STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175551	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Olathe	21250 West 151st Street Olathe, KS 66061

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 57 residents. The sample included 15 residents, with two residents reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure staff assisted Resident (R) 26 with cutting her whiskers per her preference. This deficient practice placed R26 at risk for impaired dignity and decreased psychosocial well-being. Findings Included: - R26's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, need for assistance with personal care, hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), insomnia (inability to sleep), reduced mobility, dementia (a progressive mental disorder characterized by failing memory and confusion), hyperlipidemia (condition of elevated blood lipid levels), peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), cognitive communication deficit, difficulty walking, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R26 required set up and clean up by staff for eating and oral hygiene. The MDS documented R26 was dependent on staff for bathing and toileting and was frequently incontinent of bowel and bladder. R26's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) completed 12/26/24 documented the activities of daily living (ADL) function CAA triggered secondary to R26 requiring assistance with ADLs, impaired balance and transition during transfers, and functional impairment in activity. The contributing factors include generalized weakness and decreased safety awareness. Risk factors include further ADL decline, falls, incontinence, skin breakdown, and pain. R26's plan of care would be reviewed to maintain current ADL status and functional ability, maintain continence status, decrease pain, and decrease fall and pressure ulcer risk. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's Care Plan revised on 03/29/23 documented ADL self-care performance deficit related to a left fourth toe amputation, staff were to encourage R26 to fully participate possible with each interaction. R26's plan of care documented bathing would be provided on Thursday and Sunday and R26 required the assistance of one staff. R26's plan of care dated 06/07/23 documented resistance to care related to adjustment to a nursing home, anxiety, and dementia. At times R26 declines assistance with care: medications, toileting assistance, repositioning wound care, and bathing. The plan documented R26 would be allowed time to make decisions about the treatment regime, to provide a sense of control. Staff were to try and negotiate a time for ADLs to ensure the resident participated in the decision-making process. On 04/14/25 at 07:22 AM, R26 laid in her bed, R26 had long grey hairs on her chin. On 04/15/25 at 08:17 AM, R26 sat in her wheelchair, R26 had long grey hairs on her chin. On 04/14/25 at 07:22 AM, R26 stated she does not like her chin to have long whiskers. R26 stated when she got a shower, the staff always cut her hair. R26 stated she could cut the whiskers herself if the staff helped her. On 04/16/25 at 07:15 AM, Licensed Nurse (LN) H stated shaving a lady's chin could be part of bathing, or any staff member could ask if a resident was uncomfortable having long chin hairs. LN H stated it was all the nursing staff's duties to ensure the residents were well groomed. LN H was unsure if a lady's chin hair needed to be cut should be in the care plan. On 04/16/25 at 08:15 AM, Certified Nurse Aide (CNA) M stated she was unsure what was care planned for each resident. She stated she would ask her nurse if she was unsure of a resident's preference. CNA M stated when she gave baths, she would ask the residents what their preferences were. On 04/16/25 at 01:10 PM, Administrative Nurse D stated she did not believe a lady who required shaving of her chin would need to be care planned. She stated staff should have a keen eye and ask the residents about their preferences, and that could be done during bathing. The facility's Dignity and Respect policy revised on 10/15 documented all residents be treated with kindness, dignity, and respect. The staff would display respect for residents when speaking with, caring for, or talking about them, as a constant affirmation of their individuality and dignity as human beings. Schedules of daily activities allowed maximum flexibility for residents to exercise choices about what they would do and when they would do it. The resident's individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, and entertainment were elicited and respected by the facility. Residents would be appropriately dressed in clean clothes arranged comfortably on their persons and be well groomed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 45668 The facility identified a census of 57 residents. The sample included 15 residents, with two reviewed for reasonable accommodation of needs related to assistive devices. Based on observation, record review, and interviews, the facility failed to ensure Residents (R) 37 and R42 had a way to communicate their needs due to their call lights being left out of reach. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings Included: - On 04/14/25 at 07:00 AM, an inspection of R37's (a physically impaired resident unable to self-transfer) room revealed her asleep in her bed. R37's call light was on the floor to the left side of her bed. On 04/15/25 at 07:37 AM, R42 (a cognitively and physically impaired resident unable to self-transfer) slept in her bed. Her bed remained in a low position. R42's call light was pinned to a pillow placed on her recliner across from her bed. The call light was out of reach. At 07:40 AM, Administrative Nurse D entered the room, moved the call light to R42's bed, and stated staff were expected to ensure the call lights remained within reach at all times. On 04/16/25 at 12:03 PM, Certified Nurse Aide (CNA) M stated staff was expected to ensure the call lights were pinned to the residents or placed within the resident's reach. On 04/16/25 at 12:33 PM, Licensed Nurse (LN) G stated call lights needed to be kept within reach of the residents when staff left the room. On 04/16/25 at 01:10 PM, Administrative Nurse D staff were expected to ensure the residents had access to their call lights. She stated the call lights were to be pinned to the residents or their beds within the resident's reach. The facility's Fall Management System dated 12/2024 indicated the facility promoted an environment that remains free from accident hazards. The policy indicated the facility assessed and provided the appropriate equipment to ensure resident safety. The policy indicated the facility appropriately assessed and implemented interventions to prevent falls and minimize complications if falls occurred. The facility did not provide a policy related to the accommodation of needs as requested on 04/16/25.