STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175343	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claridge Court	8101 Mission Road Prairie Village, KS 66208

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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 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. 45668 The facility identified a census of 37. The sample included 12 residents with 12 reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R)7's Care Plan to reflect her implemented restorative services and goals. This deficient practice placed R7 at risk for impaired care due to uncommunicated care needs. Findings Included: - The Medical Diagnosis section within R7's Electronic Medical Records (EMR) included diagnoses of left-sided hemiparesis (weakness and paralysis on one side of the body), left-sided hemiplegia (paralysis of one side of the body), and left-hand contracture (abnormal permanent fixation of a joint or muscle). R7's Quarterly Minimum Data Set (MDS) completed 11/22/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated she required substantial to maximal assistance with bed mobility, transfer bathing, toileting, personal hygiene, and dressing. The MDS noted she had an upper extremity impairment to one side and used a wheelchair for mobility. The MDS indicated she received restorative services for active range of motion (ROM). R7's Activities of Daily Living (ADLs) Care Area Assessment (CAA) completed 08/28/23 indicated she required assistance with her ADLs and mobility related to poor strength, endurance, and balance. The CAA indicated she had left-sided hemiparesis and was at risk for a decline in her ADLs. R7's Care Plan initiated 08/18/23 indicated she was at risk for ADLs self-performance deficit related to her left-sided hemiparesis. The plan indicated he had a left-hand contracture and instructed staff to provide skin care and monitor her hand for skin breakdown (08/31/23). The plan indicated she may need assistance with meal set-up and staff were to offer support. The plan lacked documentation related to her implemented range of motion exercises to maintain or improve her left-sided hemiparesis and hand contracture. On 02/26/24 at 08:10 AM R7 sat in her room. R7 stated staff wrapped her arm up at night to prevent swelling and she received upper body services for her left side. She stated she used to wear a brace on her left hand but refused to wear it. She stated the restorative aid comes 3-4 times weekly to work with her. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/24 at Certified Nurses Aid (CNA) O stated she completed weekly upper body range of motion exercises with R7. She stated R7 had left-side weakness and paralysis due to her medical conditions. She stated the restorative programs were not included in the care plans but included in the task section of the EMR. On 02/27/24 at 02:23 PM Licensed Nurse (LN) H stated she would have to ask the restorative aid or therapy what services R7 received. She stated that restorative services should be included in the care plan to allow all staff to know what services were provided due to her contractures. On 02/27/24 at 02:32 PM Administrative Nurse E stated the restorative services for R7 were not in the care plan but would be found under the tasks. A review of R7 Tasks in her EMR with Administrative Nurse E revealed no documented information related to her upper body range of motion exercises. Administrative Nurse E stated the services should be listed somewhere for all staff to review. The facility's provided Comprehensive Care Plan policy revised 09/2019 indicated the facility will update and revise each resident's plan of care to include current care treatment goals, and measurable objectives, and provide person-centered care. The facility failed to revise R7's Care Plan to reflect her implemented restorative services and goals. This deficient practice placed R7 at risk for impaired care due to uncommunicated care needs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834 The facility identified a census of 37 residents. The sample included 12 residents with two reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to maintain Resident (R) 2's low air-loss mattress pump settings at the correct weight range. This placed R2 at increased risk for pressure ulcer development. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), difficulty in walking, generalized muscle weakness, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and cerebrovascular disease affecting right dominant side (group of conditions that affect the circulation of blood to the brain, causing limited or no blood flow to affected areas of the brain). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 13 which suggested intact cognition. The MDS documented R2 used a wheelchair and required partial/moderate assistance moving from a seated to a lying position, substantial/maximal assistance from moving from a seated to a standing position and was dependent on staff for transfers. The MDS further documented R2 had a skin tear, was at risk for developing pressure ulcers, and had pressure-reducing devices in place for her chair and bed. The MDS documented R2 was frequently incontinent of urine having had seven or more incontinent episodes with at least one episode of continent voiding. The Pressure Ulcer/Injury Care Area Assessment (CAA) dated 12/21/23, documented R2 was at risk for skin breakdown due to incontinence and limited mobility. The Functional Abilities CAA dated 12/21/23, documented R2 had an activities of daily living (ADL) self-care performance deficit and directed staff to assist R2 with daily tasks. R2's Care Plan with an initiated date of 01/09/24, documented R2 was at risk for impaired skin integrity due to CHF and incontinence. A goal with an initiated date of 01/09/24 documented R2 would remain free from skin breakdown