATE] documented R41 had severely impaired cognition. The MDS documented R41 was dependent on staff assistance for activities of daily living (ADLs). The MDS documented R41 had bilateral lower extremity impairment of range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension).</p> <p>R41's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/15/24 documented R41 had a diagnosis of dementia. R41 had memory loss and disorganized thinking.</p> <p>R41's Care Plan dated 07/09/24 documented that staff would change the oxygen tubing weekly and as needed. The plan of care documented that staff would monitor the oxygen concentrator to ensure proper operation and clean the filters weekly and as needed. The plan of care documented that staff would monitor his oxygen saturation every shift and report any changes to the physician. The care plan documented the facility would provide education regarding the use of oxygen and would demonstrate proper placement of the oxygen equipment.</p> <p>R41's EMR under the Orders tab revealed the following physician orders:</p> <p>Titrate oxygen via nasal cannula to maintain oxygen saturation above 90 percent every shift dated 06/11/24.</p> <p>On 08/05/24 at 09:09 AM R41 laid on his back on the bed. The bed was in a low position R41 was not wearing an oxygen nasal cannula. A nasal cannula and oxygen tubing were wrapped tightly around the back of a Broda chair (specialized wheelchair with the ability to tilt and recline) in the room. Another nasal cannula and oxygen tubing were draped over the oxygen concentrator next to his bed.</p> <p>On 08/06/24 at 12:24 PM, R41's nasal cannula and oxygen tubing were hung over the top of the oxygen concentrator and rested on the floor behind the concentrator. A black bag was attached to the oxygen concentrator.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/06/24 at 02:23 PM, R41 lay on his bed with his eyes closed and a nasal cannula was intact on his face. Oxygen tubing and a nasal cannula were draped over the back of the Broda chair and not placed in the black bag that was attached to the back of the Broda chair.</p> <p>On 08/06/24 at 09:10 AM, Certified Nurse Aide (CNA) N stated all oxygen nasal cannulas should be stored in a bag when not in use. CNA N stated the oxygen nasal cannulas are changed weekly.</p> <p>On 08/06/24 at 09:12 AM, Licensed Nurse (LN) H stated all of the residents who are on oxygen therapy are given containers and bags for oxygen cannulas and nebulizers. LN H stated all oxygen should be placed in bags or canisters when not in use for sanitation, and never wrapped around handles of oxygen canisters or draped over chairs.</p> <p>On 08/06/24 at 10:43 AM, Administrative Nurse D stated she expected the oxygen nasal cannulas to be stored in a sanitary manner. Administrative Nurse D stated the nasal cannulas are changed weekly and a black bag was provided to store the nasal cannula when not in use. Administrative Nurse D said it should never be placed on the floor or draped over a chair.</p> <p>The facility was unable to provide a policy related to sanitary storage of oxygen equipment when not in use.</p> <p>The facility failed to ensure R41's oxygen tubing was stored in a sanitary manner to decrease exposure and contamination. This placed R41 at increased risk for respiratory infection and complications.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037</p> <p>The facility identified a census of 57 residents. The sample included 15 residents with one resident 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 ensure a form of communication was established between the facility and the dialysis center for Resident (R) 3. This deficient practice placed R3 at risk of potential adverse outcomes and physical complications related to dialysis.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R3's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dependence on renal dialysis, end-stage renal disease (inability of the kidneys to excrete wastes, concentrate urine, and conserve electrolytes), and a need for assistance with personal care. <p>The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R3 received hemodialysis services during the observation period.</p> <p>R3's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 06/06/24 documented during the assessment period, R3 required staff assistance for activities of daily living (ADLs). R3 received renal dialysis on Monday, Wednesday, and Friday.</p> <p>R3's Care Plan dated 05/29/24 documented that staff would observe, monitor, and assess the arteriovenous (AV-a surgically created connection between an artery and a vein) for signs or symptoms of infection, compromise, and impairment.</p> <p>R3's EMR under the Orders tab revealed the following physician orders:</p> <p>Dialysis on Monday, Wednesday, and Friday at 10:30 AM dated 05/29/24.</p> <p>R3's clinical record reviewed from 05/29/24 to 08/06/24 lacked evidence of consistent communication between the facility and the dialysis provider.