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49634 The facility identified a census of 57 residents. The sample includes 15 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances and concerns. Findings Included: - On 04/14/25 at 7:55 AM, an inspection of the facility revealed no designated grievance drop boxes or system available in the areas accessible to the residents and visitors of the facility. On 04/15/25 at 01:30 PM, the Resident Council members reported they were not aware if the facility provided a way to complete anonymous grievances. The council reported they must take the grievance to a staff member. The Resident Council stated the staff helped the residents fill out grievances. The Resident Council stated residents could also talk to the social services person. On 04/15/25 at 02:35 PM, Activities Director Z stated there was not an anonymous grievance box. She stated the residents were able to call the facility hotline and leave an anonymous report. On 04/15/25 at 03:04 PM, Administrator Nurse D stated the facility did not have an anonymous reporting box. She stated the residents gave the grievance to a staff member or an administrative person. Administrator D stated the facility had a hotline, and staff could call for the resident if the resident was unable to make the phone call. The facility's Grievance policy dated 12/24 documented that it was the policy of this facility to establish a grievance process that allowed the resident(s) a way to execute their right to voice concerns or grievances to the facility or other agency/entity without fear of discrimination or reprisal. Such grievances included those concerning care and treatment that has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their facility stay. The facility would make information on how to file a grievance available to the residents and make prompt efforts to resolve grievances that the residents may have.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 49634 The facility identified a census of 57 residents. The sample includes 15 residents. Based on observation, record review, and interviews, the facility failed to provide consistent weekend activities. This deficient practice placed the affected residents at risk for decreased psychosocial well-being. Findings included: - A review of the facility's Activity Calendar for February, March, and April 2025 was completed. The review revealed in February 2024 the following weekend activities were scheduled: a movie matinee, and residents' choice. Activities in March revealed the following weekend activities were scheduled: a movie matinee, and residents' choice. Activities for April on each Sunday revealed a movie matinee, residents' choice, on Saturday 04/05/25 an easter egg hunt, and on 04/12/25 a jazz concert. On 04/15/25 at 01:30 PM, Resident Council members reported activities rarely occurred on weekends. The council reported there were movie matinees upstairs on the assisted living floor. The council reported they would like activities on the weekends, with interactive groups The Resident Council stated they would like to have staff lead the activities. On 04/15/25 at 02:25 PM, Activities Staff Z confirmed the facility did not have consistent scheduled activities on the weekends. Activity Staff Z stated she did have an assistant who helped on the weekends, and the facility was working on weekend activities. She stated she was going to start more weekend activities in April. On 04/16/25 at 08:15 AM, Certified Nurses Aid (CNA) M stated she was unsure if there were weekend activities. She stated she did not work many weekends in the facility. The facility's Activities Program policy dated 12/24 documented it was the policy of this facility was to ensure that activities were available to meet resident needs and interests that support the physical, mental, and psychosocial well-being of the resident. Activities may be facility-sponsored group or independent. The facility failed to provide consistent activities for the residents during weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being.

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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** 41037 The facility identified a census of 57 residents. The sample included 15 residents with three reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to implement a physician's order for a fluid restriction for Resident (R) 28. The facility also failed to ensure the physician's order was followed for a daily weight for R34 to monitor for congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). The facility failed to ensure the physician's order was followed to wrap R26's bilateral lower extremities. These deficient practices placed these residents at risk of delayed treatment and untreated illness. Findings included: - R28's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of edema (swelling resulting from an excessive accumulation of fluid in the body tissues), chronic kidney disease, congestive heart failure, muscle weakness, need for assistance with personal care, and pain. The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 required partial to moderate assistance with toileting and mobility. The MDS also documented R28 required substantial to maximum assistance with bathing, lower extremity dressing, and transfers. The MDS documented R28 was at risk for the development of pressure ulcers and placed pressure-reducing devices on her bed and in her chair. The MDS documented R28 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and opioid (a class of controlled drugs used to treat pain) medication. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R28 was dependent on staff for bathing, transfers, toileting, lower extremity dressing, mobility, repositioning in bed, and personal hygiene. The MDS documented R28 was at risk for the development of pressure ulcers. The MDS documented R28 had pressure-reducing devices on her bed and in her chair. The MDS documented R28 had received antipsychotic medication, anticoagulant medication, antidepressant medication, antianxiety medication, diuretic medication, antibiotic medication, and opioid medication. R28's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 07/01/24 documented she had generalized weakness and decreased safety awareness. R28's risk factors included further decline in activities of daily living, falls, incontinence, skin breakdown, and pain. R28's Care Plan dated 07/23/21 documented staff would administer medication as ordered by the physician and monitor for side effects or effectiveness. R28's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two-gram low sodium diet and a two-liter (2000 milliliters) fluid restriction due to CHF dated 02/05/2025. Review of R28's EMR lacked documentation or monitoring of her fluid restriction. On 04/15/25 at 08:06 AM, R28 sat on her bed with the head of the bed elevated. R28's mattress had slid forward and was bending back toward R28. R28's bilateral heels pressed against the bent portion of the mattress without any pressure-reducing devices. On 04/16/25 at 12:32 PM, Licensed Nurse (LN) I stated when a new diet order or a fluid restriction was received from a physician a copy would be sent to dietary. LN I stated the fluid restriction would be documented on the Treatment Administration Record (TAR). On 04/16/25 at 01:10 PM, Administrative Nurse D stated R28's new diet and fluid restriction order had been entered into R28's EMR incorrectly and was overlooked. Administrative Nurse D stated once the physician entered a new order a nurse must confirm the new order and ensure the correct departments were notified of the new order. Administrative Nurse D stated the fluid restriction would be documented and monitored on the resident's TAR. The facility's Provision of Quality Care policy last reviewed on 01/25/25 documented that based on comprehensive assessments, the facility would ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, comprehensive person-centered care plans, and the residents' choices. - R34's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), urinary tract infection (UTI - an infection in any part of the urinary system) and need for assistance with personal care. The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented R34 had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) during the observation period. The MDS documented R34 required substantial to maximum assistance of staff for toileting. The MDS documented R34 had received diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. The MDS documented R34 had an indwelling catheter. The MDS documented that R34 was dependent on assistance for toileting. The MDS documented R34 had received diuretic medication during the observation period. R34's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 08/16/24 documented she had generalized weakness and decreased safety awareness. R34's risk factors were a possible decline in her ability to perform activities of daily living, falls, pain, or skin breakdown. