STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175187	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Ridge Health & Rehabilitation	6501 W 75th Street Overland Park, KS 66204

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)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 62 residents. The sample included three residents reviewed for weight loss. Based on record review and interviews, the facility failed to implement interventions to prevent further weight loss for Resident (R) 1 after she experienced a significant weight loss, and the facility implemented an initial intervention in September 2024. R1 continued to experience significant weight loss and Consultant GG followed R1 but did not recommend further interventions to prevent weight loss and the facility failed to implement further weight loss prevention interventions. This deficient practice resulted in a significant weight loss of 25.6% for R1. Findings included: - R1 admitted to the facility on [DATE] and transferred to the hospital on 12/26/24. R1's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness, mild intellectual abilities, cognitive communication deficit, need for assistance with personal care, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R1 required set-up or clean-up assistance with eating and had no weight loss/gain since admission. The Quarterly MDS dated [DATE], documented a BIMS score was not assessed. R1 required set-up or clean-up assistance with eating and R1 had weight loss not from a prescribed weight-loss regimen. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 07/09/24, lacked an analysis of findings. The Activities of Daily Living (ADLs) - Functional/Rehabilitation Potential CAA dated 07/09/24, lacked an analysis of findings. The Nutritional Status CAA dated 07/09/24, lacked an analysis of findings. R1's Care Plan dated 10/14/24, documented R1 had an alteration in self-care and directed staff to know R1 required set-up assistance with eating. (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 0692 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan dated 10/14/24, documented R1 had a risk for alteration in nutrition and directed staff to monitor and report to R1's medical doctor as needed for any signs and symptoms of decreased appetite, nausea and vomiting, unexpected weight loss, and complaints of stomach pain. The plan directed staff provided diet and nutritional supplements to R1; staff administered vitamin replacements as ordered; and staff monitored and reported to R1's medical doctor signs and symptoms of dysphagia (difficulty swallowing). R1's EMR revealed the following orders: An order with a start date of 07/11/24 and discontinued date of 09/05/24 for Juven (supplement used to support wound healing and lean body mass) two times a day for wound healing. An order with a start date of 07/11/24 and discontinued date of 11/20/24 for liquid protein (supplemental protein) 30 milliliters (mL) two times a day (BID) for wound healing. An order with a start date of 09/17/24 for Mighty Shakes (supplemental shakes to provide dietary calories and protein for malnutrition recovery) three times a day (TID) for weight loss. An order with a start date of 09/17/24 and completion date of 10/17/24 for twice weekly weight for one month to monitor for weight loss; an order with a start date of 11/20/24 for liquid protein 30 mL twice daily. An order with a start date of 12/02/24 to weigh three times a week for two weeks for weight loss on Monday, Wednesday, and Friday. Review of R1's Medication Administration Record (MAR) from 09/17/24 to 12/26/24 revealed a lack of evidence that staff monitored the resident's Mighty Shake intake percentages with administration TID. R1's EMR documented the following weights: 220.0 pounds (lbs.) on 07/03/24, 199.0 lbs. on 09/04/24, 199.0 lbs. on 09/06/24, 194.0 lbs. on 09/10/24, 195.8 lbs. on 09/23/24, 185.6 lbs. on 09/28/24, 187.0 lbs. on 09/30/24, 178.2 lbs. on 10/07/24, 182.6 lbs. on 10/10/24, 179.0 lbs. on 10/14/24, 187.4 lbs. on 11/01/24, 172.2 lbs. on 11/06/24, 163.6 lbs. on 12/01/24, 166.8 lbs. on 12/04/24, 164.6 lbs. on 12/09/24, and 164.2 lbs. on 12/13/24. R1 had 25.6% significant weight loss between 07/03/24 to 12/01/24. R1's Task tab of her EMR revealed a task, revised 08/28/24, for Snacks scheduled at 08:00 PM daily. R1's EMR revealed the following: A Weight Change Note on 09/10/24 at 10:48 AM documented a weight warning and a weight of 199 lbs. Consultant GG requested a reweigh related to weight loss indicated and noted they suspected an error in the weight entry. A Weight/Skin Committee Interdisciplinary Team (IDT) note on 09/17/24 at 12:30 PM documented R1 needed a reweigh, had weight loss noted as trending, and Consultant GG following the weight loss. R1 received a regular diet with no supplements recommended at that time. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A Physician Progress Note on 09/17/24 at 04:08 PM documented nursing reported a significant weight loss and R1 ate 50 to 75% of her meals. The provider gave R1 a Mighty Shake which she drank. The note indicated an order to check R1's protein with her next labs, staff continued to follow weights, Consultant GG followed R1, staff encouraged oral intake, R1 received liquid protein, and the provider added Mighty Shakes TID. A Physician Progress Note on 09/27/24 at 04:35 PM documented the facility continued to monitor R1's weights, Consultant GG followed R1, and staff continued supplements as directed. A Nursing Note on 10/01/24 at 11:47 AM documented the IDT reviewed R1 at a weekly risk review for questionable weight loss of 12 lbs. in one month. The note documented the facility put an intervention to reweigh R1 in place. R1 continued on a regular diet with 75 to 100% meal intake, R1 received liquid protein BID, and R1 received Mighty Shakes TID. The facility continued the current plan of care. A