STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175549	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Commons Rehab & Health Care Center	12340 Quivira Road Overland Park, KS 66213

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 57 residents. The sample included 15 residents reviewed for dignity. Based on observations, interviews, and record review, the facility failed to ensure a dignified care environment for Resident (R) 8 when staff spoke to her in a disrespectful manner when the resident asked for assistanceFindings Included:- R8's Electronic Medical Records (EMR) included diagnoses of depression, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), muscle weakness, and dysphagia (difficulty swallowing). R8's Quarterly Minimum Data Set (MDS) completed 07/31/25 indicated a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted upper extremity impairment on one side. The MDS noted she required substantial to maximal assistance for transfers, bathing, dressing, toileting, bed mobility, personal hygiene, and putting on footwear. The MDS noted she was frequently incontinent of urine. The MDS noted she had one non-injury fall since admission. R8's Functional Abilities Care Area Assessment (CAA) completed 12/13/24 indicated she required staff assistance for her activities of daily living. The CAA noted she was to anticipate her needs to prevent falls, skin breakdown, incontinence, and potential decline in her activities. R8's Care Plan initiated 12/06/25 indicated she required assistance from one staff member for bed mobility, dressing, toileting, transfers, bathing, and putting on her footwear. The plan noted she was at risk for falls. The plan instructed staff to anticipate her needs, keep personal items within reach, and encourage her to use her call light before transferring. The plan indicated she was to have a Call, Don't Fall sign in her room. A review of the facility's Monthly Grievance Logs indicated R8 filed a grievance on 09/10/25 related to Certified Nurse's Aide (CNA) M's conduct. A review of the grievance report revealed it was documented as a staff concern. The grievance indicated CNA M was repeatedly rude to R8. The grievance indicated that CNA M told R8 that all the direct care staff did not like her because she had to go to the bathroom too much. The report indicated CNA M denied making the comment, but indicated she was short with R8 and had not provided good customer service. The report indicated CNA M was given corrective action and instructed not to provide care for R8. The note indicated R8 felt safe. The report indicated R8's family felt safe with the resolution on 09/12/25. On 09/30/25 at 01:20 PM, members of the facility's resident council indicated R8 struggled with being bullied by CNA M. The council report concerns that the facility did not talk to R8 about how the incident affected her. On 09/30/25 at 01:40 PM, R8 asked to talk about CNA M and became tearful. R8 indicated she asked for help from staff to use the bathroom. and said CNA M entered her room and told he she would have to wait to go to the bathroom, and indicated to the resident that staff were upset that the resident was wet all the time. R8 reported that it made her feel like a burden to staff, and she said she did not want to be around people who did not like her. On 09/30/25 at 02:00 PM, Administrative Staff A was notified, and he stated that he had the facility immediately suspend CNA M. He stated he had no awareness of R8's potential psychosocial trauma, but the facility would immediately screen R8. On 09/30/25 at 02:20 PM, Certified Nurse's Aide (CNA) N stated that staff were expected to treat all residents with respect and dignity. She stated any rudeness from staff would be reported immediately to Administrative Staff A and Administrative Nurse D. On 09/30/25 at 02:00 PM, Administrative Nurse A stated that staff were trained annually and frequently on resident rights, dignity, and abuse topics. She stated that staff were expected to be polite and respectful to all residents. The facility's Resident Rights policy (undated) indicated the facility was to ensure all residents were treated in a dignified manner. The policy indicated the facility was to provide ongoing education and In-service.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 57 residents. The sample included 15, with one reviewed for advance directives. Based on observations, interviews, and record review, the facility failed to follow Resident (R) 59's chosen advanced directives (legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves) related to her do not resuscitate (DNR) wishes for cardio pulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating). Findings Included:- R59's Electronic Medical Records (EMR) included diagnoses of muscle weakness, atrial fibrillation (rapid, irregular heartbeat), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), heart failure, and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R59's admission Minimum Data Set (MDS) completed [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted no upper or lower extremity impairments. The MDS noted she required moderate to substantial assistance with bathing, dressing, bed mobility, personal hygiene, and toileting. The MDS noted she was continent of bowel and bladder. R59's Cognitive Loss Care Area Assessment (CAA) completed [DATE], noted she triggered related to her poor insight, reduced memory recall, and poor safety judgment. The CAA noted that a plan of care was implemented to address her potential risks related to her cognitive decline. R59's Care Plan initiated [DATE] indicated her advanced directives listed