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's Care Plan, dated 09/02/24 documented weight fluctuations were expected related to her diuretic medication. R34's EMR under the Orders tab revealed the following physician orders: Daily weight. Call physician if a three-pound gain in one day or five-pound weight in one week dated 08/05/24. Spironolactone (diuretic) oral tablet 25 milligrams (mg) give one tablet by mouth daily for CHF dated 08/05/24. Lasix (furosemide - diuretic) tablet 20 mg give 0.5 tablet by mouth daily for CHF dated 11/28/24. Review of R34's Medication Administration Record (MAR), Treatment Administration Record (TAR), and under the Vital Signs reviewed from 01/01/25 to 04/14/25 (103 days) lacked evidence staff measured and recorded R34's weight on following 18 dates: 01/05/25, 01/25/25, 01/29/25, 02/07/25, 02/08/25, 02/14/25, 02/18/25, 02/20/25, 02/24/25, 03/04/25, 03/07/25, 03/11/25, 03/14/25, 03/17/25, 03/18/25, 03/27/25, 03/29/25, and 04/12/25. R34 refused on the following 10 dates: 01/06/25, 01/09/25, 01/10/25, 01/11/25, 01/12/25, 01/15/25, 01/17/25, 01/26/25, 02/17/25, and 03/16/25. The clinical record lacked evidence of physician notification the daily weights were not obtained or refused. On 04/14/25 at 08:40 AM, R34 sat in her recliner with her feet elevated. R34's catheter bag with amber-colored urine in the drainage bag laid directly on the floor under the footrest of her recliner. The catheter drainage bag did not have a privacy bag. On 04/16/25 at 02:03 PM, Certified Nurse Aide (CNA) N stated everyone works together to get the daily weights and report the weight to the charge nurse. CNA N stated that R34 never refused to be weighed. On 04/16/25 at 12:32 PM, Licensed Nurse (LN) I stated everyone would be responsible for ensuring daily weights were obtained as ordered. LN I stated the physician should be notified if a daily weight was refused frequently. LN I stated the physician notification was documented under the progress notes. On 04/16/25 at 01:10 PM, Administrative Nurse D stated she expected all staff to ensure daily weights were obtained as ordered. Administrative Nurse D stated she expected the physician to be notified if a resident refused frequently and the notification would be documented under the progress notes. The facility's Provision of Quality Care policy last reviewed on 01/25/25 documented based on comprehensive assessments, the facility would ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, comprehensive person-centered care plans, and the residents' choices. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R26's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, need for assistance with personal care, hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), insomnia (inability to sleep), reduced mobility, dementia (a progressive mental disorder characterized by failing memory and confusion), hyperlipidemia (condition of elevated blood lipid levels), peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), cognitive communication deficit, difficulty walking, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R26 required set up and clean up by staff for eating and oral hygiene. The MDS documented R26 was dependent on staff for bathing and toileting and was frequently incontinent of bowel and bladder. The MDS documented R26 was at risk for pressure ulcers, and no unhealed pressure ulcers. The MDS documented R26 required a pressure-reducing mattress for her bed, and a pressure-reducing cushion for her chair. R26's Pressure Ulcer/ Injury Care Area Assessment (CAA) dated 12/26/24 documented Pressure Ulcers CAA triggered secondary to potential for pressure ulcers. Contributing factors include activities of daily living (ADL), functional mobility impairment, and incontinence. Risk factors include pain, development of pressure ulcers, skin conditions, and fluid deficit risk. A Licensed Nurse (LN) assessed R26's skin each week and put proper interventions in place to prevent skin breakdown. Skin was also assessed by caregivers with each bath and each time the resident was dressed. The physician was to be notified of any abnormal findings and treatment orders were to be obtained. The dietitian was monitoring R26's food and fluid intake, and implementing dietary interventions, as necessary. R26's plan of care would be initiated to improve current ADL status and functional ability, maintain continence status, prevent pain, and decrease pressure ulcer, and fluid deficit risk. R26's Care Plan revised 06/24/24 documented R26 had an actual skin impairment related to a history of venous ulcers, lymphedema, itchy skin, psoriasis (a chronic skin disorder characterized by red patches covered by thick, dry silvery adherent scales), and bilateral lymphedema. R26's plan of care dated 03/20/23 documented nursing staff would apply lymphedema pumps to bilateral extremities as ordered. R26 was to avoid scratching and keep hands and body parts from excessive moisture, staff were directed to keep R26's fingernails short. R26's plan of care dated 02/15/24 documented staff were to evaluate and offload or float heels while in bed or wheelchair, and staff were to always apply soft boots. Staff were to encourage good nutrition and hydration to promote healthier skin. R26's plan of care dated 02/14/24 documented staff were to encourage R26 to allow pumps and treatments to be completed. at times. R26's Braden Scale for Prediction Pressure Sore Risk dated 02/05/25 documented a score of 16 indicating a low risk for pressure ulcers. R26's Skin Evaluation dated 04/13/25 documented R26 was without new or existing compromise of skin integrity to bilateral lower extremities, with dryness and lymphedema to bilateral lower extremities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's physician's orders under the Orders tab revealed the following orders: Heel protector boots should be always worn when in the wheelchair or in bed every shift, dated 05/24/24. Pressure-reducing device to bilateral extremities while in chair or bed, every shift to offload bilateral extremities, float heels, or apply soft boots to bilateral extremities for pressure relief, dated 05/04/24. Pressure-reducing cushion in wheelchair every shift, dated 05/04/24. Pressure-reducing mattress every shift, dated 05/04/24. Apply Skin-prep (liquid skin protectant) to bilateral heels every shift for wound prevention, dated 05/04/24. Apply barrier cream to buttocks and coccyx reddened areas every shift for wound prevention, dated 05/04/24. No ace wraps to bilateral extremities per vascular, dated 12/04/24. Use compression socks, or tub grips on legs, wash legs every day with soap and water, pat dry apply Eucerin (moisturizing lotion) or lotion on the legs daily, and apply tub grips. Every day shift for lymphedema management, dated 04/04/25. On 04/15/25 R26 at 07:22 AM, R26 sat in her wheelchair, R26 bilateral lower extremities were wrapped with ace wraps, and she did not have tubi grips applied to her bilateral lower extremities. On 04/15/25 at 12:50 PM, Licensed Nurse (LN) G stated R26 did have an order for Kerlix (wound dressing) and ace wraps, for bilateral lower extremities, when her legs were weeping. She stated R26's vascular physician stated no ace wraps to bilateral lower extremities. LN G stated the nurse on duty would have applied the ace wraps to R26's legs, and it should have been tubi grips and boots. On 04/16/25 at 01:20 PM, Administrative Nurse D stated all physician's orders should be followed. The facility's Infection Prevention Control policy revised 12/23 documented it is the policy of this facility that: a resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and a resident having pressure injury's receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Olathe	21250 West 151st Street Olathe, KS 66061