Physician Progress Note on 10/10/24 at 02:56 PM documented R1 reported she was hungry and the provider gave her some crackers. The note documented the plan to continue to monitor weights and continue supplements with Consultant GG following. A Weight Change Note on 10/15/24 at 01:30 PM documented a weight of 179.0 lbs. Consultant GG reviewed R1's weights related to weight loss and Consultant GG questioned accuracy of the weights. R1 continued on a regular diet with regular texture and thin liquids with 76 to 100% intake at mealtimes. R1 received Mighty Shakes TID with 100% intake, which left Consultant GG suspicious of accuracy in weights. Consultant GG requested a reweigh. A Physician Progress Note on 10/15/24 at 03:10 PM documented R1 had a good appetite and ate 100% of meals. The note documented a plan to continue to monitor R1's weights and continue supplements as directed with Consultant GG following the resident. The provider questioned the accuracy of R1's weights as R1 ate 100% of her meals and snacks. A Physician Progress Note on 10/25/24 at 04:15 PM documented R1 participated in therapy services. The note documented a plan to continue to monitor R1's weights and continue supplements as directed with Consultant GG following. The provider questioned accuracy of R1's weights as R1 ate 100% of her meals and snacks. A Physician Progress Note on 10/29/24 at 01:15 PM documented R1 ate well. The note documented a plan to continue to monitor weights and continue supplements as directed with Consultant GG following. The provider questioned accuracy of R1's weights as R1 ate 100% of her meals and snacks. A Weight Change Note on 11/05/24 at 12:23 PM documented a weight of 187.4 lbs. R1 had weight loss with current interventions in place noted as R1 started on a new psychotropic (medication that alters mood or thought) medication that may cause weight gain and R1 was less active and resting more. The note documented the facility worked on getting R1 mentally stable. R1 received a regular diet with 76 to 100% intake at meals and received Mighty Shakes TID. The note documented the facility continued R1's plan of care. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A Weight Change Note on 11/19/24 at 12:52 PM documented a weight of 172.2 lbs. R1 had a questionable 15 lbs. weight loss in three days with no current interventions in place. R1 had behaviors that made her noncompliant with cares. R1 received a regular diet with 76-100% intake and Mighty Shakes. The note documented the facility continued R1's plan of care. A Physician Progress Note on 11/29/24 at 06:44 PM documented R1 had agitation, behaviors, urine frequency, and mobility deficits. The note documented a plan to obtain labs and a UA, and the facility continued to monitor weights and continued supplements as directed while Consultant GG followed. A Physician Progress Note on 12/02/24 at 04:53 PM documented R1 seen for weight loss and nursing reported R1 ate well and had supplements ordered. The note documented a plan to continue to monitor weights with weights obtained three times a week for two weeks and continue supplements as directed while Consultant GG followed. A Weight Change Note on 12/03/24 at 01:31 PM documented a weight of 163.6 lbs. Consultant GG reviewed R1's weights related to weight loss with what appeared to be some inconsistent weights. R1 received nutritional supplements TID and a regular diet with 76 to 100% intake. A Physician Progress Note on 12/13/24 at 03:54 PM documented R1 started on antibiotics for leukocytosis but the facility did not obtain the UA. Nursing reported R1 had a good appetite despite noted weight loss and she received supplements ordered per Consultant GG. The note documented a plan to continue to monitor weights and continue supplements as directed while Consultant GG followed. A Weight Change Note on 12/17/24 at 12:19 PM documented a weight of 164.2 lbs. R1 received a regular diet with 76 to 100% intake and Mighty Shakes TID. The note documented to continue with current plan of care. A Nursing Note on 12/22/24 at 12:48 PM documented R1 refused to eat breakfast and lunch. Staff offered R1 different options for her meals, but she still refused. A Physician Progress Note on 12/23/24 at 04:42 PM documented nursing reported R1 was lethargic that morning and did not get up to eat. R1's family voiced concern about significant weight loss. The note documented a plan to do laboratory tests STAT (immediately), continue to monitor weights with Consultant GG following, continue supplements as directed, discuss medications with psychiatry, and consider routine cancer screenings. A Nursing Note on 12/26/24 at 09:49 AM documented R1 was transported to the hospital on a stretcher by ambulance following a temperature spike. On 01/13/25 at 02:34 PM, Certified Nurse Aide (CNA) M stated the CNAs obtained resident weights and Administrative Nurse D and Administrative Nurse E monitored weights. She stated she prevented resident weight loss by encouraging residents to eat more, giving more water, giving alternative meals and snacks throughout the day. CNA M stated if a resident received Mighty Shakes, the kitchen placed the shakes on the trays or the Certified Medication Aide (CMA) or nurse gave the shakes. She stated she did not know about R1's weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 01/13/25 at 02:37 PM, CMA R stated the CNAs obtained weights and wrote them down for the nurse to put into the computer. She stated the CMAs gave supplemental shakes and documented intake percentages. CMA R stated if she saw a Mighty Shakes order without percentage documentation, she would ask the nurse to change it. She stated she prevented resident weight loss by encouraging residents to eat. On 01/13/25 at 02:42 PM, Licensed Nurse (LN) G stated the CNAs obtained the weights and the nurses helped. She stated the nurses, Administrative Nurse D, and