

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2026
NAME OF PROVIDER OR SUPPLIER North Point Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 908 N Pearl Street Paola, KS 66071	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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. Based on observation and interview, the facility failed to store and prepare food in the kitchen under sanitary conditions to prevent food borne illnesses. Findings included:- Observation of the kitchen and food storage areas on 08/03/2026 at 10:00 AM with Dietary Staff BB (Certified Dietary Manager) revealed the following areas of concern: 1. Built-in Refrigerators: A bag of cooked bacon with no label and no date. A bottle of coffee creamer was labeled with a name and no date. Dietary Staff BB reported it belonged to a staff member and should not be in the refrigerator. A bottle of sweet-and-sour sauce with no date. A bottle of soy sauce with no date. A deli sandwich with no label and no date. 2. Built-in Freezer: A bag of frozen cookies with no label and no date. On 08/03/2026 at 10:15 AM, Dietary Staff BB stated she expected all the food to be labeled and dated. On 08/03/2026 at 10:37 AM, the west hallway dining room had a kitchen with a warmer table and serving area. There was a refrigerator that had a sign Kitchen Staff Only. The refrigerator had two packages of cheese with no date and no label, and the bologna in the packet was undated. The dishes on the counter were stored upright and were not covered. On 08/03/2026 at 10:52 AM, Dietary Staff BB reported that the kitchen staff serves from the west hallway kitchen area after they bring the food from the main kitchen. She reported that all the food in that kitchen should also be labeled and dated, and the plates should be stored inverted or covered. On 08/05/2025 at 04:45 PM, Administrative Staff A stated she expected all food to be labeled and dated and the dishes to be covered or stored correctly. The facility's policy Food Receiving and Storage, dated 07/2014, documented that all foods stored in the refrigerator or freezer will be covered, labeled, and dated. The facility's policy Clean Dish Storage Policy dated 01/27/2026 documented that the facility will store clean dishes in a sanitary manner that protects them from contamination and supports safe food service in accordance with applicable federal requirements and professional food-safety standards. Clean items must be stored in a clean, dry, designated area; covered or inverted when practical.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews and record review, the facility failed to ensure adequate infection control practices related to linen storage, hand hygiene, and Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) while providing care to Resident (R) 45. Findings included:- On 08/04/2026 at 07:58 AM, during an observation, the linen cart located on the south hallway lacked a covering over clean towels, washcloths, and sheets. On 08/04/2026 at 11:30 AM, during an observation, the linen cart on the south hallway lacked a covering over the clean linens. On 08/04/2026 at 08:58 AM, during the observation of Certified Nurse Aide (CNA) M and CNA N passing water and ice to the residents' rooms on the west hall, neither CNA performed hand hygiene between resident rooms five, seven, nine, 11, 12, and 15. On 08/04/2026 at 09:11 AM, during an observation of indwelling catheter (tube placed in the bladder to drain urine into a collection bag) care for R45, CNA N and CNA M performed hand hygiene and donned gloves, but neither CNAs wore a gown. On 08/04/2026 at 01:39 PM, CNA M reported that she did not wash her hands when she provided water and ice to the residents but should have. On 08/04/2026 at 01:39 PM, CNA N and CNA M each stated that they should have worn a gown while providing urinary catheter care to R45. On 08/05/2026 at 09:13 AM, Administrative Nurse D said she expected the staff to wear a gown when providing care for residents that require EBP and expected the staff to perform hand hygiene handwashing when they provided residents with water and ice. The facility policy Enhanced Barrier Precautions, dated 01/27/2026, documented it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The facility policy Hand Hygiene, dated 01/27/2026, documented that all staff will perform proper hand hygiene procedure to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to include Resident (R) 45 or his representative in the development and planning of the resident's care plan when they failed to notify and invite them to the care plan meetings. Findings included:- R45's Electronic Medical Record (EMR) revealed diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord) and aphasia (condition with disordered or absent language function). R45's 09/10/2025 admission Minimum Data Set (MDS) documented no Brief Interview for Mental Status (BIMS) interview was completed; the resident was rarely or never understood. The staff assessment documented R45 had severely impaired cognition. The MDS documented no behavior, and he was dependent on staff for all activities of daily living (ADLs). R45's 09/11/2025 Communication Care Area Assessment (CAA) documented R45 had a potential for decline in his communication related to his diagnoses. R45 was in a car wreck when he was [AGE] years old, and it severed his spinal cord. R45 recognizes family and can at times answer yes or no questions and could at times understand what staff were asking him to do. R45's Care Plan, dated 09/17/2025, instructed staff to use communication techniques which helped R45 communicate. Staff were instructed to provide adequate time for R45 to respond and repeat as necessary. Staff were instructed not to rush him, and sometimes it would take a while for R45 to understand what was being