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 57 residents. The sample included 15 residents with six reviewed for 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). Based on record review, interviews, and observations, the facility failed to follow preventative wound care practices related to Residents (R) 29 and R42's low air-loss mattress (specialized mattress used to reduce pressure on the body) settings. The facility additionally failed to float R28 and R37's heels per their wound care interventions. This deficient practice placed both residents at risk for complications related to skin breakdown and pressure ulcers. Findings included: - The Medical Diagnosis section within R29's Electronic Medical Records (EMR) noted diagnoses of hemiplegia and hemiparesis (weakness and paralysis on one side of the body), major depressive disorder (major mood disorder), and dysphagia (difficulty swallowing). R29's Quarterly Minimum Data Set (MDS) completed 01/13/25 revealed a Brief Interview for Mental Status Score of zero indicating severe cognitive impairment. The MDS indicated he had bilateral upper and lower extremity impairments. The MDS indicated he was dependent on staff assistance for bed mobility, transfers, toileting, bathing, dressing, personal hygiene, and Broda chair (specialized wheelchair with the ability to tilt and recline) mobility. The MDS indicated he was at risk for developing 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). The MDS indicated he had pressure-relieving devices for his bed and chair. The MDS noted he weighed 186 pounds (lbs). R29's Pressure Ulcer Care Area Assessment (CAA) completed 10/07/24 indicated he required total assistance from staff and was at risk for falls, skin breakdown, pressure injury development, and incontinence. The CAA noted he was provided pressure-reducing devices. The CAA noted staff would continue to provide repositioning and care plan interventions were implemented to reduce the risks associated with pressure injuries. R29's Care Plan initiated on 11/28/20 indicated he required assistance with his activities of daily living (ADL). The plan indicated he required assistance from one staff for bathing, dressing, toileting, bed mobility, and transfers. The plan noted he was at risk for pressure ulcer development. The plan indicated he had pressure-reducing devices, preventative skin care, repositioning, and nutritional management in place. The plan noted he had a low air-loss mattress in place and instructed staff to check its function every shift. The plan lacked documentation related to the mattress's setting or care instructions. A review of the manual of low air-loss mattress manufacturers' operation (Drive Model) 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 an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R29's EMR under Vitals indicated he weighed 190.2 lbs. on 04/14/24. On 04/14/25 at 07:57 AM, R29 slept in his bed. His bed was set to a low height with his call light next to him within reach. R29's low air-loss mattress was set to 450 lbs. The mattress pump had fixed weight settings of 250lbs or less, 300lbs, 350lbs, 400lbs, 450lbs, 500lbs, 550lbs, and 600 to 1000lbs. On 04/16/25 at 12:03 PM, Certified Nurse Aide (CNA) M stated the air mattress settings were by the resident's current weight. She stated staff would check if the bed alarms or pump alarms were going off. On 04/16/25 at 12:33 PM, Licensed Nurse (LN) G stated the mattress pumps were set by weight. She stated staff should be checking them each shift to ensure the correct settings were entered. On 04/16/25 at 01:10 PM, Administrative Nurse D stated the mattresses should be set by the resident's weight per the manufacturer's recommendation. She stated staff were also to perform a softness check with their hands to ensure the beds were not too firm. The facility's Skin and Wound Monitoring and Management policy revised 12/2023 indicated the facility was to promote interventions that prevent pressure injury development and heal injuries that were present. The policy identified nutritional monitoring, repositioning, weekly wound assessments, and pressure-reducing devices. - The Medical Diagnosis section within R42's Electronic Medical Records (EMR) noted diagnoses of Dementia (a progressive mental disorder characterized by failing memory and confusion), insomnia (difficulty sleeping), muscle weakness, and cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R42's Quarterly Minimum Data Set (MDS) completed 01/13/25 revealed a Brief Interview for Mental Status (BIMS) score of ten indicating moderate cognitive impairment. The MDS indicated she required substantial to maximal assistance for bed mobility, transfers, toileting, bathing, dressing, personal hygiene, and wheelchair mobility. The MDS indicated she had frequent bowel and bladder incontinence. The MDS noted she was at risk for the development of 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). The MDS indicated she had pressure-reducing devices for her bed and wheelchair in place. The MDS indicated she weighed 136 pounds (lbs.). R42's Functional Abilities Care Area Assessment (CAA) completed 08/30/24 indicated she required assistance from staff related to her impaired mobility, poor cognition, and medical diagnoses. The CAA noted she had generalized weakness and decreased safety awareness. The CAA noted care planned interventions were implemented to address her risks. R42's Pressure Ulcer CAA completed 08/30/24 indicated she was at risk for the development of pressure ulcers. The CAA noted she had incontinence, decreased mobility, cognitive loss, and recurrent urinary tract infections (UTIs) as risk factors for pressure ulcer development. The plan instructed staff to complete weekly skin assessments and provide preventative care. The CAA noted care planned interventions were implemented to address her risks. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R42's Care Plan initiated on 06/22/23 indicated was at risk for the development of pressure ulcers due to decreased mobility and her medical diagnoses. The plan noted she required assistance from staff for bed mobility, transfers, toileting, dressing, bathing, and personal hygiene. The plan indicated she had a history of pressure injuries but no current wounds. The plan instructed staff to provide repositioning throughout the day. The plan instructed staff to complete weekly wound assessments. The plan noted she had a pressure-reducing device for her wheelchair and a low air-loss mattress (specialized air mattress used to reduce pressure applied to the body). The plan lacked documentation related to the mattress's setting or care instructions. A review of the manual of low air-loss mattress manufacturers' operation (Drive Model) 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 an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety. R42's EMR under Vitals noted her weight was 130.4 lbs. on 04/07/25. On 04/14/25 at 07:20 AM, R42 slept in her bed. Her bed was set to a low height with her call light next to her bed within reach. R42's low air-loss mattress was set to 350 lbs. (maximum setting). The mattress pump had fixed weight settings of 50lbs, 100lbs, 150lbs, 170lbs, 200lbs, 250lbs, 300lbs, and 350lbs. Her call light was pinned to her blanket. On 04/15/25 at 07:37 AM, R42 slept in her bed. Her bed remained in a low position. Her mattress pump was set to 350lbs. R42's call light was pinned to a pillow placed on her recliner next to her bed. The call light was out of reach. At 07:40 AM, Administrative Nurse D entered the room moved the call light