STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Post Acute Rehabilitation Center	7600 Antioch Road Overland Park, KS 66204

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility had a census of 79 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to ensure staff performed appropriate glove changing and hand hygiene for two residents, Resident (R) 18 and R52, when they did not remove their soiled gloves after incontinence care and continued to touch other surfaces and resident belongings.Findings included:- On 02/17/26 at 07:40 AM, Certified Nurse Aide M pushed R18 in her wheelchair to the bathroom and put on clean gloves. CNA M locked the wheelchair, put her right hand under R18's left arm, and R18 grabbed the bar on the wall by the toilet and stood up. CNA M pulled down R18's pants and incontinence brief, and R18 sat down on the toilet. CNA M removed and discarded her incontinence brief and put on a clean one. CNA M had R18 stand so she could perform incontinence care. When CNA M was finished, she pulled up the incontinence brief with the same soiled gloves and pulled up R18's pants. CNA M transferred R18 back into her wheelchair, pushed her up to the sink, picked up R18's toothbrush, put toothpaste on it, and handed it to her. CNA brushed R18's hair and took a wet paper towel and wiped off R18's mouth. CNA M bagged the trash, removed the soiled gloves, and pushed R18 out to the dining room.On 02/17/26 at 07:55 AM, CNA M verified she had not removed her gloves after providing personal care and she said she should have. On 02/17/26 at 09:33 AM, Certified Nurse Aide (CNA) M pushed R52 in her wheelchair to the bathroom and CNA M donned clean gloves. CNA M locked the wheelchair, put her right hand under R52's left arm, and R52 grabbed the bar on the wall by the toilet and stood up. CNA M pulled down R52's pants and incontinence brief, and R52 sat down on the toilet. CNA M removed and discarded her incontinence brief and put on a clean one. CNA M had R52 stand so she could perform incontinence care. When CNA M was finished, she pulled up the incontinence brief with the same soiled gloves and pulled up R52's pants. CNA M transferred R52 back into her wheelchair, had her wash her hands in the sink, pushed her in her wheelchair over to a bedside table, opened up a coloring book, and gave her a container with colored pencils. CNA M removed the soiled gloves.On 02/17/26 at 09:50 AM, CNA M verified she did not change her gloves after she provided personal care and did not wash her hands.On 02/18/26 at 08:30 AM, Administrative Nurse D stated she expected staff to change her gloves and wash her hands after providing personal care to residents.The facility's Infection Prevention and Control Program policy, dated 06/21, documented that the facility personnel would conduct themselves and provide care in a way that minimized the spread of infection. Facility personnel would wash their hands after each direct resident contact for which hand washing was indicated by accepted professional practice. Validation of the personnel infection prevention and control practices is monitored by the infection preventionist through skills competency evaluation, such as observation of hand hygiene.

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	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility had a census of 79. The sample included 18 residents. Based on record review, interview, and observation, the facility failed to treat residents with respect, dignity, and privacy related to nasal spray administration, and having an uncovered urinary collection bag visible to guests and other residents. Findings included: - On 02/17/26 at 12:10 PM, observation revealed R8's urinary collection bag sat between his legs in the wheelchair, as he propelled through the dining room. Continued observation revealed R8's urinary collection bag lacked a dignity cover and was half full of yellow urine. On 02/18/26 at 08:40 AM, Administrative Nurse D stated staff should not administer nasal spray at the dining room table and staff should take the resident to her room or a private area. Administrative Nurse D verified the residents catheter bag should be covered and urine not visible. The facility's Resident Rights policy, dated 03/01/25, documented, each resident would be treated with kindness, dignity and respect including privacy in treatment and in the care of personal needs.