said, and they were to face him when speaking and make eye contact with him. R45's EMR documented a care meeting was held on 02/11/2026 with R45, his guardian, and a Program of All-Inclusive Care for the Elderly (PACE is a health care program that helps people at risk for needing a nursing home stay in their own homes and communities) representative. R45's EMR lacked documentation that care plan conferences occurred with the facility staff. Observed on 08/03/2026 at 11:55 AM, R45 laid in his bed watching television; he was able to answer simple yes or no questions. On 08/03/2026 at 12:34 PM, R45's guardian reported that she had never been invited to a care plan meeting with the facility staff since R45 had been admitted to the facility on [DATE]. R45's guardian also said that she and R45 had only attended a care plan meeting with the PACE staff. On 08/05/2026 at 09:10 AM, Administrative Nurse D reported that the care plan meetings were completed by the interdisciplinary team, which included the Social Service Designee (SSD), and that person would call the family to set up a care plan meeting. Administrative Nurse D reported she was not sure if a care plan meeting occurred with just the facility and R45's guardian or with PACE. On 08/05/2026 at 01:40 PM, Administrative Nurse E reported that she expected the care plan meetings to be completed quarterly. Administrative Nurse E reported that the SSD arranged all the care plan meetings and that the care plan meetings were documented in a progress note in the residents EMR. The facility's Care Plan Conference Invitation Policy, dated 01/27/2026, documented that the facility will invite the resident, family, and chosen representatives to participate in care plan conferences and provide input into the resident's person-centered plan of care. Within one week of admission, approximately three weeks after admission. Then quarterly thereafter or as needed for significant changes or concerns.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, observation, and interviews, the facility failed to ensure Resident (R) 39's legal representative was updated with changes to R39's treatments or medications. Findings included:- R39's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus and vascular dementia. R39's 01/27/2026 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS documented R39 had no behaviors and was dependent on staff for toileting and personal hygiene. R39's 01/28/2026 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R39 had just been admitted to hospice with the diagnosis of vascular dementia. R39 was alert to self; he had good family support, and they visited him often. R39's Care Plan, dated 07/24/2024, instructed staff to notify R39's durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) with any changes related to R39. R39's Electronic Medication Administration Record (EMAR) documented an order for fluconazole (a prescription antifungal medication used to treat and prevent various infections caused by yeast and fungi) 100 milligrams (mg) a day for 14 days, ordered on 07/30/2026. R39's 07/30/2026 Progress Note documented R39 was seen by the provider that day, and new orders were received for fluconazole 100 mg a day for 14 days. The progress note lacked documentation that R39's DPOA had been notified. Observed on 08/03/2026 at 10:50 AM, R39 laid in bed on his right side; there was a sign that reminded him to use the call light before he used the bathroom, and he had yellow mucus running out of his nose. On 08/03/2026 at 01:10 PM, R39's DPOA reported that she had not been notified of the new medication order for fluconazole. R39's DPOA reported that the facility had not always notified her of new orders. On 08/05/2026 at 08:34 AM, Licensed Nurse (LN) H reported that the nurse should have called the family or representative and updated them on any new medications or treatments that had been ordered and documented that they had been notified in the progress notes. On 08/05/2026 at 09:14 AM, Administrative Nurse D said that it was expected for the nurse to call and notify the family or representative of all new orders and document the notification in the EMR. The facility did not provide a policy for notification of changes to orders.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to update the plan of care for Resident (R) 36 when the resident began using insulin and required blood sugar monitoring. Findings included:- R36's electronic medical record (EMR) documented the diagnosis of diabetes mellitus.R36's Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the medication list did not indicate insulin use.R36's Annual MDS, dated [DATE], documented a BIMS score of 15 and documented that R36 received seven days of insulin.R36's Care Plan, dated 06/27/2026, lacked information that R36 had started to use insulin and required blood sugar monitoring.R36's Medication Administration Record (MAR), dated 06/28/2026, indicated insulin 100 units, inject 10 units subcutaneously (beneath the skin) at bedtime for diabetes and check blood glucose. In the morning, administer 14 units subcutaneously.R36's Progress Note, dated 07/16/2026 at 06:46 PM, documented that R36 was to have her blood sugar checked before lunch and dinner for blood sugar monitoring.On 08/05/26 at 10:22 AM, Administrative Nurse E said that R36 was a new diabetic and her care plan had not been updated to reflect it.On 08/05/26 at 12:15 PM, Administrative Nurse D said that if a resident had a new diagnosis, then the care plan should have been updated to reflect the diagnosis.The facility policy North Point Care Plan Revisions Upon Status Change, dated 01/27/2026, documented the purpose of the procedure was to provide a consistent process for reviewing and revision the care plan for those residents experiencing a status change.		