to R42's bed, and stated staff were expected to ensure the call lights were within reach at all times. She stated the low air-loss settings were set by the manufacturer's recommendation and assessments. On 04/16/25 at 09:21 AM, R42 at her breakfast in bed. Her mattress settings were set to 350lbs. On 04/16/25 at 12:03 PM, Certified Nurse Aide (CNA) M stated the air mattress settings were by the resident's current weight. She stated staff would check if the bed alarms or pump alarms were going off. On 04/16/25 at 12:33 PM, Licensed Nurse (LN) G stated the mattress pumps were set by weight. She stated staff should be checking them each shift to ensure the correct settings were entered. On 04/16/25 at 01:10 PM, Administrative Nurse D stated the mattresses should be set by the resident's weight per the manufacturer's recommendation. She stated staff were also to perform a softness check with their hands to ensure the beds were not too firm. The facility's Skin and Wound Monitoring and Management policy revised on 12/2023 indicated the facility was to promote interventions that prevent pressure injury development and heal injuries that were present. The policy identified nutritional monitoring, repositioning, weekly wound assessments, and pressure-reducing devices. 41037 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R28's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of edema (swelling resulting from an excessive accumulation of fluid in the body tissues), chronic kidney disease, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), muscle weakness, need for assistance with personal care, and pain. The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 required partial to moderate assistance with toileting and mobility. The MDS also documented R28 required substantial to maximum assistance with bathing, lower extremity dressing, and transfers. The MDS documented R28 was at risk for the development of pressure ulcers and placed pressure-reducing devices on her bed and in her chair. The MDS documented R28 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and opioid (a class of controlled drugs used to treat pain) medication. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R28 was dependent on staff for bathing, transfers, toileting, lower extremity dressing, mobility, repositioning in bed, and personal hygiene. The MDS documented R28 was at risk for the development of pressure ulcers and placed pressure-reducing devices on her bed and in her chair. The MDS documented R28 received antipsychotic medication, anticoagulant medication, antidepressant medication, antianxiety medication, diuretic medication, antibiotic medication, and opioid medication. R28's Pressure Ulcer Care Area Assessment (CAA) dated 07/01/24 documented she had the potential for the development of pressure ulcers. R28's contributing factors included her impaired mobility, incontinence, and fluid deficit risk. R28's Care Plan dated 12/13/24 documented the staff would educate R28 on causative factors and measures to prevent skin injury. R28's EMR under the Orders tab revealed the following physician orders: Pressure-reducing boots to bilateral lower extremities while in bed dated 08/27/24. On 04/15/25 at 08:06 AM, R28 sat on her bed with the head of the bed elevated. R28's mattress had slid forward and was bending back toward R28. R28's bilateral heels pressed against the bent portion of the mattress, without any pressure-reducing devices. On 04/16/25 at 07:15 AM, Licensed Nurse (LN) H stated the nurse was responsible to floating of heels or applying soft boots to heels. He stated the order was on the Treatment Administrative Report (TAR). He stated the nurse could delegate the task to a Certified Nurse's Aide (CNA), but the nurse should verify the task was performed before signing the TAR. On 04/16/25 at 08:15 AM, CNA M stated the CNAs get a brief overall description of what task should be performed for each resident. CNA M stated if the CNAs were unsure, they could always ask the LN. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/16/25 at 01:10 PM, Administrative Nurse D stated specific interventions should be followed, and any resident at risk of pressure ulcers should have their heels floated or soft boots applied to heels. The facility's Skin and Wound Monitoring and Management policy revised on 12/2023 indicated the facility was to promote interventions that prevent pressure injury development and heal injuries that were present. The policy identified nutritional monitoring, repositioning, weekly wound assessments, and pressure-reducing devices. 49634 - R37's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of end stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer function adequately), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), hyperlipidemia (condition of elevated blood lipid levels), hypertension (high blood pressure), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), open wound right foot, acquired absence of right toes, cognitive communication deficit, need for assistance with personal care, muscle weakness difficulty walking, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and respiratory failure with hypoxia (occurs when the lungs cannot adequately exchange oxygen and carbon dioxide in the blood). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R37 had impairment on one side of her lower body. The MDS documented R37 was dependent on staff for toileting and needed substantial to maximal assistance for bathing. The MDS documented R37 had a recent surgery and shortness of breath or trouble breathing. R37's Pressure Ulcer/ Injury Care Area Assessment (CAA) dated 01/28/25 triggered secondary to the potential for pressure ulcers. Contributing factors include activities of daily living (ADL), functional, mobility impairment, and incontinence. Risk factors include pain, development of pressure ulcers, and skin condition. The CAA documented a Licensed Nurse (LN) would assess skin each week and put proper interventions in place to prevent skin breakdown. The CAA documented skin was also assessed by caregivers with each bath and each time the resident was dressed. The CAA documented the physician was to be notified of any abnormal findings, and treatment orders were to be obtained. The CAA documented the dietitian would monitor R37's food and fluid intake, and implement dietary interventions, as necessary. The CAA documented R37's plan of care would be initiated to improve current ADL status and functional ability, maintain continence status, prevent pain, and decrease pressure ulcer and fluid deficit risk. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37s Care Plan dated 01/23/25 documented R37 had a pressure ulcer or potential for pressure ulcer development related to impaired mobility. R37's plan of care documented a pressure ulcer, and the surgical wound showed signs of healing and remained free from infection, and staff were to administer treatments as ordered by the physician. The care plan for R37 documented staff would educate residents, family, and caregivers as to causes of skin breakdown, including transfer and positioning requirements; the importance of taking care during ambulating and mobility, good nutrition, and frequent repositioning. R37's plan of care documented staff would encourage fluid intake and assist in keeping skin hydrated, nursing would be notified of any new areas of skin breakdown. The plan of care documented R37 required a pressure relieving and reducing device on the bed and wheelchair, and nursing staff would perform a head-to-toe weekly head-to-toe assessment. R37's Braden Scale for Prediction Pressure Sore Risk dated 03/26/25 documented a score of 15 indicating a low risk for pressure ulcers. R37s Licensed Nurse (LN) Weekly and as needed (PRN) Skin assessment dated [DATE] documented a surgical