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	01/14/2026

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility identified a census of 38 residents. The sample included 13, with two reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure potentially hazardous kitchen equipment in a safe, locked area and out of reach of six cognitively impaired, independently mobile residents.Findings Included: - On 01/12/26 at 07:00 AM, a walkthrough of the facility revealed the hallway door to the kitchen was left fully open. An inspection of the interior kitchen revealed that both interior kitchen doors were left open. No staff were observed in the kitchen or the surrounding dining area. No residents were in or around the kitchen area at the time of observation, but had access to that area.An inspection of the sink area in the kitchen revealed an unsecured lock on a cabinet below the sink. The cabinet contained four spray bottles of all-purpose cleaner. The containers contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed.An inspection of the interior kitchen area revealed an unlocked electrical panel labeled LP3. The panel contained the label warning Hazardous voltage, will cause death or injury.An inspection of the interior kitchen revealed a heated plate warmer containing a plate. An inspection of the warmer revealed a temperature inside of the warmer of 167 degrees Fahrenheit.An inspection of the kitchen's steam table area revealed that three of the five steam wells were on and set to high settings (level 10). The wells were empty and hot to the touch. An inspection of the three active steam wells revealed temperatures of 238 degrees, 323 degrees, and 374 degrees Fahrenheit.On 01/12/26 at 07:13 AM, Dietary Staff CC entered the kitchen. Dietary Staff CC stated she had to go down to prepare the breakfast meals and just returned to the floor. She stated the steam wells were usually turned on before the food was brought up to ensure the food remained heated.On 01/12/26 at 07:13 AM, Dietary Staff DD entered the kitchen area to prep breakfast. She stated staff usually turn the steam table on before breakfast arrived to ensure the food remained hot when served. She stated she was not sure if it was okay to leave the area unsupervised during meal delivery upstairs.On 01/12/26 at 07:15 AM, Dietary Staff DD stated the kitchen doors were to be locked when not directly supervised, but the residents know not to walk around to the serving side where the steam table was located. She stated the steam table needed to be monitored while heated.On 01/14/26 at 01:30 PM, Dietary Staff BB stated that staff came in early to warm up the steam table and prepare for breakfast. He stated staff were expected to monitor the kitchen area while it was open.The facility's Hazardous Areas, Devices and Equipment policy, revised (undated), indicated the facility was to assess and identify potential hazards within the resident's environment to minimize the risks and prevent potential accidents and injuries.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 38 residents. The sample included 13 residents, with one resident reviewed for hospitalization. Based on record review and interviews, the facility failed to provide a written notice of transfer/discharge as soon as practicable, and the facility also failed to provide a bed hold notice with the required information for Resident (R) 20. Findings included:- R20's Electronic Medical Record (EMR) from the Diagnosis tab documented 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), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and convulsions (involuntary series of contractions of a group of muscles).R20?s EMR under the Progress Notes tab revealed the following facility-initiated transfer documentation:On 06/04/25 at 01:16 AM, an Alert Note documented R20 was transferred to the hospital. The facility lacked a Bed Hold Notice that included the facility's per diem rate to hold a bed and the required written notification of transfer, as soon as practicable, upon his transfer to the hospital on [DATE].On 06/26/25 at 07:27 PM, a Health Status Note documented R20 was transferred to the hospital.The facility lacked a Bed Hold Notice that included the facility's per diem rate to hold a bed and the required written notification of transfer, as soon as practicable, upon his transfer to the hospital on [DATE].On 07/21/25 at 05:02 PM, a Health Status Note documented R20 was transferred to the hospital.The facility lacked a Bed Hold Notice that included the facility's per diem rate to hold a bed and the required written notification of transfer, as soon as practicable, upon his transfer to the hospital on [DATE].On 10/21/25 at 06:41 PM, a Health Status Note documented R20 was transferred to the hospital.The facility lacked the required written notification of transfer for R20, as soon as practicable, upon his transfer to the hospital on [DATE].On 01/13/26 at 02:09 PM, Administrative Staff B provided R20's bed hold dated 10/21/25. She stated she was unable to locate any other bed holds or any written notifications for R20's facility-initiated transfers to the hospital. Administrative Staff B stated the nurse would notify the legal representative by phone; the facility did not provide the legal representative with written notification.On 01/14/26 at 12:09 PM, Administrative Nurse E stated the resident or legal representative would be notified at the time of the transfer to the hospital. Administrative Nurse E stated the legal representative would be notified if the resident was cognitively impaired. He stated the nurse would be responsible for notifying the legal representative and providing the bed hold. Administrative Nurse E stated social services of financial should follow up to ensure the notices had been provided. The facility's undated Transfer and Discharge Notice/ Involuntary Discharge Policy documented the facility would permit each resident to remain in the facility and would not transfer or discharge a resident unless one of the allowable reasons outlined in this policy was met. All transfers and discharges would be person-centered, medically appropriate, properly documented, and communicated to the resident, resident representative, and applicable external agencies.

