

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  Ignite Medical Resort Rainbow Boulevard, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 Rainbow Blvd, Suite 400 Kansas City, KS 66103	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45668</p> <p>The facility had a census of 91 residents. The sample included eight residents. Based on observation, record review, and interview, the facility failed to secure hazardous materials when the facility failed to ensure a Sharps container (bin to place used needles and lancets) was maintained within acceptable standard of practice regarding capacity and access to used needles and lancets. This deficient practice placed four cognitively impaired, independently mobile residents at risk for preventable injuries and accidents.</p> <p>Findings Included:</p> <p>- On 03/21/24 at 09:12 AM a walkthrough of the fourth-floor hallway revealed a medication cart stationed next to the conference room. An inspection of the medication cart revealed the Sharps bin was overfilled past the fill line indicated on the container and had lancets resting on top of the bin that remained accessible.</p> <p>On 03/21/23 at 12:13 PM contents from the Sharps bin overflowed onto the floor and were picked up by an unidentified staff member. The staff member shoved the contents back into the box with their bare hands and left the area. The medication cart was removed from the area at 02:05 PM.</p> <p>On 03/21/24 at 02:20 PM Licensed Nurse (LN) G stated nursing staff should replace the Sharps bins before the contents reach the full mark. She stated staff should never attempt to push or reach inside the bins due to the risk of being stuck by the hazardous materials.</p> <p>On 03/21/23 at 03:20 PM Administrator A stated staff were expected to replace the Sharps bins or notify maintenance instead of allowing the bins to overflow.</p> <p>A review of the facility's Injection Safety and Sharps Injury Protection Plan revised 01/2024 indicated the facility was to ensure the safe usage and disposal of hazardous materials. The plan noted the bins were to be changed out frequently and never allowed to be filled past the full mark. The plan indicated staff should never attempt to push down materials into the bins.</p> <p>The facility failed to secure hazardous materials when the facility failed to ensure a Sharps container was safely maintained. This deficient practice placed four residents at risk for preventable injuries and accidents.</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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>45668</p> <p>The facility reported a census of 91 residents. The sample included eight with three reviewed for behavioral health services. Based on record review, observations, and interviews, the facility failed to adequately meet Resident (R)1's behavioral health needs related to non-pharmacological care approaches resulting in repeated behavioral episodes. This deficient practice placed R1 at risk for behavioral outbursts and injuries.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).</li> </ul> <p>R1's Quarterly Minimum Data Set (MDS) completed 03/08/24 noted a Brief Interview for Metal Status score of 14 indicating intact cognition. The MDS indicated he had no displayed behaviors during the reviewed period. The MDS indicated he had no extremity impairments and could independently wheel himself around the facility in his wheelchair.</p> <p>R1's Cognitive Loss and Behavioral Care Area Assessments (CAA's) completed 09/08/23 noted his medical diagnoses and refusal for medication placed him at risk for problems related to his decision-making abilities and unsafe behaviors.</p> <p>R1's Care Plan initiated on 01/03/23 noted he had a history of verbal aggression towards other residents. The plan noted for staff to offer choices, administer his medications, and anticipate his needs as behavioral interventions (01/03/23). An intervention initiated on 01/03/23 indicated staff were to guide R1 away from the source of his distress, engage him in conversation, and walk away with a later approach if he remained agitated. The plan noted physical aggression (behavioral event) on 07/31/23. The plan indicated a psychology visit, medication review, and consult with a geriatric-psychiatric specialist was completed for this event. The plan noted another physical aggression (behavioral event) occurred on 02/11/24. The plan indicated non-pharmacological interventions were implemented for behavioral de-escalation on 02/11/24. The plan lacked detail as to what interventions were implemented for this event.</p> <p>A review of a Facility Investigation completed on 07/29/23 revealed the facility received a report R1 had verbal aggression towards R2 (resident with a BIMS of 15 indicating intact cognition) on 07/29/24. The note indicated R1 denied verbally aggressive threats towards R2.</p> <p>A review of an Incident Report completed on 07/31/23 revealed R1 displayed verbal aggression towards R2 while exiting the third-floor dining area on 07/31/23. The report indicated R2 reported to staff R1 made contact with her arm. R2 was assessed and had a faint scratch and dry skin on her right arm. The report indicated both residents were separated and assessed. The note indicated R1 was moved to the fourth floor and placed on temporary 15-minute checks for 48 hours to ensure safety.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R1's EMR noted he was admitted to an acute psychiatric care facility on 08/13/23 related to his ongoing behaviors.</p> <p>R1's Physician's Orders indicated medication-based behavioral monitoring was implemented on 11/20/23 noting interventions of redirection, moving from the environment, preventing self-harm from objects, providing one-to-one staff support, and notifying the medical provider.