incision to the right foot from the amputation of toes, treatment was in the plan. Followed by the wound care provider. R37's EMR under the Orders tab documented the following physician's orders: -Wound treatment: Apply skin-prep (liquid skin protectant) to the right dorsal foot every day shift, every Tuesday, Thursday, and Saturday for wound care dated 04/03/25. -Wound treatment: cleanse right toe amputation site for wound care, apply gauze, abdominal pad (ABD), wrap with kerlix, and apply tub grip, every day shift every Tuesday, Thursday, and Saturday for wound care and PRN for wound care If dressing is removed or soiled dated 04/03/25. -Pressure-reducing device to bilateral extremities while in chair or bed, every shift to offload bilateral extremities, or apply soft boots to bilateral extremities for pressure relief dated 03/24/25. On 04/14/25 at 07:10 AM, R37 laid on the bed, R37's heels laid directly on her mattress. R37's heels were not offloaded, and R37 did not have soft boots applied to her feet. On 04/15/25 at 07:12 AM, R37 laid on her bed. R37's heels laid directly on her mattress. R37's heels were not offloaded, and R37 did not have soft boots applied to her feet. On 04/16/25 at 07:15 AM, LN H stated floating of heels or applying soft boots to heels, would fall on the nurse. He stated the order was on the Treatment Administrative Report (TAR) he stated the nurse could delegate the task to a Certified Nurse's Aide (CNA), but the nurse should verify the task was performed before signing the TAR. On 04/16/25 at 08:15 AM, CNA M stated the CNAs got a brief overall description of what task should be performed for each resident. CNA M stated if the CNAs were unsure, they could always ask the LN. On 04/16/25 at 01:10 PM, Administrative Nurse D stated specific interventions should be followed, and any resident at risk of pressure ulcers should have their heels floated or soft boots applied to heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Infection Prevention Control policy revised on 12/23 documented it is the policy of this facility that: a resident who entered the facility without pressure injury does not develop pressure injury unless the resident's clinical condition or other factors demonstrated that a developed pressure injury was unavoidable; and a resident having pressure injury's received necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.

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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** 45668 The facility identified a census of 57 residents. The sample included 15 residents, with five reviewed for accidents. Based on record review, interviews, and observations, the facility failed to ensure a safe care environment free from potential hazards related to following Residents (R) 50, R29, and R26's implemented fall interventions. This deficient practice placed the residents at risk for preventable falls and injuries. Findings Included: - The Medical Diagnosis section within R50's Electronic Medical Records (EMR) noted diagnoses of senile degeneration of the brain (a progressive mental disorder characterized by failing memory and confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and overactive bladder. R50's Annual Minimum Data Set (MDS) completed 03/14/25 revealed a Brief Interview for Mental Status Score of three indicating severe cognitive impairment. The MDS noted she had no upper or lower extremity impairments. The MDS indicated she was dependent on staff assistance for bed mobility, transfers, toileting, bathing, dressing, personal hygiene, and wheelchair mobility. The MDS indicated she had two non-injury falls since her last assessment. R50's Falls Care Area Assessment completed 04/14/25 noted she was at high risk for falls related to her weakness and required assistance to complete her activities of daily living (ADL). The CAA noted a care plan was implemented to prevent falls with major injuries. R50's Care Plan initiated on 03/21/24 indicated she was at risk for an ADL deficit and falls related to her impaired cognitive status, impulsiveness, and poor balance. The plan noted she required assistance from staff to complete bathing, transfers, bed mobility, dressing, personal hygiene, and toileting (03/21/24). The plan instructed staff to ensure her call light was within reach and her bed was maintained in the lowest position (03/21/24). The plan indicated she had a non-injury fall on 12/28/24. R50's plan was updated on 01/03/25 to implement the use of a Dycem (non-slip mat used to prevent falls) under the cushion of her wheelchair cushion. The plan noted she had a minor injury fall on 02/24/25. R50's plan was updated on 02/25/25 to implement the use of an anti-rollback device on her wheelchair. On 04/14/25 at 07:35 AM, R50 slept in her bed. Her bed was in the lowest position. Her call light was pinned to her covered within reach. An inspection of R50's wheelchair revealed no anti-rollback device or Dycem mat. On 04/15/25 at 08:00 AM, R50 was in the west dining room for breakfast. R50's ate her entire breakfast without concerns. R50's wheelchair had no anti-rollback device. R50 was taken back to her room. Upon transfer, R50's wheelchair had no Dycem in place. On 04/15/25 at 12:20 PM, R50 sat in the dining room in her wheelchair for lunch. R50's wheelchair had no anti-rollback device or Dycem. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 12:03 PM, Certified Nurse Aide (CNA) M stated that R50's chair may have been recently switched out and the equipment may not have been applied to the new chair. She stated staff had access to the care plan to view the fall interventions and would have reported to the nurses if something was not in place. On 04/16/25 at 12:32 PM, Licensed Nurse (LN) G stated that R50's chair should have had the fall interventions implemented. She stated if the interventions were dropped or no longer needed, they should have been removed from the care plan. She stated that R29 was a high fall risk and needed the floor mat in place. On 04/16/25 at 01:10 PM, Administrative Nurse D stated staff were expected to review the implemented fall interventions and ensure they were in place for the residents in their care. The facility's Fall Management System dated 12/2024 indicated the facility promoted an environment that remains free from accident hazards. The policy indicated the facility appropriately assessed and implemented interventions to prevent falls and minimize complications if falls occurred. - The Medical Diagnosis section within R29's Electronic Medical Records (EMR) noted diagnoses of hemiplegia and hemiparesis (weakness and paralysis on one side of the body), major depressive disorder (major mood disorder), and dysphagia (difficulty swallowing). R29's Quarterly Minimum Data Set (MDS) completed 01/13/25 revealed a Brief Interview for Mental Status Score of zero indicating severe cognitive impairment. The MDS indicated he had bilateral upper and lower extremity impairments. The MDS indicated he was dependent on staff assistance for bed mobility, transfers, toileting, bathing, dressing, personal hygiene, and Broda chair (specialized wheelchair with the ability to tilt and recline) mobility. The MDS indicated no falls since his last assessment. R29's Falls Care Area Assessment (CAA) completed 10/07/24 indicated he required total assistance from staff and was at risk for falls, skin breakdown, pressure injury development, and incontinence. The CAA noted he was a high fall risk. The CAA noted staff would continue to provide safety cues for him and care plan interventions were implemented to reduce the risks associated with falls. R29's Care Plan initiated on 11/28/20 indicated he required assistance with his activities of daily living (ADLs). The plan indicated he required assistance from one staff for bathing, dressing, toileting, bed