her as a DNR on [DATE]. The plan instructed staff to honor her advanced directives and end-of-life decision. R59's EMR under Miscellaneous revealed a Do Not Resuscitate Directive signed by R59 and her medical provider on [DATE]. R59's EMR under Physicians Orders revealed she had a DNR order started on [DATE]. A Facility Incident Report #0354 completed on [DATE] indicated R59 was found unresponsive by staff on [DATE] at 04:55 PM. The report indicated that the staff noted her nursing report sheet indicated she was a full code. The report revealed staff began CPR on R59 without verifying R59's advanced directives in her EMR. At 04:57 PM, Emergency medical services (EMS) arrived and took over CPR. The report indicated R59's pulse returned, and she was transported to an acute medical facility for treatment. On [DATE] at 01:20 PM, Certified Nurse's Aide (CNA) N stated she would check the care plan with the nurse to verify a resident's code status. On [DATE] at 01:27 PM, Licensed Nurse (LN) G stated staff were expected to check either the orders or the care plan for updated advanced directives. She stated the forms were signed upon admission and updated for the care plan, Kardex (nursing tool that gives a brief overview of the care needs of each resident), and orders. She stated that direct care staff were expected to check with the nurse during emergencies. On [DATE] at 02:00 PM, Administrative Nurse A stated that staff were expected to verify the code status of each resident in the care plan or orders before attempting CPR. She stated that if changes were made to a resident's code status, it was immediately relayed to the team. The facility did not provide a policy related to advance directives as requested on [DATE]. The facility implemented the following corrective actions related to this incident:1. The facility completed an audit of current residents to verify the appropriate code statuses for each resident on [DATE].2. The facility completed staff education for all direct care staff related to advanced directives and where the appropriate place to find the code status for each resident on [DATE].3. The facility will complete five staff interviews weekly to ensure staff knowledge of advanced directives starting on [DATE]. 4. The facility will complete practice codes weekly on alternating shifts to ensure staff knowledge for six weeks starting on [DATE]. 5. The facilities Quality Assurance team reviewed the results of the audits and interviews to ensure ongoing compliance starting on [DATE]. This deficient practice was deemed as past non-compliance when the facility implemented the following corrective actions on [DATE], prior to the surveyor entering the facility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 57 residents. The sample included 15 residents, with five reviewed for unnecessary drugs. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 6 was free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication use without a proper indication for use written by the physician. Findings included: - R6's Electronic Medical Record (EMR) documented diagnoses of neurocognitive disorder with Lewy bodies (a type of progressive brain disorder that leads to a decline in thinking, reasoning, and independent function) and a cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).R6's admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented R6 required maximum or full staff assistance with activities of daily living and received antipsychotic medication. R6's Psychotropic Drug Use Care Area Assessment (CAA) dated 08/23/25 stated R6 was at risk for side effects due to the daily use of quetiapine (an antipsychotic). R6's Care Plan dated 08/18/25 included the Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) for quetiapine which stated elderly patients with dementia (progressive mental disorder characterized by failing memory, confusion)-related psychosis treated with antipsychotic drugs were at an increased risk of death and quetiapine was not approved for the treatment of patients with dementia-related psychosis. The care plan directed staff to request the physician review and evaluate medications, review pharmacy consult recommendations, and follow up. The Physician Order dated 08/17/25 directed staff to administer quetiapine, 25 milligrams (mg) by mouth at bedtime, for mood disorder. R6's September 2025 Medication Administration Record (MAR) for antipsychotic medication monitoring lacked documentation of any abnormal behaviors. R6's EMR lacked a written physician rationale for the use of an antipsychotic, quetiapine, without an approved indication of use. On 09/29/25 at 07:20 AM, Certified Medication Aide (CMA) R administered medications to R6 in his room. He took the pills whole without problems and was polite and thanked the CMA R. On 09/30/25 at 02:19 PM, Administrative Nurse D verified the pharmacist's recommendation included choices for the physician to indicate the use of quetiapine, and the physician did not write a rationale for the use of the unapproved antipsychotic. She stated psychiatry had not been to the facility to assess the resident. The facility's Psychotropic (alters mood or thought) Medication Use policy, dated February 2025, stated residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. The policy stated antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders: Schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), Tourette's Disorder (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds), or Huntington Disease (rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder). Diagnoses alone do not warrant the use of psychotropic medication.