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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 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 identified a census of 79 residents. The sample included 19 residents with five residents reviewed for unnecessary medications. Based on interviews, observation, and record review the facility failed to follow physician orders for an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) medication for Resident (R) 2. The facility also failed to ensure an appropriate indication, or a documented physician rationale, which included multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefit reviews for the continued use of antipsychotic medication for R 78, who had a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).Findings included:- R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of altered mental status, schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) type, and need for continuous supervision. The Quarterly Minimum Data Set (MDS) dated 11/20/25 documented a staff assessment for mental status which indicated R2 had modified independence (difficulty in new situations) for daily decision making. The MDS documented R2 received antipsychotic medication, antidepressant (a class of medications used to treat mood disorders) medication, anticonvulsant (a medication that prevents or treats seizures and convulsions) medication, and antidepressant (a class of medications used to treat mood disorders) medication during the observation period. R2's Psychotropic Drug Use Care Area Assessment (CAA), dated 10/02/25 documented she recently returned from the hospital for medication management of her schizoaffective disorder. R2's Care Plan, documented the following: 09/25/24 - Staff would encourage her to express her feelings. 09/25/24 - Staff would assist her to identify her strengths, positive coping skills and reinforce those. 10/03/24 - Staff would administer medication as ordered. 06/27/25 - Staff would monitor, record, and/or notify the physician of any mood patterns. 06/27/25 - Medication had to be given at a specific time. R2's EMR under the Orders tab revealed the following physician orders: Invega sustenna (antipsychotic) intramuscular suspension prefilled syringe 234 milligrams (mg)/1.5 milliliters (ml) (Paliperidone Palmitate). Inject 1.5 ml intramuscularly one time a day every 28 day(s) related to schizoaffective disorder; bipolar type dated 02/11/26. Review of R2's EMR under the Misc tab revealed an After Visit Summary from a hospital stay, which documented an order to start the antipsychotic medication Invega on 01/16/26. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's EMR under the Orders tab review of the January 2026 Medication Administration Record (MAR) documented the resident refused her Invega injection on 01/13/26. The facility provided documentation verifying the medication was administered by the nurse practitioner on 01/13/26. Review of R2's February 2026 MAR revealed Invega was not administered on 02/10/26 as ordered, the resident's record noted a number seven which represented for the reader to see the resident's nursing notes. Review of R2's Progress Note tab lacked any documentation or rational why the medication was not administered as ordered. On 02/12/26, the resident's antipsychotic medication Invega was administered at 31 days. On 02/17/26 at 07:40 AM, R2 laid on her bed with the blankets pulled over her head. R2's overhead lights were on in the room, and her door was closed. On 02/18/26 at 10:35 AM, Administrative Nurse F stated when R2 refused her medication, staff reattempted to offer the medication several times and if she continued to refuse the medication, the physician would be notified. Administrative Nurse F stated the Invega would be offered again the next day. A note would be documented in R2's EMR in the nurses' notes section and the physician would be notified, which would also be documented in the nurses' notes. On 02/18/26 at 11:40 AM, Administrative Nurse D stated she would expect the physician to be notified of R2's refusal of her antipsychotic medication. Administrative Nurse D stated she was not sure why the medication was not administered as the physician had ordered. The facility's Psychotropic Drug Use policy last revised 11/2024 documented it was the policy of the facility to ensure that residents who have not used psychotropic medication are not given these medications unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. - R78's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure), delusional misidentification syndrome (a group of rare psychiatric disorders characterized by persistent false beliefs that people, places, or objects have been replaced, transformed, or duplicated), anxiety (mental or emotional reaction characterized by apprehension, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (a major depressive disorder that causes persistent feelings of sadness). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R78 had long and short-term memory problems, with severely impaired decision-making skills. R78 was dependent upon staff assistance for all activities of daily living. The MDS documented R78 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication daily. The Significant Change MDS, dated 12/29/25, documented R78 had long and short-term memory problems, with severely impaired decision-making skills. R78 was dependent upon staff assistance for all activities of daily living. The MDS documented R78 received an antipsychotic medication daily. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R78's 12/30/25 Care Plan included the following interventions: 05/08/25 – Remind R78 to attend activities of choice. 05/13/25 – Administer medications as ordered and monitor for side effects and effectiveness. Consult with the pharmacy and the physician to consider dosage reduction when clinically indicated. The care plan directed staff to provide non-pharmacological interventions and encouraged them to express feelings. 02/10/26 – Monitor for episodes of psychotic behavior as evidenced by agitation. The Physician's Order, dated 05/01/25, directed staff to administer Seroquel (an antipsychotic medication), 25 milligrams (mg), by mouth at supper for anxiety. The order was changed on 10/12/25 to Seroquel 25 mg, administer 0.5mg, by mouth, in the evening for delusional misidentification syndrome. R78's EMR lacked evidence of a documented physician rational with included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing Seroquel use. On 02/17/26 at 07:45 AM, R78 was in bed, with her eyes closed. On 02/17/26 at 08:30 AM, Certified Nurse Aide (CNA) M stated R78 rarely left her room and did not have any behaviors that she was aware of. On 02/17/26 at 10:00 AM, Licensed Nurse (LN) G stated R78 did not have behaviors, did not like to attend activities, and stayed in her room most of the time. On 02/18/26 at 10:30 AM, Administrative Nurse D stated she was unable to provide a risk versus benefit or indications for the inappropriate diagnosis of the Seroquel medication. The facility's Psychotropic Drug Use policy, dated 11/24, documented that the facility would ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. Psychotropic medication shall not be administered for discipline or convenience. The LN would review the classification of the drug, the appropriateness of the diagnosis, its indications/behavior monitors, and related adverse side effects with the attending physician.

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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 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. The facility had a census of 79 residents. The sample included 18 residents, with 2 reviewed for hospitalization. Based on interviews and record review the facility failed to notify the Office of the Long-Term Care Ombudsman (LTCO- a public official who works to resolve resident issues in nursing facilities) and failed to provide the residents with written information regarding the facility's bed hold policy when they were transferred to the hospital for two residents, (R) 51 and R1. Findings included: - The Nurse's Notes dated 02/17/25 at 04:35 PM, documented R51 admitted to the acute care hospital for wound surgery. The Nurse's Note dated 04/02/25 at 01:13 PM documented R51 returned to the facility on a stretcher, transported by Medical Transport company. R51 had multiple wounds that were clean, dry and intact. R51's clinical record lacked a bed hold policy and a resident or resident representative signature. R51's clinical record lacked documentation staff notified the Long-Term Care Ombudsman (LTCO) of R51 s discharge from the facility to the hospital. On 02/18/26 at 08:30 AM, Social Service Designee X verified the facility was unable to provide written evidence upon request that they had a bed hold policy for R51 and stated when residents were discharged , they should have had the resident or family sign the facility bed hold policy. Social Service X verified the facility lacked evidence the LTCO was notified of R51's discharge to the hospital and verified she would send a monthly report to the Ombudsman regarding the residents who were discharged from the facility. The facility's Transfer or Discharge Noise, policy, dated March 2025, documented residents (or residents' representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language they understand. A copy of the notice must be sent to the Office of the State-Long Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. The facility's Bed Hold, policy, dated November 2016, documented the facility would provide written information to the residents and/or the resident's representative regarding bed hold policies in the event of a transfer from the facility to a general acute care hospital or for a therapeutic leave. The bed hold policy would be provided to the resident and/or representative in a language they can understand at the time of admission, transfer to the general acute hospital, and start of the resident's therapeutic leave. The bed hold policy provides all residents and residents representative written information regarding the facility and state bed hold policies, which address holding or reserving a resident's bed during periods of absence. - The Nurse's Note, dated 11/15/25 at 10:18 AM, documented R1 admitted to the hospital for shortness of air (difficulty breathing). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's clinical record lacked evidence of the ombudsman notification for the 11/15/25 hospital transfer. The Nurse's Note, dated 11/24/25 at 10:18 AM, documented R1 admitted to the hospital for pneumonia (an infection that inflames the air sacs in one or both lungs). R1's clinical record lacked evidence that the resident's family/representative received the bed hold notification or that the Ombudsman was notified of the hospital transfer. On 02/18/26 at 08:00 AM, Social Service X verified that the facility was unable to provide written evidence upon request that it had a bed-hold policy or an ombudsman notification for R1's hospital transfers. On 02/18/26 at 08:30 AM, Administrative Nurse D stated she was unaware R1 lacked a bed hold notification for 11/24/25, and the ombudsman should be notified monthly of hospital transfers. The facility's Admission, Transfer, and Discharge policy, dated 03/25, documented the facility would notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility would send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 79 residents. The sample included 19 residents, with one reviewed for communication. Based on observation, interview, and record review, the facility failed to ensure staff used alternative communication methods for one sampled resident, Resident (R) 18, who had a language barrier and spoke in Farsi (Persian).Findings included:- R18's Electronic Medical Record (EMR) documented diagnoses of senile degeneration of the brain (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R18 had long and short-term memory problems with severely impaired decision-making skills. R18 required partial staff assistance with dressing, showers, toileting hygiene, mobility, and transfers. The MDS documented R18 had adequate hearing, clear speech, and usually made herself understood.R18's 01/01/26 Care Plan included the following interventions:07/22/20 - R18 spoke in Farsi and was able to communicate with the translator. R18's daughter is available to translate 24/7. R18's family provided a notebook with key phrases in Farsi to English in her room. R18 preferred using her daughter or family to translate. The care plan directed staff to anticipate and meet her needs and provide a translator as necessary to communicate with her.10/15/20 - R18 preferred to communicate in her language and directed staff to use a translator service.03/15/24 - R18 often preferred her children to translate for her.11/15/24 - Keep her television on Farsi speaking channel at all times.During an observation on 02/17/26 at 07:40 AM, Certified Nurse Aide (CNA) M told R18 she would help her get up to go to the bathroom. R18 talked to CNA M in her native language. When this surveyor asked what R18 said, CNA M stated, I don't know. When asked how CNA M knew what R18 needed or wanted, CNA M stated R18 could say a few words, like water, but otherwise CNA M did not know. CNA M stated she had worked at the facility for a short time and did not know of any other ways to communicate with R18.On 02/17/26 at 10:30 AM, Licensed Nurse (LN) G stated they use an interpreter service or the family if they try to communicate with R18 or had difficulty understanding what she wanted or needed.On 02/18/26 at 08:30 AM, Administrative Nurse D stated the family prefers they call them to translate if the staff do not know what the resident wanted or needed. Administrative Nurse D said it was easier than calling the translator service.The facility did not provide a policy regarding communication, as requested on 02/18/26 at 12:00 PM.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 79 residents. The sample included 19 residents with one resident reviewed for positioning and mobility. Based on observation, record review and interview, the facility failed to ensure staff provided the physician ordered foam dressings to protect the skin integrity of Resident (R) 3's bilateral hand contractures (abnormal permanent fixation of a joint or muscle). Findings included:- R3's Electronic Medical Record (EMR) documented diagnoses of contracture of the left and right hands, and hemiparesis/hemiplegia (weakness and paralysis on one side of the body).R3's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R3 was dependent on staff for all activities of daily living (ADL). R3's Functional Abilities (Self Care and Mobility) Care Area Assessment (CAA), dated 03/14/25, documented she continued to use a Broda chair (specialized wheelchair with tilt and recline) for mobility and a Hoyer lift (total-body