due to incontinence and brief use. A Care Plan intervention with an initiated date of 01/09/24, directed staff to encourage R2 to frequently shift her weight and for staff to monitor R2's skin for moisture, and apply barrier products as needed. R2's Care Plan with an initiated date of 10/17/23 documented R2 was on diuretic therapy (medication to promote the formation and excretion of urine). R2's Care Plan lacked evidence that a low air loss mattress was in place for R2. R2's EMR, under the Orders tab, documented an order dated 12/09/23, for an air loss mattress (a mattress designed to prevent and treat pressure wounds) for skin breakdown prevention. The order lacked evidence of a mattress setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R2's EMR documented R2 weighed 109.2 lbs. on 01/15/24 and 109.6 on 02/25/24. A review of the low air-loss mattress manufacturer's operation (Protekt Aire 6000) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range selected. The manual recommended the pump be set based on the resident's weight. The manual indicated the firmness of the mattress could be set within 50 lbs. weight intervals. On 02/26/24 at 01:30 PM, R2 sat in a wheelchair in her room. R2's air loss mattress was set for a body weight of 180 lbs. On 02/27/24 at 01:31 PM, R2 sat in a wheelchair in her room and watched TV. R2's air loss mattress was set for a body weight of 180 lbs. On 02/27/24 at 02:15 PM, Licensed Nurse (LN) H stated some of the low air loss mattresses provided by hospice were set based on a resident's weight. LN H further stated if the weight settings on a low air loss mattress were set too high, it made the mattress firmer, which could then contribute to skin breakdown. LN H stated a weight setting of 180 lbs. on a low air loss mattress for a resident who weighed 109.6 lbs. would be too high. On 02/27/24 at 02:31 PM Administrative Nurse E stated R2's low air loss mattress was provided by hospice and hospice would set the pressure for the mattress and that facility staff would monitor it. Administrative Nurse E stated the facility expected the nurses and Certified Nurse Aides (CNA) to check the mattress every shift to ensure it was on and working correctly. Administrative Nurse E stated she was unsure if R2's mattress was a weight-based mattress, or one based on comfort level. Administrative Nurse E observed R2's low air loss mattress in R2's room and noted the setting of 180 lbs. Administrative Nurse E stated a setting of 180 lbs. for R2, who weighed 109.6 lbs., was too high for her weight. On 02/27/24 at 03:01 PM Administrative Nurse E stated she spoke with a facility nurse and was informed that hospice had set the mattress to 180lbs due to the head of R2's bed not inflating properly. Administrative Nurse E further stated the facility would contact the company and order a new bed for R2. The facility provided a Wound Care Policy with a revision date of 04/01/22, documented It is the policy to utilize evidence-based clinical practices to provide pressure injury and wound treatments in our skilled nursing and rehabilitation health centers. The facility will comply with current nursing standards, as well as state and federal guidelines related to the identification, treatment, and documentation of alterations in the skin integrity of our residents. The facility failed to maintain R2's low air-loss mattress pump settings at the correct weight range. This placed R2 at increased risk for pressure ulcer development.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility had a census of 104 residents. The sample included 23 residents with four residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure an environment free from accident hazards when the facility failed to utilize wheelchair foot pedals while transporting Resident (R)18 and R22 around the facility. This deficient practice placed both residents at risk for preventable injuries and falls. Finding Included: - R18's Care Plan initiated 12/13/24 indicated he was at risk for falls related to his weakness, unsteadiness, poor safety awareness, and severe cognitive impairment. R22's Care Plan initiated 10/18/20 indicated she was at risk for falls related to poor gait/balance, muscle weakness, and severe cognitive impairment. On 02/26/24 at 07:20 AM R22 sat in her wheelchair in the hallway in front of the elevator. Certified Nurses Aid (CNA) M pushed R22 back to her room. R22's wheelchair had no foot pedals and her shoes drug on the floor as staff pushed her. On 02/26/24 at 11:32 AM CNA N pushed R18 (severely cognitively impaired resident) down the main hallway to the dining area. R18's wheelchair lacked foot pedals and his feet contacted the ground several times while being pushed. On 02/26/24 at 11:38 AM R22 was wheeled to the dining room area for lunch services by CNA M. R22's feet slid on the ground several times during transport. On 02/27/24 at 02:08 PM, CNA M stated each resident had foot pedals, but some prefer to use their feet to propel themselves. She stated the resident's feet should never drag while being pushed. On 02/27/24 at 02:32 PM Administrative Nurse E stated staff were expected to ensure the resident's feet never touch the ground while in transport. She stated staff were to ask the residents if they were okay to lift their legs. She stated all the residents had foot pedals and should use them when needed. The facility's provided Accommodation of Needs policy (undated) the facility will ensure each resident's needs for adaptive equipment will be met based on the individual needs/preferences, physical environment, and treatment goals. The facility failed to utilize a wheelchair foot pedal while transporting R18 and R22 around the facility. This deficient practice placed both residents at risk for preventable injuries and falls.