mobility, and transfers. The plan noted he had a history of non-injury falls. The plan instructed staff to ensure his personal items were left within reach. The plan instructed staff to encourage him to use his call light and provide two-hour repositioning. The plan indicated he was to have a fall mat next to his bed while in bed. On 04/14/25 at 07:24 AM, R29 slept in his bed. His bed was in the lowest position. His call light was within reach. His fall mat was propped up against the wall by his dresser. On 04/14/25 at 0820 AM, R29's fall mat was propped against the wall next to his dresser. R29 slept in his bed. On 04/15/25 at 07:21 AM, R29 slept in his bed. His fall mat was placed on the floor next to his bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 12:03 PM, Certified Nurse Aide (CNA) M stated direct care staff were expected to ensure fall mats were placed next to the beds after transferring the residents back to bed. She stated R29's ability to move has declined but he was still a fall risk. On 04/16/25 at 12:32 PM, Licensed Nurse (LN) G stated if the interventions were dropped or no longer needed, they should have been removed from the care plan. She stated that R29 was a high fall risk and needed the floor mat in place. On 04/16/25 at 01:10 PM, Administrative Nurse D stated staff were expected to review the implemented fall interventions and ensure they were in place for the residents in their care. The facility's Fall Management System dated 12/2024 indicated the facility promoted an environment that remains free from accident hazards. The policy indicated the facility appropriately assessed and implemented interventions to prevent falls and minimize complications if falls occurred. 49634 - R26's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, need for assistance with personal care, hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), insomnia (inability to sleep), reduced mobility, dementia (a progressive mental disorder characterized by failing memory and confusion), hyperlipidemia (condition of elevated blood lipid levels), peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), cognitive communication deficit, difficulty walking, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R26 required to set up and clean up by staff for eating and oral hygiene. The MDS documented R26 was dependent on staff for bathing and toileting and was frequently incontinent of bowel and bladder. The MDS documented R26 was at risk for pressure ulcers, and no unhealed pressure ulcers. The MDS documented R26 required a pressure-reducing mattress for her bed and a pressure-reducing cushion for her chair. R26's Falls Care Area assessment dated [DATE] documented staff would continue with the current plan of care to prevent injury. R26's Care Plan dated 02/21/25 documented R26 was at risk for falls related to weakness, medication, and history of falls. R26's plan of care documented therapy would perform an evaluation and treatment per physicians' orders. R26's plan of care dated 02/21/25 documented a non-injury fall, and the intervention was for staff to ensure R26's bed was in the lowest position and the call light was within her reach. R26's plan of care dated 03/14/25 documented a non-injury fall the intervention put in place was to place access furniture placement and environment to mimic her home. On 04/14/25 at 07:23 AM, R26 laid on her bed, R26's bed was elevated approximately three feet. R26's bed was not in a low position. (continued on next page)

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The Healthcare Resort of Olathe	21250 West 151st Street Olathe, KS 66061

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/25 at 07:28 AM, R26 laid on her bed, R26's bed was elevated approximately three feet. R26's bed was not in a low position. On 04/16/24 at 07:15 AM, Licensed Nurse (LN) H stated all nursing staff have access to each resident's care plan. He stated CNAs could ask the nurse to ensure the beds were in the correct position. LN H stated that R26's bed should be in a low position. On 04/16/25 at 08:15 AM, Certified Nurses Aide (CNA) M stated the CNA's get a brief overall description of what task should be performed for each resident. CNA M stated if the CNAs were unsure, they could always ask the LN. On 04/16/25 at 01:10 PM, Administrative Nurse D stated all nursing staff have access to the resident's care plan, and specific interventions should be followed for every situation. The facility's Fall Management System policy dated 12/24 documented it was the policy of this facility to provide an environment that remains as free of accident hazards as possible. It was also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 57 residents. The sample included 15 residents, with two residents reviewed for catheters (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). Based on observation, record review, and interviews, the facility failed to ensure the standard of care was provided for Resident (R) 34 who had a history of urinary tract infection (UTI - an infection in any part of the urinary system) when her catheter drainage bag laid directly on the floor. This deficient practice placed R34 at risk of catheter-related complications and further UTIs. Findings included: - R34's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), urinary tract infection (UTI - an infection in any part of the urinary system), and need for assistance with personal care. The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented R34 had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) during the observation period. The MDS documented R34 required substantial to maximum assistance of staff for toileting. The MDS documented R34 had received diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. The MDS documented R34 had an indwelling catheter. The MDS documented that R34 was dependent on assistance for toileting. The MDS documented R34 had received diuretic medication during the observation period. R34's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 08/16/24 documented she required assistance with toileting needs and she had recurrent UTIs. R34's Care Plan, dated 08/28/24 documented she had an indwelling catheter 16 French with a 30-milliliter (ml) bulb. The plan of care documented staff would provide her with catheter care every shift and as needed. R34's EMR under the Orders tab revealed the following physician orders: Indwelling catheter French 16 with a 30 ml to closed drainage system, diagnosis to support use: neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying) dated 03/18/25. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ciprofloxacin (antibiotic) hci tablet 250 milligrams (mg) give one tablet by mouth every 12 hours for UTI for seven days dated 08/26/24. Doxycycline hyclate (antibiotic) tablet 100 mg give one tablet by mouth two times a day for UTI for seven days dated 08/29/24. Merrem (antibiotic) intravenous solution reconstituted 500 mg (Meropenem) administer 500 mg intravenously every eight hours for UTI for five days dated 09/25/24. Doxycycline hyclate tablet 100 mg give one tablet by mouth two times a day for UTI, for seven days dated 12/04/24. On 04/14/25 at 08:40 AM, R34 sat in her recliner with her feet elevated. R34's catheter bag with amber-colored urine in the drainage bag that laid directly on the floor under the footrest of her recliner. The catheter drainage bag did not have a privacy bag. On 04/16/25 at 2:03 PM, Certified Nurse Aide (CNA) N stated a resident's catheter should never be placed on the floor. CNA N stated there should be a privacy bag to put the catheter drainage bag in to prevent the bag from touching the floor. On 04/16/25 at 12:32 PM, Licensed Nurse (LN) I stated a resident's catheter bag should never be placed on the. LN I stated the catheter drainage bag should be placed below the resident's bladder and not be placed where it possibly could pull on the catheter tubing. On 04/16/25 at 01:10 PM, Administrative Nurse D stated she would expect a catheter bag to be placed below the bladder, in a privacy bag, and not on the floor. The facility's Indwelling Catheter Care policy documented it was the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, and comfort, and decrease the risk of infection.