mechanical lift) for transfers. R3 needed assistance with peri-care and clothing management.R3's Care Plan revised on 02/02/26, directed staff to place foam or other available foam dressing in bilateral palms under nails daily or as tolerated for skin integrity. The Care Plan directed staff to please place Hydrofera blue foam (absorbent foam dressing) or other available foam dressing in both palms and under nails daily or as tolerated for skin integrity in the setting of severely contracted hands.R3's Orders tab documented an order dated 01/08/26 for Hydrofera blue foam or other available foam dressing in both palms under nails daily, or as tolerated, for skin integrity in the setting of severely contracted hands. R3's Occupational Therapy (OT) dictation from her certification period 10/27/25 to 12/01/25 documented R3 was referred due to new skin breakdown noted on bilateral palms and severely contracted hands. R3 had typically been resistive/become agitated at attempts to place palm protectors and orthotics in prior plans of care. During evaluation, R3 had small antibacterial foam placed in her palms which seemed to be protecting the palms, other than her left second fingernail digging into the skin on top of her third finger. R3 has more active range of motion in her right hand, which is more severely contracted, and the nails are curled under; less mobility in the left hand however fingertips are not curled under. R3 was pleasant to the therapist and allowed examination of her hands however upon trial of carrot orthotic she stated she was not doing that and withdraws her hand. She allowed foam to be reapplied without issue. The skin of both hands appeared dry and flaky this date with left hand more impacted than right. She would benefit from participation in skilled OT plan of care to address these deficits.On 02/16/26 at 09:11 AM, R3 sat in her Broda chair in her room. R3's bilateral hands and fingers were tightly closed with no foam support noted in the palms of her hands.On 02/17/26 at 11:25 AM, R3 sat in her Broda chair watching tv near the dining area. R3's bilateral hands and fingers did not have foam supports under her fingers for her contractures.On 02/17/26 at 11:33 AM, Licensed Nurse (LN) H said R3 should have foam in her hands but could not say why R3 did not have them in her hands.On 02/18/26 at 08:33 AM, Administrative Nurse D stated she expected R3's foam to be put in both of her hands daily. Administrative Nurse D said the staff should place the foam in the palms of her hands each morning for her contracted fingers.The Contracture Documentation policy revised 03/25 documented a resident with a limited range of motion or contracture shall receive appropriate treatment and services, based on the comprehensive assessment of the resident, to increase range of motion and/or to prevent further decrease. An assessment of the resident's joint mobility should be completed by the physical therapist or a licensed nurse to reflect the following: resident's joint limitations by category of limitation, resident's ability to participate in activities geared to stretching and range of motion (ROM) exercises, identify risk factors for secondary complications and need for special positioning, transfer and skin care precautions, resident's needs for adaptive devices to improve participation in ADL's. A program shall be developed by the Interdisciplinary Team based on the resident's comprehensive assessment and shall be included in the resident's care plan. A (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order shall be obtained to provide the range of motion program to the resident and any recommended splints, braces, assistive devices to assist in reducing further decline in joint range of motion. The effectiveness of the program, whether improved joint mobility, or maintained mobility, or deterioration of the joint movement is observed, shall be included.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 79 residents. The sample included 19 residents, with four reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide a safe environment for one resident, Resident (R) 52, who sustained a skin tear after staff lowered her to the ground and was not using a gait belt during ambulation.Findings included: - R52's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), repeated falls, muscle weakness, and unsteadiness on the feet.The Significant Change Minimum Data Set (MDS), dated [DATE], documented R52 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R53 was dependent upon staff for toileting hygiene, and required partial staff assistance with transfers and personal hygiene. R52 had no functional impairment to upper or lower extremities and had no falls.The Fall Risk Assessments, dated 10/10/25, documented R52 was a medium risk for falls.R52's 12/23/25 Care Plan included the following interventions:03/25/19 - Provide R52 a safe environment, the call light within reach, and the bed in low position at night.08/23/23 - Educate R52 