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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** The facility had a census of 57 residents. The sample included 15 residents, with six residents reviewed for pressure ulcers (PU- localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review, the facility failed to thoroughly assess Resident (R) 41's Stage three PU (full-thickness pressure injury extending through the skin into the tissue below) and Stage four PU (a deep pressure wound that reaches the muscles, ligaments, or even bone).Findings included: - R41's Electronic Medical Record (EMR) documented a diagnosis of osteomyelitis (infection of the bone and bone marrow) of the sacrococcygeal region (area at the very base of the spine), encompassing the sacrum (a triangular bone) and the coccyx (the tailbone).R41's admission Minimum Data Set (MDS), dated [DATE], was in progress. R41's Care Plan dated 09/19/25 documented R41 had an actual pressure injury to his left gluteus (buttocks muscle) and right heel. R41's Physician Order dated 09/22/25 directed staff to provide wound care to R41's right heel and left gluteus, ensure heel protectors were on while he was in bed, provide a low air loss mattress, and have Wound Care Plus evaluate and treat R41. R41's Skin Assessment dated 09/22/25 included measurements of the gluteal PU, 3.5 centimeters (cm) by 2.7 cm by 0.3 cm deep when the resident returned from the hospital. The assessment lacked documentation of the characteristics of the PUs.R41's Skin Assessment dated 09/29/25 documented the gluteus PU measured 18.1 cm by 5.5 cm. The right heel PU measured 3.5 by 2.7 cm. The assessment lacked depth measurement or characteristics of the wound. The facility lacked documentation the physician was informed of the increased size of the PU. On 09/29/25 at 01:33 PM, Licensed Nurse (LN) F and LN I performed wound care for R41's PUs. The nurses washed hands and donned personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) prior to the wound care. LN F cleaned the gluteus wound, which was approximately two to three cm deep, and five cm long by five cm wide. LN F took a picture for the measurements, but did not measure the depth. LN F applied collagen to the wound bed and covered it with a silicone-faced dressing. LN F also provides wound care to R41's right heel. On 09/30/25 at 02:36 PM, Administrative Nurse D stated R41 was admitted with pressure ulcers on 09/17/25. She verified staff were to measure and assess PU weekly and document the results. She stated R41's physician had been notified of the increase in size, but the facility did not have documentation. The facility's Pressure Injury Assessment and Treatment Guideline, dated January 2025, documented the following information should be recorded in the resident's electronic medical record: type of wound and location, stage of the pressure wound, wound measurements, undermining or tunneling, drainage or odor. Staff were to document assessment of the wound bed, including type and amount of tissue visualized, the wound edges, and the surrounding tissue.

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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. The facility reported a census of 57 residents. The Sample included 15, with three reviewed for falls. Based on observations, record review, and interviews, the facility failed to implement Resident (R) 8's fall interventions related to fall prevention signs.Findings Included:- R8's Electronic Medical Records (EMR) included diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), muscle weakness, and dysphagia (difficulty swallowing). R8's Quarterly Minimum Data Set (MDS) completed 07/31/25 indicated a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted upper extremity impairment on one side. The MDS noted she required substantial to maximal assistance for transfers, bathing, dressing, toileting, bed mobility, personal hygiene, and putting on footwear. The MDS noted she was frequently incontinent of urine. The MDS noted she had one non-injury fall since admission. R8's Functional Abilities Care Area Assessment (CAA) completed 12/13/24 indicated she required staff assistance for her activities of daily living. The CAA noted she was to anticipate her needs to prevent falls, skin breakdown, incontinence, and potential decline in her activities. R8's Care Plan initiated 12/06/25 documented she required assistance from one staff member for bed mobility, dressing, toileting, transfers, bathing, and putting on her footwear. The plan noted she was at risk for falls. The plan instructed staff to anticipate her needs, keep personal items within reach, and encourage her to use her call light before transferring. The plan indicated she was to have a Call, Don't Fall sign in her room. On 09/29/25 at 07:22 AM, an inspection of R8's room revealed no Call Don't Fall sign in place in her room or bathroom. R8 was unable to locate the signs in her room. On 09/30/25 at 09:00 AM, an inspection of R8's room revealed no Call Don't Fall sign in place in her room or bathroom. On 09/30/25 at 01:20 PM, Certified Nurse's Aide (CNA) N stated that fall signs were usually placed by the bed or toilet to prevent the residents from self-transferring. On 09/30/25 at 02:00 PM, Administrative Nurse A stated nurses were responsible for ensuring the fall interventions were implemented in the resident rooms. She stated the interdisciplinary team reviewed the intervention effectiveness weekly, and the interventions were expected to be implemented immediately to prevent falls. The facility's Accidents policy, revised (undated), stated that the facility would ensure a safe environment for all residents. The policy indicated staff would assess each resident's potential risks, including functional abilities, potential falls, assistive devices, and environment, to ensure resident safety.