Administrative Nurse E monitored for weight changes. LN G stated she prevented weight loss by encouraging residents to eat and administering supplements or appetite stimulants. She stated the CMAs gave the supplemental shakes and documented percentages on Mighty Shakes. LN G stated she had never put percentage documentation on a Mighty Shake order. She stated R1 had weight loss, but she did not remember if R1 received supplements or not. She stated staff struggled to get R1 up for meals and R1 refused a lot of meals. LN G stated R1 slept through a lot of meals but staff offered meals when she woke up. On 01/13/25 at 03:00 PM, Administrative Nurse D stated the CNAs obtained resident weights and told the nurse who put them into the computer. She stated the IDT monitored weights and Consultant GG looked at weights once a week during weekly risk meetings. Administrative Nurse D stated the facility put weight loss interventions on the MAR and in the care plan. She stated the kitchen delivered Mighty Shakes and magic cups (fortified frozen supplement) on their trays and the CMA or nurse passed Med Pass (supplemental shake) or Glucerna (supplemental shake) supplements. Administrative Nurse D stated she did not know if Mighty Shakes had intake percentages documented with administration, but staff should document intake with meals. She stated R1 was a busy person, she would start eating then leave so staff redirected her back to her meal. R1 sometimes ate in the main dining room but she would yell and needed to eat in her room. Administrative Nurse D stated Consultant GG documented in her notes when she reviewed R1. She stated R1 had medication changes and she did not know if R1 slept more because of medication changes. On 01/13/25 at 03:04 PM, Administrative Nurse E stated R1 always moved around, and staff redirected her to eat meals with difficulty sometimes. He stated a couple of times, the facility reweighed R1 then put her on Mighty Shakes TID and liquid protein 30 mL. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 01/16/25 at 04:16 PM, Consultant GG stated when she reviewed residents, she assessed their appetite; if they had any difficulty swallowing or chewing; and if they had any nausea, vomiting, constipation, diarrhea, or weight fluctuations. She stated she talked to the resident and asked their allergies and preferences then she tried to work with the kitchen on their preferences. Consultant GG stated she visited the facility once a week and reviewed flagged weights in the risk meeting. She stated R1's weights bounced around, but she assessed if it was a clinically significant change and if there were any interventions to put in place. She stated R1 had a supplement in place, received medication reviews, had laboratory tests done, had medication changes, and the provider evaluated to figure out what was going on. Consultant GG stated R1 had a couple of weights that required reweighs and she tried to figure out if staff weighed R1 with foot pedals or not for accuracy. She stated sometimes R1 rested more, and the facility re-evaluated all of R1's psychotropic medications to see if that caused her to sleep more. Consultant GG stated she believed the kitchen provided R1 with fortified foods while honoring her preferences but she did not work in the kitchen so she could not attest to that. She stated the facility had snacks available at the nurse's station but she did not pass snacks so she could not attest to R1 receiving them. She stated she reviewed the documentation in R1's chart and supplemental shakes had percentages for her to track intake. Consultant GG stated R1 had a lot of behaviors and was very finicky. She stated there were other things that took place that constituted as an intervention to look at R1's whole picture because medication reviews and laboratory tests added a piece to the puzzle. She stated she did not suggest snacks as an intervention, and she could not answer if R1 received fortified foods. Consultant GG stated medication changes could affect weight and R1 had a lot of behavior documentation. She stated she felt the facility did everything they could and put interventions into place to figure out R1's weight loss. The facility's Nutrition policy, revised December 2024, directed facility approaches to address weight loss included an ongoing search for the cause of the weight loss and once the facility identified the cause, the facility made relevant care plan changes and evaluated ongoing interventions. The policy directed if the dietitian determined a resident had a significant change in their condition, the facility offered additional nutrition to those residents with options that included super cereal, large portions, between meal snacks, and commercial nutritional supplements. The facility's Nutrition Status Management policy, revised December 2024, directed if there was a significant change in the resident's condition related to weight or nutrition, the dietitian made recommendations to offer additional nutrition to those residents with options that included fortified cereal, large portions, between meal snacks, and commercial nutritional supplements. The policy directed IDT and the dietitian monitored and evaluated the resident's response or lack of response to the interventions and revised or discontinued the approaches or justified the continuation of current approaches. The facility failed to implement interventions to prevent further weight loss for R1 after she experienced a significant weight loss, and the facility implemented an initial intervention in September 2024. R1 continued to experience significant weight loss and Consultant GG followed R1 but did not recommend further interventions to prevent weight loss and the facility failed to implement further weight loss prevention interventions. This deficient practice resulted in a significant weight loss of 25.6% during her admission.