and remind her to call for assistance with all transfers.01/17/24 - Care in pairs.03/12/24 - Remind her to lock her braes before transfers.01/07/25 - Ensure nonskid footwear on al all ties.12/12/25 - Ensure use of a gait belt during all transfers.The Interdisciplinary Team Note, dated 12/15/25 at 11:28 AM, documented R52 had a fall on 12/12/25 at 07:30 PM. The root cause analysis determined that during the process of transferring R52 from the wheelchair to the bed, the resident's knees buckled, and the caregiver lowered her slowly to the floor. After a head-to-toe assessment was completed, a skin tear was noted on the right elbow. The intervention put into place was to ensure the use of a gait belt during transfers. The caregiver stated, R52 seemed weak, and her knees buckled, so she helped her down on the floor, and she ended up with a wound on her right arm.The Nurse's Note, dated 12/12/25 at 09:12 PM, documented a caregiver helped R52 to bed. In the process of the transfer from the wheelchair to bed, her knees buckled, and the caregiver lowered her to the floor. A head-to-toe assessment was completed after the fall, and a skin tear was noted on the right elbow. The skin tear was cleansed and covered with a Band-Aid.On 02/17/26 at 09:33 AM, Certified Nurse Aide (CNA) M pushed R52 in her wheelchair to the bathroom and put on clean gloves. CNA M locked the wheelchair, put her right hand under R52's left arm, and R52 grabbed the bar on the wall by the toilet and stood up. CNA M pulled down R52's pants and incontinence brief, and R52 sat down on the toilet. CNA M removed and discarded her incontinence brief and put on a clean one. CNA M had R52 stand so she could perform incontinence care. When CNA M was finished, she pulled up the incontinence brief with the same soiled gloves and pulled up R52's pants. CNA M transferred R52 back into her wheelchair, had her wash her hands in the sink, pushed her in her wheelchair over to a bedside table, opened up a coloring book, and gave her a container with colored pencils. CNA M then removed the soiled gloves. When this surveyor asked CNA M if she was supposed to use a gait belt during her transfers or if there was to be two staff to assist with her care, she stated, [R52] did not need a gait belt for transfers and CNA M said she did not know there R52 needed two staff in the room to provide care.On 02/17/26 at 10:00 AM, Licensed Nurse (LN) G stated she was unsure about two staff members to assist with R52's cares but due to her falls, staff were always to use a gait belt for her transfers.On 02/17/26 at 02:00 PM, Administrative Nurse D stated that staff were to follow the care plan of care in pairs and to always use a gait belt during transfers for R52.The facility's Fall Prevention policy, dated 06/17, documented the facility was to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury. For those residents who continue to have falls, incident reports would be completed per facility policy, with resulting investigations followed up by interventions that are appropriate for the type of falls the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175550	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Post Acute Rehabilitation Center	7600 Antioch Road Overland Park, KS 66204

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was experiencing. Care staff would be apprised of interventions needed for that resident to assist with preventing further falls and minimizing the potential for injury.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 79 residents. The sample included 19 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure that the physician responded to the recommendation made by the Consultant Pharmacist (CP) to ensure that Resident (R)78's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication Seroquel had an appropriate Centers for Medicare and Medicaid Services (MS) indication for use.Findings included:- R78's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure), delusional misidentification syndrome (a group of rare psychiatric disorders characterized by persistent false beliefs that people, places, or objects have been replaced, transformed, or duplicated), anxiety (mental or emotional reaction characterized by apprehension, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (a major depressive disorder that causes persistent feelings of sadness).