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 47834 The facility had a census of 37 residents. The sample included 12 residents and five Certified Nurse Aides (CNAs) reviewed for performance evaluations and required in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's performance evaluation records revealed the following: CNA P, hired on 03/11/19, no yearly performance evaluations were provided upon request. CNA Q, hired on 05/24/22, no yearly performance evaluations were provided upon request. CNA MM, hired on 04/13/21, no yearly performance evaluations were provided upon request. CNA NN, hired on 08/21/18, no yearly performance evaluations were provided upon request. CNA OO, hired on 09/11/01, no yearly performance evaluations were provided upon request. Review of the email communications regarding yearly merit increases, provided by the facility, to the five CNA staff reviewed for yearly evaluations lacked evidence of any performance evaluations and/or goals or discussion regarding areas of improvement. On 02/27/24 at 10:17 AM Administrative Staff A stated the facility did not do a formal yearly performance evaluation on paper. Administrative Staff A stated they would meet with staff yearly to discuss a merit increase and performance would be discussed at that time; however, there was nothing put into writing and staff would not sign any document to show what had been discussed during the meeting. Administrative Staff A further stated the meetings were more of a conversation than a formal performance evaluation and if there were any issues then staff would have been placed on a performance improvement plan. The undated facility provided Performance Management policy documented it is the policy to conduct periodic performance reviews for all team members. The performance review is a formal process in which leaders can assess team member's strengths, areas for improvement, and potential growth. Performance reviews will be objective, and performance based. Leaders must support reviews by using specific examples and facts. Any performance review that indicates improvement is needed, a performance improvement plan must be developed and implemented. This plan will set forth performance goals, time frames, and dates for retraining and reevaluation. The facility failed to ensure five of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 37 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure a pulse was assessed and documented consistently for Resident (R) 4's carvedilol (medication used to treat high blood pressure) for hypertension (HTN-elevated blood pressure) to monitor for efficacy and adverse effects. This placed R4 at increased risk for unnecessary medication administration and possible adverse side effects. Findings included: - The electronic medical record (EMR) for R4 documented diagnoses of chronic respiratory failure with hypoxia (occurs when the respiratory system cannot adequately provide oxygen to the body). HTN, ischemic cardiomyopathy (the heart's decreased ability to pump blood properly, due to myocardial damage), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Quarterly Minimum Data Set (MDS) dated [DATE] documented that a Brief Interview of Mental Status (BIMS) assessment could not be conducted due to severe cognitive impairment. The MDS indicated R4 required supervision with set-up assistance for bed mobility, transfers, walking, personal hygiene, toileting, and dressing. R4 was dependent on one staff for help with activities of daily living (ADLs), and R4 required supplemental oxygen. The Functional Care Area Assessment (CAA) dated 09/27/23 documented R4 continued to require assistance with ADLs and mobility. Nursing provided ADL, mobility, and transfer assistance. The Fall CAA dated 09/27/23 documented nursing provided safety cues and monitoring. R4 used a gait belt for transfers and had a call light at the bedside. R4's Care Plan dated 06/08/22 directed staff to administer anti-hypertensive medications as ordered. Staff should monitor for side effects, such as orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down), increased heart rate, and effectiveness. R4's Order Summary dated 06/02/23 documented an order for carvedilol one tablet of 3.125 milligrams (mg), give one tablet by mouth two times a day related to chronic heart failure. R4's clinical record lacked evidence the staff monitored R4's pulse consistently before the administration of the carvedilol. On 02/26/24 at 07:26 AM R4 sat in her recliner with her feet extended and elevated. On 02/26/24 at 11:34 R4 sat at the dining room table. She chatted with visitors and table mates. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/24 at 01:21 PM Licensed Nurse (LN) H stated that for carvedilol, a beta-blocker, the pulse should be monitored and documented before the medication was given. LN H stated the facility did have parameters for beta-blockers that the physician put in place. On 02/27/24 at 02:50 PM Administrative Nurse E stated normally nurses only assess vitals once a week. Administrative Nurse E stated the pharmacist did not want the facility to monitor pulse before giving carvedilol. Administrative nurse E stated that once-a-week vital signs assessments were sufficient. The Medication Administration Policy documented that if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. The facility failed to ensure that staff consistently monitored R4's pulse before the administration of carvedilol. This placed R4 at risk for unnecessary medication administration and possible adverse side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45668 The facility had a census of 37 residents. The sample included 12 residents of which five were reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management before starting Resident (R)14's Seroquel (antipsychotic- class of medications used to treat mental disorder characterized by a gross impairment in reality testing). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications. Findings Included: - The Medical Diagnosis section within R14's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder), muscle weakness, and difficulty walking. R14's Quarterly Minimum Data Set (MDS) completed 01/18/23 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe cognitive impairment. The MDS indicated she had delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue) but no behavioral symptoms. The MDS indicated she received antipsychotic medication on a routine basis. R14's Dementia Care Area Assessment (CAA) completed 10/24/23 indicated she had short and long-term memory impairment. The CAA noted she required cueing and assistance from staff to participate and stimulate her mind. R14's Psychotropic Drug Use CAA completed 10/24/23 indicated she was at risk for side effects related to her psychoactive medications. The CAA instructed staff to monitor medication with black box warnings (BBW- highest safety-related warning that medications can be assigned by the Food and Drug Administration). R14's Care Plan initiated on 02/08/22 indicated she had a history of behavior concerns related to dementia. The plan instructed staff to approach her in a non-threatening manner, orient her to reality, divert her attention, and talk to her to calm her down (02/18/22). The plan indicated she started Seroquel and instructed staff to monitor for side effects of the medication (10/24/23). The care plan lacked unsuccessful behavioral interventions that were attempted to manage her symptoms. A review of R14's EMR under Physician's Orders indicated an order dated 09/12/23 for her to receive 12.5 milligrams (mg) of Seroquel by mouth at bedtime for anxiety, delusions, and paranoia related to major depressive disorder. On 12/08/23 the Seroquel order was increased to give 12.5mg twice daily. On 01/26/24 the Seroquel order was increased to give 12.5mg every eight hours. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's EMR lacked documented physician rationale that included multiple unsuccessful attempts for non-pharmacological behavioral symptom management for her Seroquel medication started on 09/12/23. The facility was unable to provide this documentation on request. On 02/27/24 at 07:34 AM Licensed Nurse (LN) H prepared R14 morning medication. LN H administered R14's medications without issues or concerns. R14 was calm and took her medication including Seroquel without behavior. On 02/27/24 at 02:15 PM, LN H stated residents with dementia were at risk for taking antipsychotic medication due to a higher mortality rate. She stated that R14's behaviors had improved in the past few months from her medication. She stated staff should also provide redirection and re-orient R14 when she is confused. On 02/27/24 at 02:32 PM Administrative Nurse E stated the facility would provide redirection, re-orientation, activities, and call family for support during R14's behaviors. She stated the medical provider usually would not document rationale or notes. A review of the facility's Psychotropic Medication Use policy 10/2022 noted the facility will provide clinical indication and comprehensive assessment to ensure the use of antipsychotic medication is necessary. The policy indicates the physician will provide a clinical rationale and complete gradual dose reductions to ensure the lowest effective dose unless contraindicated. The facility failed to ensure physician documented rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management was completed before the use of R14's Seroquel. This placed the R14 at risk for unnecessary psychotropic medications and related complications.

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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. 49634 The facility identified a census of 37 residents. The facility had one kitchen and one kitchenette. Based on observation, record review, and interviews, the facility failed to ensure that food items were properly stored in a safe and sanitary manner after the original sealed package had been opened. The facility failed to ensure foods were labeled and dated after opening. This placed all residents who ate food from the facility at risk for food-borne illness. Findings included: - During the initial tour on 02/22/24 at 07:33 AM, observation revealed the following: Half of a brown cake in the small refrigerator was uncovered and not dated. Two bags of sausage lay on top of the cooking stove. A canister of sugar under the work prep table was not labeled or dated. A cooler with a see-through glass door revealed small bowls of lettuce, tomatoes, ham, cheese, onions, and a container of fish were not covered, and these items were not dated. Half of a bag of ravioli was open to the air in a small freezer and was not dated. Avocadoes and pea salad were not dated in the small side refrigerator. The walk-in freezer had one box labeled pies stored on the freezer floor. The walk-in refrigerator had a steam table pan with red sauce which contained olives sitting on the shelf, there was no date or label. On 02/27/24 at 10:44 AM a follow-up inspection of the kitchen was completed. The inspection revealed all containers were labeled and dated appropriately, and there were no food boxes on the freezer floor. On 02/27/24 at 11:00 AM Dietary staff BB stated all foods out of their original containers should be dated and labeled, and no foods should be stored on the freezer floors. The Production, Purchasing, and Storage Policy revised on 01/24 stated all stored foods not in their original packages, must be stored in approved containers that have tight-fitting lids. All containers must be labeled, and both the bin and the lid must be labeled and dated. The policy states to use of food-grade plastic bags for food storage. The facility failed to store food in a safe, sanitary manner. This deficient practice placed residents at risk for contamination and food-borne illness.