</p> <p>On 08/06/24 at 12:58 PM, R3 walked around in his room without difficulty.</p> <p>On 08/06/24 at 01:55 PM, Licensed Nurse (LN) I stated the facility did not send communication sheets with R3 to dialysis. LN I stated the dialysis provider would call the facility if there had been a change, if lab work had been obtained, or any other changes. LN I stated the facility did not notify the dialysis provider of any pre-dialysis assessments on the days R3 went for dialysis treatment.</p> <p>On 08/06/24 at 02:46 PM, Administrative Nurse D stated she believed that the facility system was to send a dialysis communication sheet with any resident who received dialysis though the dialysis provider did not always return the communication sheets. Administrative Nurse D stated she would have to check with Administrative Nurse E.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/06/24 at 03:20 PM Administrative Nurse E stated the facility had stopped sending dialysis communication sheets with the residents to their dialysis providers due to the provider not returning the communication sheet.</p> <p>The facility's undated Hemodialysis Policy documented the facility was to provide excellence in care and services to residents with End-Stage Renal Disease (ESRD) receiving hemodialysis at a certified renal dialysis unit off-site. Coordination of care included Information transmitted to the dialysis unit by the facility prior to dialysis, and information transmitted to the facility by the dialysis unit after dialysis. The facility staff would initiate a written communication form that would accompany the resident off-site to the dialysis unit and return, completed by the dialysis unit staff for every visit.</p> <p>The facility failed to ensure a form of communication was established between the facility and the dialysis center for R3. This deficient practice placed R3 at risk of potential adverse outcomes and physical complications related to dialysis.</p>

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>41037</p> <p>The facility identified a census of 57 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required communication training. This placed the residents at risk for impaired care and decreased quality of life.</p> <p>Findings included:</p> <p>- On 08/06/24 at 01:15 PM the training record on file at the facility for agency Certified Nurses Aid (CNA) M and agency Licensed Nurse (LN) G revealed the following:</p> <p>CNA M's facility-provided credentialing file lacked documented training completed for communication. The file noted he was provided abuse, neglect, and exploitation (ANE), dementia, and infection control training.</p> <p>LN G's facility-provided credentialing file lacked documented training completed for communication. The file noted she was provided abuse, neglect, and exploitation (ANE), and dementia.</p> <p>08/07/24 at 07:04 AM Administrative Nurse D stated the facility relied on the contracted agency to provide the required education for the agency nursing staff. She stated the facility had not ensured the agency staff had the education and/or training required for direct care staff.</p> <p>The facility was unable to provide a policy related to required education for direct care staff.</p> <p>The facility failed to ensure the completion of the required communication training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.</p>

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<p>F 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.</p> <p>41037</p> <p>The facility identified a census of 57 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required resident's rights training. This placed the residents at risk for impaired care and decreased quality of life.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 08/06/24 at 01:15 PM the training record on file at the facility for agency Certified Nurses Aid (CNA) M and agency Licensed Nurse (LN) G revealed the following: <p>CNA M's facility-provided credentialing file lacked documented training completed for resident rights. The file noted he was provided abuse, neglect, and exploitation (ANE), dementia, and infection control training.</p> <p>LN G's facility-provided credentialing file lacked documented training completed for resident rights. The file noted she was provided abuse, neglect, and exploitation (ANE), and dementia training.</p> <p>08/07/24 at 07:04 AM Administrative Nurse D stated the facility relied on the contracted agency to provide the required education for the agency nursing staff. She stated the facility had not ensured the agency staff had the education and/or training required for direct care staff.</p> <p>The facility was unable to provide a policy related to required education for direct care staff.</p> <p>The facility failed to ensure the completion of the required resident's rights training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.</p>