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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** The facility had a census of 57 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 3 received care and services for dialysis (a procedure where impurities or wastes were removed from the blood) consistent with professional standards of practice, which include ongoing communication and collaboration with the dialysis facility. Findings included:- R3's Electronic Medical Record (EMR) included diagnoses of acute osteomyelitis (local or generalized infection of the bone and bone marrow) of the left foot and ankle, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), non-pressure chronic ulcer, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), end-stage renal disease, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), muscle weakness, and fatigue.R3's admission Minimum Data Set (MDS) dated [DATE] documented that R3 had intact cognition, functional range of motion limitation in both upper and lower extremities and used a wheelchair. R3 required substantial to maximal assistance with eating, oral care, personal hygiene, and upper body dressing. R3 was dependent on toileting, bathing, lower body dressing, rolling side to side in bed, sitting to lying and lying to sitting, sitting to standing, and transfers. The MDS further documented that R3 had pain almost constantly, unhealed pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) present upon admission, and a surgical wound. R3 received nutrition or hydration interventions to manage skin problems, pressure and surgical wound care, application of nonsurgical dressings other than to the feet, and application of dressing to the feet. The Dehydration/Fluid Maintenance Care Area Assessment (CAA) dated 08/22/25 documented R3 had a Multidrug-Resistant Organism (MDRO- common bacteria that have developed resistance to multiple types of antibiotics) of the left ankle wound and received antibiotic therapy while at dialysis after the treatment. R3's Care Plan dated 08/16/25 documented R3 needed hemodialysis (a procedure where impurities or wastes are removed from the blood) related to renal failure. A Care Plan revision, dated 08/21/25, directed staff to fill out a communication sheet and send it with R3 to dialysis and ensure that it is returned and completed. The Physician Order dated 09/16/25, directed staff to fill out the Dialysis Communication sheet and send it with R3 to dialysis and ensure that it was returned and completed. Upon review of the Dialysis Communication Form (which states to utilize each visit and then scan it into the EMR), the facility failed to provide the portion of the form's Resident Condition on 08/19/25, 08/30/25, 09/02/25, 09/09/25, 09/16/25, 09/20/25, and 09/27/25.On 09/30/25 at 10:00 AM, staff assisted R3 with transferring into a wheelchair for travel to the dialysis center. On 09/30/25 at 03:49 PM, Administrative Nurse D and Licensed Nurse (LN) H verified that the facility staff were to provide information on the resident's condition on the Dialysis Communication Sheet and had failed to do so on the dates previously noted.The facility's Dialysis Communication policy, dated 12/2024, documented that a dialysis communication form would be used to send information to and from the facility to the dialysis center and back. The nurse in charge of the care of the resident on the days scheduled for dialysis shall initiate the dialysis communication form and ensure the form is sent with the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 57 residents. The facility had six medication carts and two medication rooms. Based on observation, interview, and record review, the facility failed to remove outdated or expired medication from potential administration to residents.Findings included:- On 09/29/25 at 07:42 AM, the Blue Medication cart contained two expired medications:Heartburn relief liquid antacid, 12 fluid ounces, with the expiration date of 10/2024. Vitamin D3, 50 micrograms (mcg), bottle of soft gels, expired April 2023.On 09/30/25 at 09:00 AM, the Blue medication room had an emergency kit box with two vials of Ativan (antianxiety drug) with an expiration date of 07/2024. On 09/29/25 at 07:45 AM, Certified Medication Aide (CMA) S verified the expiration dates on the medications. On 09/30/25 at 09:00 AM, Administrative Nurse F verified the expiration dates on the two vials of Ativan. On 09/30/25 at 09:22 AM, Administrative Nurse D verified the pharmacist should have removed the expired vials of Ativan medication from service. She verified staff should have removed the non-narcotic expired medications from service. The facility's Medication Storage in the Facility policy, dated May 2019, documented that outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled, or without a secure closures would be immediately withdrawn from stock by the facility. They would be disposed of according to drug disposal procedures and reordered from the pharmacy if a current order exists.