</p> <p>A review of an Incident Report completed 02/11/24 revealed R3 reported R1 exhibited verbal aggression towards her while in the dining room. The report indicated as staff attempted to separate the two residents, R1 aggressively kicked R3 in her left leg. The report indicated that law enforcement was notified and arrived at the facility. The report indicated R1 calmed down and remained in the facility. The note indicated R1 was placed on temporary 15-minute checks for 48 hours to ensure safety.</p> <p>R1's EMR revealed a Progress Note dated 02/12/24 noted R1 aggressively chased a female nurse and cornered her at the nursing station. The note indicated R1 attempted to slap and hit his female nurse until she exited the floor. The note failed to document if any non-pharmacological behavior de-escalation interventions were attempted during this behavioral episode or if the medical provider was notified.</p> <p>R1's EMR revealed a Progress Note dated 02/17/24 noted R1 had increased behaviors towards staff and other residents. The note indicated a call was placed to his representative and medical provider but did not note if any non-pharmacological behavior de-escalation interventions were attempted during this behavioral episode or if the medical provider was notified.</p> <p>A review of R1's EMR noted his room was changed on 03/04/24 at his request.</p> <p>R1's EMR noted he was sent out to an acute care facility related to medical concerns on 03/19/24.</p> <p>On 03/21/24 at 02:10 PM, Certified Nurses Aid (CNA) M stated R1 had behaviors towards certain other residents. She stated R1 and R2 would often encounter each other in the hallways. She stated R1's room was at the end of the hallway and R2 would pass him going to the dining area. She stated staff should provide behavioral interventions such as moving them to separate hallways or ensuring they don't cross paths for appointments or activities.</p> <p>On 03/21/24 at 02:40 PM, Licensed Nurse (LN) G stated R1 and R2 fed off each other's behaviors. She stated R1 was moved to R2 hallways due to the passing of his roommate. She stated staff should use distraction techniques such as music, activities, games, conversation, or conversation to prevent R1's behaviors from occurring. She stated these behavioral interventions should be listed on the care plan.</p> <p>On 03/21/23 at 03:20 PM Administrative Nurse D stated R1's behaviors had improved recently. She stated that R2 often triggered R1's behaviors were manageable and redirectable. She stated staff should attempt to keep them separated and always to around to intervene if they became aggressive. She stated that non-pharmacological behavioral interventions could include change of environment, distraction techniques, being aware of their proximity to each other, activities, food, and spending time with him.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Behavioral Management policy revised 04/2023 indicated the facility will promote an environment with respect, dignity, cleanliness, and free from abuse. The policy indicated the facility would promote a person-centered approach to ensure each resident's behavioral needs were fully addressed and continually re-evaluated with individualized interventions implemented.</p> <p>The facility failed to adequately meet R1's behavioral health needs related to non-pharmacological approaches resulting in repeated behavioral episodes. This deficient practice placed R1 and the other affected residents at risk for behavioral outbursts and injuries.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668</b></p> <p>The facility identified a census of 91 residents with two kitchenettes. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards for food storage and maintaining a sanitary food service environment. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns.</p> <p>Findings Included:</p> <p>- On [DATE] at 09:11 AM an inspection of the facility's fourth-floor kitchenette was completed with the following findings:</p> <p>An inspection of the microwave revealed old food particles and debris covering the inside of the microwave.</p> <p>The kitchenette's condiment food chiller had food debris and stains covering the outer and inner surfaces. The kitchenette's dual coffee pot and pod machine had old coffee room-temperature coffee inside the coffee pot. The coffee outside of the coffee pot was covered in old coffee grounds and brown stains. The coffee flow reservoir had a dried calcium-stained ring flowing into the inlet of the coffee pot.</p> <p>An ice chest stored in the dining area was half full of warm stale-smelling water.</p> <p>An inspection of the kitchenette's refrigerator revealed dried food stains inside and outside of the refrigerator. There was no evidence refrigerator temperatures were assessed.</p> <p>An inspection of the storage cabinets of the kitchenette revealed towels with brown stains next to a glass water pitcher. The cabinet contained an uncovered food thermometer directly touching the dirty cabinet surfaces.</p> <p>The kitchenette's ice machine had calcium-encrusted stains on the ice outlets of the machine.</p> <p>On [DATE] at 09:30 AM an inspection of the facility's third-floor kitchenette was completed.</p> <p>An inspection of the refrigerator temperature log revealed it was last checked on ,d+[DATE]. The refrigerator contained expired thickened orange juice ([DATE]), expired thickened cranberry juice ([DATE]), and three expired thickened lemonade juices (,d+[DATE], ,d+[DATE], and ,d+[DATE]). The refrigerator also contained an opened but undated/unlabeled sandwich and pie. The freezer unit contained opened and undated packages of cookie dough.</p> <p>The kitchenette's condiment food chiller contained an opened but undated small carton of 2% milk.</p> <p>(continued on next page)</p>

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