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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. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 39 received assistance with activities of daily living (ADL) for nail care. Findings included:- R39's Electronic Medical Record (EMR) revealed a diagnosis of diabetes mellitus and vascular dementia.R39's 01/27/2026 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS revealed no behaviors noted, and R39 was totally dependent with toileting and personal hygiene.R39's 01/28/2026 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R39 had just been admitted to hospice with the diagnosis of vascular dementia, was alert to self, he had good family support, and they visited him often.R39's Care Plan, dated 06/10/2024, instructed the nursing staff to trim his nails as needed.Review of the facility's Bath Schedule showed R39 was scheduled for a shower on Sunday, Wednesday, and Friday morning.R39's health aide care provided from 06/03/2026 through 07/03/2026, located in the hospice chart, documented he had no care refusals.Review of R39's EMR Tasks from 07/03/2026 through 08/03/2026 documented R39 refused one shower on 07/31/2026; the EMR lacked documentation that he refused nail care.On 08/04/2026 at 08:03 AM, R39 was seated in his wheelchair in the dining room eating breakfast. R39's fingernails were long and had a brown substance under all his fingernails.On 08/04/2026 at 11:57 AM, R39 was seated in his wheelchair in the dining room eating lunch. R39's fingernails were long and had a brown substance under all his fingernails.On 08/05/2026 at 07:59 AM, R39 was seated in his wheelchair in the dining room eating breakfast, and he was wearing clean clothes. R39's fingernails were long and had a brown substance under all his fingernails.On 08/05/2026 at 08:21 AM, Certified Nurse Aide (CNA) P reported that R39 had refused his baths at times. CNA P also reported that the hospice aide would do R39's shower twice a week, and she was to be there that day. CNA P then reported that R39's nails were to have been trimmed by the nurse as he was a diabetic and the residents' fingernails should have been cleaned by the staff during the showers and as needed.On 08/05/2026 at 08:28 AM, CNA O reported she was the bath aide today and reported that R39 would receive his shower by the hospice aide this morning. CNA O reported that the nurse would cut his nails as he was a diabetic. CNA O reported that the staff would complete bath sheets on bath days even if the resident refused. CNA O reported that the resident and nurse would sign the bath sheet if the resident refused.On 08/05/2026 at 08:43 AM, Licensed Nurse (LN) G reported that she was unsure when R39 last had his fingernails trimmed and said that the staff or hospice aide were to let the nurse know when his nails required trimming; she expected the staff to provide nail cleaning on shower days or as needed. LN G reported that if a resident refused care, it should have been documented in the EMR.On 08/05 /2026 at 10:10 AM, Consultant Staff HH reported that R39 had never refused his shower. She reported that R39 had been scheduled for Wednesdays and Fridays for personal cares. Consultant Staff HH reported that she had not been allowed to trim his fingernails and that she verbally told the nurse when they needed trimmed.On 08/05/2026 at 11:35 AM, Administrative Nurse D said that it had been expected for the staff to provide nail care bath days and when needed, as residents allowed.The facility's policy Activities of Daily Living (ADLs), dated 01/27/2026, documented that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interviews, and record review, the facility failed to ensure Resident (R) 48's feeding tube (G-tube: tube surgically placed through an artificial opening into the stomach) was monitored for placement prior to administration of medications and enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). Findings included:- R45's Electronic Medical Record (EMR) revealed diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord) and dysphagia (swallowing difficulty).R45's 09/10/2025 admission Minimum Data Set (MDS) documented no Brief Interview for Mental Status (BIMS) interview was completed; the resident was rarely or never understood. The staff assessment documented R45 had severely impaired cognition. The MDS documented R45 had no behaviors. He was dependent on staff for all activities of daily living (ADLs) except eating, as R45 had a feeding tube.R45's 09/11/2025 Feeding Tube Care Area Assessment (CAA) documented R45 received enteral feedings. It documented staff were to ensure the head of the bed was elevated while administering feedings. Nursing staff was to provide G-tube care following policy and procedure.R45's Care Plan, dated 09/17/2025, instructed staff to provide tube feeding five times a day and provide 60 milliliters (mL) of water flush before and after each feeding. R45's Care Plan, dated 08/03/2026, lacked any instructions on checking to ensure placement of the feeding tube.R45's Physician Orders directed to administer one carton of Isosource 1.5 (type of enteral feeding) five times a day. Provide a 60 mL water flush before and after each feeding for nutrition; date ordered 08/29/2025. R45's Physician Orders directed to administer free water flushes of 300 mL of water every four hours via G-tube for hydration, date ordered 06/18/2026.R45's Physician Orders dated 08/03/2026 lacked documentation to check for placement or residual of the feeding tube.On 08/04/2026 at 11:08 AM, Licensed Nurse (LN) G assisted R45 down to his room in his electric wheelchair. She reported that R45 could not move the chair himself. LN G performed hand hygiene and applied gloves and a gown. LN G connected the feeding tube to the syringe and poured 60 mL of water; then she administered his