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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. The facility identified a census of 38 residents. The sample included 13 residents, with two reviewed for pressure ulcers (localized injuries to the skin and/or underlying tissue, usually over a bony prominence, caused by pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R) 18's pressure-reducing interventions were implemented correctly when R18's low air-loss mattress (a specialized adjustable air mattress that reduces pressure applied to the body) was not set within her current weight range.Findings Included:- The Medical Diagnosis section within R18's Electronic Medical Records (EMR) included dementia (a progressive mental disorder characterized by failing memory and confusion), type two diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, and chronic kidney disease.R18's Quarterly Minimum Data Set (MDS) completed 12/08/25 indicated a Brief Interview for Mental Status (BIMS) score of seven, indicating moderate cognitive impairment. The MDS noted she required substantial to maximal assistance with bathing, dressing, toileting, transfers, personal hygiene, and bed mobility. The MDS noted she was at risk for developing pressure ulcers but had no unhealed wounds. The MDS noted that she had pressure-reducing devices for her bed and chair.R18's Pressure Ulcer Care Area Assessment (CAA) (completed 06/16/25) revealed she was at risk for pressure ulcers related to her decline in mobility, incontinence, and decreased cognition. R18's Care Plan (initiated 03/31/25) documented the following interventions:03/31/25- The plan indicated she was admitted to the facility with open areas to her coccyx and was at risk for further breakdown.03/31/25- The plan instructed staff to inspect her skin during each bathing occurrence.03/31/25- The plan indicated she had a low-air-loss mattress to relieve pressure.04/10/25- The plan instructed staff to provide side-to-side turning while in bed.05/27/25- The plan indicated she was placed on hospice service. The plan noted that hospice provided her a low-air-loss mattress and instructed staff to ensure it was set to 170 pounds (lbs.).R18's EMR under Physician's Orders revealed an order dated 06/14/25. The order indicated she had a low-air-loss mattress and instructed staff to ensure the pump was set to normal pressure at 170 lbs.On 01/12/26 at 07:45 AM, R18 lay in her bed and waited for her breakfast to arrive. Her bed was in the lowest position, and the call light was next to her. Her low-air-loss mattress pump was set to maximum weight setting (350 lbs.). The mattress pump had fixed weight settings of 80lbs, 120lbs, 150lbs, 180lbs, 210lbs, 250lbs, 280lbs, 320lbs, and 350lbs.On 01/13/26 at 08:30 AM, R18's low-air-loss mattress pump remained set to 350lbs.On 01/14/26 at 10:20 AM, R18's low-air-loss mattress pump remained set to 350lbs.On 01/14/26 at 10:23 AM, Licensed Nurse (LN) G verified R18's bed was set to 350 lbs. LN G stated her bed was to be set to her weight range, closest to 170 lbs. He stated the mattress pump was recently replaced, and the direct care staff may have bumped into the control panel while making the bed. He stated staff were expected to check the setting at least three times daily.On 01/14/26 at 12:00 PM, Administrative Nurse D stated staff were expected to check the mattress settings each shift and ensure they were set to the care-planned settings.A review of the low-air-loss mattress manufacturers' operation (Drive Model) manual indicated that 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 and comfort settings. The manual indicated that an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety.The facility's Wound Care Prevention and Management policy (undated) indicated the facility was committed to the prevention of avoidable pressure injuries and to provide treatment services to heal existing wounds. The policy indicated the facility was to assess and implement interventions to include pressure-reducing devices, skin assessments, repositioning, nutritional monitoring, and preventative skin treatment.