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 57 residents. The facility identified 15 residents on 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). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control practices related to wearing personal protective equipment (PPE) related to residents on EBP.Findings Included: - On 09/30/25 at 07:36 AM, Certified Nurse Aide (CNA) M and CNA N used a total lift to transfer Resident (R) 23, who had wounds and a urinary catheter, from his bed to a wheelchair. The CNAs did not wear gowns for infection control during the transfer. On 09/30/25 at 07:45 AM, Licensed Nurse (LN) G verified staff should have worn gowns when transferring R23, as his physician ordered on 09/26/25. On 09/30/25 at 02:32 PM, Administrative Nurse E verified that staff should have worn gowns during the transfer. The facility's Infection Prevention and Control Manual Enhanced Barrier Precautions policy, undated, stated Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics) in nursing homes. EBP involved gown and gloves used during high-contact resident care activities for residents at increased risk for MDRO acquisition (such as residents who have wounds or indwelling medical devices). EBP expands the use of a gown and gloves to focus on resident care activities that have been demonstrated to result in the transfer of MDROs to the hands and clothing of healthcare personnel. - Resident (R) 13's Electronic Medical Record (EMR) documented diagnoses of urinary tract infection (UTI- an infection in any part of the urinary system), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), acute kidney failure, retention of urine, and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R13's admission Minimum Data Set (MDS) dated [DATE] documented R13 had intact cognition, had functional range of motion impairment of both lower extremities, and used a wheelchair. R13 was dependent on staff for toileting, bathing, lower body dressing, rolling side to side in bed, and sit-to-stand transfers. R13 required partial to moderate assistance with upper body dressing and chair/bed transfers. The MDS further documented that R13 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and a UTI in the past 30 days. R13's Urinary Incontinence Care Area Assessment (CAA) dated 09/26/25 documented R13 had two nephrostomy (an artificial opening created between the kidney and the skin which allows for the urinary diversion) tubes and a suprapubic (urinary bladder catheter inserted through the abdomen into the bladder) catheter. R13's Feeding Tube (g-tube- the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall) CAA dated 09/26/25 documented R13 had a feeding tube that was only used for flushing each shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175549	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Commons Rehab & Health Care Center	12340 Quivira Road Overland Park, KS 66213

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's Care Plan dated 09/16/25 documented that R13 was on 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) due to catheters, nephrostomy, and g-tube. The Care Plan directed staff to wash/sanitize hands before entering the room and when leaving the room, and to wear a gown and gloves when performing high-contact activities. The Physician Order dated 09/18/25 directed staff to use EBP with dressing, bathing, transfers, changing linens, providing hygiene, toileting or peri care, device care, or wound care. On 09/30/25 at 10:25 AM, Licensed Nurse (LN) J prepared R13's medication for administration through the g-tube. LN J sanitized hands by using alcohol gel, placed gloves on, and entered the room. R13's door had a sign with information regarding EBP and a clear plastic pocket container with blue plastic gowns. LN J proceeded to administer medications and water through the g-tube without wearing a protective gown. On 09/30/25 at 01:03 PM, LN J verified that gloves and gowns should be worn during the administration of medications through R13's g-tube. On 09/30/25 at 01:25 PM, Administrative Nurse D and LN H both verified R13 had EBP, and the use of gloves and gowns were to be worn while administering g-tube medications. The facility's undated Infection Prevention and Control Manual-Enhanced Barrier Precautions policy documented EBP as an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics) in nursing homes. EBP expands the use of gowns and gloves beyond anticipated blood and body fluid exposures. EBP is recommended for residents with any of the following: infection or colonization with an MDRO or a wound or indwelling medical device, even if the resident is not known to be infected or colonized with an MDRO. Indwelling medical devices include central venous (blood vessel) catheters, urinary catheters, feeding tubes, or tracheostomies (opening through the neck into the trachea through which an indwelling tube may be inserted)/ventilators (a medical device that provides breath to persons who cannot breathe on their own).