medication and rinsed the feeding tube with 60 mL of water. LN G then administered one carton of Isosource 1.5 through his feeding tube. LN G did not check placement or residual prior to administering water, Isosource, or medication.On 08/04/2026 at 11:48 AM, LN G reported she forgot to check for placement of R45s feeding tube when she administered his water and enteral feeding. She reported she normally did and had checked for residual this morning.On 08/05/2026 at 11:35 AM, Administrative Nurse D expected the nurse to check the measurement (length) of the feeding tube prior to use to check for placement. She said she believed the direction to do so was on R45's orders and did not know why LN G said she checked for residual.The facility's policy Care and Treatment of Feeding Tubes dated 01/27/2026 documented it is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The resident's plan of care will address the use of a feeding tube, including strategies to prevent complications. Tube placement will be verified before beginning a feeding and before administering medications.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to complete and document a post hemodialysis (a procedure where impurities or wastes are removed from the blood) assessment for Resident (R) 5. Findings included:- R5's Electronic Medical Record (EMR) included diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys). R5's 10/07/2025 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 13, indicating intact cognition. R5 did not reject care. The MDS recorded R5 received dialysis. R5's 07/12/2026 Quarterly MDS documented no changes in status from the above assessment. The 10/13/2026 Functionally Abilities Self-Care/Mobility Care Area Assessment (CAA) documented R5 goes to dialysis two times a week with the facility providing transportation. She used a wheelchair for mobility, and at that time, her legs were weak, and she may ask for assistance with wheelchair mobility. R5's 08/03/2026 Care Plan documentation included that R5 had ESRD and was dependent upon hemodialysis. She attended dialysis on Tuesday and Saturday with a chair time of 06:00 AM. The facility provided transportation to and from dialysis. She arrived back at the facility at about 10:15 AM. She reported that she was tired afterwards and liked to go straight to her room and take a nap. R5 would be assisted back to her room by the transportation driver. Her abilities for self-care and mobility fluctuated on dialysis days, and staff monitored for increased fatigue and offered an increased level of assistance with ADLs and mobility as needed. R5's EMR recorded a Physician Orders which directed the visualization of the chest port dressing; if not in place, replace with dressing orders as needed (PRN). An order dated 07/09/2026 directed that the dressing needed to be replaced two times a day for prevention. The chest port needed to be cleansed with iodine and wiped dry with a sterile 4x4. Apply a bio-patch and then secure with sterile dressing and tape. Provide sterile technique. Change dressing to chest port for dialysis every 48 hours and PRN on day shift. Review of R5's Progress Notes lacked documentation of a post-dialysis assessment for 08/04/2026. Review of R5's Evaluation Notes lacked documentation of a post-dialysis assessment for 08/04/2026. R5's EMR lacked evidence that the resident refused the post-dialysis assessment on 08/04/2026. On 08/04/2026 at 11:51 AM, R5 lay in bed. R5 stated she returned from dialysis about an hour ago, around 11:00 AM. She said she left for dialysis so early in the morning she was exhausted when she returned, and she just laid down. R5 reported that the staff rarely assessed her when she returned from dialysis. She stated staff did not come and check her port when she returned from dialysis. She reported she had a chest port for dialysis access site, and then she pulled her top to the side and exposed the chest port, which had a dry dressing intact without bleeding or drainage. On 08/05/2026 at 10:06 AM, Licensed Nurse (LN) H stated dialysis residents should have a pre- and post-dialysis assessment done, completed, and documented on the Dialysis Communication Form. The assessment should include vital signs, which the medication aide obtained, and an assessment of the dialysis port site and dressing or the dialysis fistula to ensure the resident was not having complications such as bleeding out following dialysis and/or the dressing is intact. LN H confirmed she was the nurse on duty on 08/04/2026 for R5. She stated R5 went to dialysis early in the morning; her chair time was at 06:00 AM, and R5 returned during LN H's shift the previous day. LN H stated the nurses should complete the post dialysis assessment and document the assessment on the Dialysis Communication Form. Upon request, LN H could not locate the form for 08/04/2026. She stated that after thinking about it, she did not recall seeing the communication form on the resident's return to the facility on [DATE]. LN H confirmed the post-dialysis assessment for 08/04/2026 was not available in the progress notes, evaluations, or any (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other location in R 5's EMR. She reported she should have documented the findings of her assessment on the Dialysis Communication Form. On 08/05/2026 at 11:16 AM, Administrative Nurse D confirmed a pre and post-assessment should be done and documented on the Dialysis Communication Form. She expected nurses to assess the residents when they return to ensure the resident has not developed any complications such as hemorrhaging following dialysis. Administrative Nurse D said the dressings should be checked to ensure they are intact to prevent contamination at the port. The 01/27/2026 facility policy titled Hemodialysis documented the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.		