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R78 had long and short-term memory problems, with severely impaired decision-making skills. R78 was dependent upon staff assistance for all activities of daily living. The MDS documented R78 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication daily.The Significant Change MDS, dated 12/29/25, documented R78 had long and short-term memory problems, with severely impaired decision-making skills. R78 was dependent upon staff assistance for all activities of daily living. The MDS documented R78 received an antipsychotic medication daily.R78's 12/30/25 Care Plan included the following interventions:05/08/25 - Remind R78 to attend activities of choice.05/13/25 - Administer medications as ordered and monitor for side effects and effectiveness. Consult with the pharmacy and the physician to consider dosage reduction when clinically indicated. The care plan directed staff to provide non-pharmacological interventions and encouraged them to express feelings.02/10/26 - Monitor for episodes of psychotic behavior as evidenced by agitation. The Physician's Order, dated 05/01/25, directed staff to administer Seroquel (an antipsychotic medication), 25 milligrams (mg), by mouth at supper for anxiety. The order was changed on 10/12/25 to Seroquel 25 mg, administer 0.5mg, by mouth, in the evening for delusional misidentification syndrome.R78's EMR lacked evidence of a documented physician rational with included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing Seroquel use.The Consultant Pharmacist Recommendations to the Physician, dated 05/21/25, documented the resident's diagnosis for the use of quetiapine (Seroquel) was not one of the CMS approved indications for use of the drug. The recommendation noted if the resident's physician wanted to continue with the use of the medication, they asked them to provide a risk versus benefit for the continued use, what has been tried and failed in the past, and other nonpharmacological options utilized to help with the condition. The physician responded by stating that requester should look in the resident's progress notes.The Consultant Pharmacist Monthly Medication Regimen Review, dated 06/29/25, 07/27/25, 08/28/25, 09/29/25, 10/30/25, 11/27/25, 12/26/25, and 01/22/26, did not make any further recommendations regarding R78's diagnosis for the use of Seroquel.On 02/17/26 at 07:45 AM, R78 was in bed, with her eyes closed.On 02/17/26 at 08:30 AM, Certified Nurse Aide (CNA) M stated R78 rarely left her room and did not have any behaviors that she was aware of.On 02/17/26 at 10:00 AM, Licensed Nurse (LN) G stated R78 did not have behaviors, did not like to attend activities, and stayed in her room most of the time. On 02/18/26 at 10:30 AM, Administrative Nurse D stated she was unable to provide a risk versus benefit or indications for the inappropriate diagnosis of the Seroquel medication. Administrative Nurse D stated she had not been informed by the CP that the diagnosis was incorrect. The facility's Medication (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Drug) Regimen Review (MRR) policy, dated 01/22, documented that each resident's drug regimen would be reviewed at least once a month by a licensed pharmacist. A medication regimen review (MRR) included a review of the resident's medical chart. Identified irregularities would be documented on a separate written report that included the resident's name, the relevant document, and the irregularity identified. The report would be sent to the attending physician, the facility's medical Director, and the Director of Nursing Services (DNS) to be acted upon.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 79 residents. The facility had five medication carts and four medication rooms. Based on observation, record review and interview, the facility failed to ensure an opened vial of tuberculin (a purified protein derivative used in skin tests to help diagnose tuberculosis [a contagious infection primarily attacking the lungs, though it can affect other organs]) in the medication room, was dated upon being opened. The facility also failed to ensure stock medication/supplements on a medication cart were not expired. Findings included: - On 02/17/26 at 07:23 AM an observation of the [NAME] Bend-1 hall medication room revealed the medication refrigerator contained an opened vial of tuberculin lacked an open date (expiration date of 11/28). On 02/17/26 at 07:25 AM, Licensed Nurse (LN) H stated she was not sure when the vial of tuberculin was opened but said it should have an open date written on the label. LN H stated she would discard the vial of tuberculin. The facility's Medication Labels and Storage policy dated March 2024, documented floor stock medications are labeled as and kept in original manufacturer's container with the expiration date and lot number clearly evident. The Date the medication was opened will be placed on the container. - On 02/16/26 at 08:30 AM, observation revealed Certified Medication Aide (CMA) M obtained medication to administer to residents from the [NAME] 2 Cart A medication cart. The cart contained one bottle of Vitamin B12 500 micrograms (mcg), 100 tablets that expired 12/2025 On 02/16/26 08:35 AM, Administrative Nurse D verified staff were to remove from stock or dispose of expired medications. The facility's Medication Labels and Storage policy dated March 2024, documented the floor stock medications are labeled and kept in the original manufacture's container with the expiration date and lot number clearly evident. The date the medication was opened would be placed on the container.