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 57 residents. The sample included 15 residents, with five residents reviewed for unnecessary medications. Based on record review and interviews, the facility failed to ensure dosing instructions for Voltaren (topical pain reliever medication) gel for Resident (R) 28. This deficient practice placed R28 at risk for unnecessary medication use and physical complications for the affected residents. Findings included: - R28's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of edema (swelling resulting from an excessive accumulation of fluid in the body tissues), chronic kidney disease, congestive heart failure, muscle weakness, need for assistance with personal care, and pain. The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 required partial to moderate assistance with toileting and mobility. The MDS also documented R28 required substantial to maximum assistance with bathing, lower extremity dressing, and transfers. The MDS documented R28 was at risk for the development of pressure ulcers and placed pressure-reducing devices on her bed and in her chair. The MDS documented R28 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and opioid (a class of controlled drugs used to treat pain) medication. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R28 was dependent on staff for bathing, transfers, toileting, lower extremity dressing, mobility, repositioning in bed, and personal hygiene. The MDS documented R28 was at risk for the development of pressure ulcers and placed pressure-reducing devices on her bed and in her chair. The MDS documented R28 had received antipsychotic medication, anticoagulant medication, antidepressant medication, antianxiety medication, diuretic medication, antibiotic medication, and opioid medication. R28's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 07/01/24 documented she had generalized weakness, and decreased safety awareness. R28 risk factors included further decline in activities of daily living, falls, incontinence, skin breakdown, and pain. R28's Care Plan dated 07/23/21 documented staff administered medication as ordered by the physician and monitored for side effects or effectiveness. R28's EMR under the Orders tab revealed the following physician orders: Voltaren external gel (anti-inflammatory class of medication used to reduce inflammation) one percent (%) (diclofenac sodium) (topical), apply to knee and shoulder topically every 12 hours as needed for pain dated 04/12/25. The order lacked a dose. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 12:32 PM, Licensed Nurse (LN) I stated every medication should have the dosage included in the physician's order. On 04/16/25 at 01:10 PM, Administrative Nurse D stated she would expect the pharmacy to catch any medication that lacked a dosage. Administrative Nurse D stated Voltaren gel should have a dosage included in the order. The facility's undated policy Pharmacy Services/Nursing Services documented it was the policy of this facility that drugs would be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. It was the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the resident's plan of care.

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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. 45668 The facility reported a census of 57 residents. The facility identified two medication rooms and four medication carts. Based on observations, record reviews, and interviews, the facility failed to secure one of four medication carts. This deficient practice placed the residents at risk for unnecessary medication and administration errors. Findings Included: - On 04/14/25 at 07:26 AM, an inspection of the west wing was completed. The west wing inspection revealed an unsecured medication cart next to the oxygen storage room revealed prescribed medications, ointments, and treatment care supplies accessible without staff supervision. On 04/14/25 at 07:30 AM, Certified Medication Aide (CMA) R came around the corner from the medication storage area and secured the cart. She stated the carts were to be locked when not supervised. On 04/16/25 at 12:33 PM, Licensed Nurse (LN) G stated the medication carts and computers were to be locked while staff were away from them. On 04/16/25 at 01:03 PM, Administrative Nurse D stated staff were expected to lock the medication carts when not in use or unsupervised. The facility's Medication Storage policy revised 12/2024 indicated the facility was to secure all medication in a clean, locked, and organized manner to ensure safe handling and administration.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 57 residents. The sample included 15 residents, with one resident reviewed for a therapeutic diet. Based on observation, record review, and interviews, the facility failed to implement a therapeutic diet as ordered by the physician order for Resident (R) 28, who had a diagnosis of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). This deficient practice placed R28 at risk of adverse side effects from unnecessary medication or complications related to CHF. Findings included: - R28's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of edema (swelling resulting from an excessive accumulation of fluid in the body tissues), chronic kidney disease, congestive heart failure, muscle weakness, need for assistance with personal care, and pain. The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 required partial to moderate assistance with toileting and mobility. The MDS also documented R28 required substantial to maximum assistance with bathing, lower extremity dressing, and transfers. The MDS documented R28 was at risk for the development of pressure ulcers and placed pressure-reducing devices on her bed and in her chair. The MDS documented R28 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and opioid (a class of controlled drugs used to treat pain) medication. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R28 was dependent on staff for bathing, transfers, toileting, lower extremity dressing, mobility, repositioning in bed, and personal hygiene. The MDS documented R28 was at risk for the development of pressure ulcers and placed pressure-reducing devices on her bed and in her chair. The MDS documented R28 had received antipsychotic medication, anticoagulant medication, antidepressant medication, antianxiety medication, diuretic medication, antibiotic medication, and opioid medication. R28's Nutritional Status Care Area Assessment (CAA) dated 07/01/24 documented a gradual weight loss was highly recommended for her overall health. R28's weight was trending down. R28's Care Plan, dated 05/26/23 documented the facility would provide her diet as ordered by the physician. R28's EMR under the Orders tab revealed the following physician orders: Regular diet with thin liquids consistency, staff would cut her food if needed dated 01/30/25. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two-gram low sodium diet and a two-liter (2000 milliliters) fluid restriction due to CHF dated 02/05/2025. Review of R28's dietary meal ticket listed her diet as regular. On 04/15/25 at 08:06 AM, R28 sat on her bed with the head of the bed elevated. R28's mattress had slid forward and was bending back toward R28 with her bilateral heels pressed against the bent portion of the mattress without any pressure-reducing devices. On 04/16/25 at 11:23 PM, Certified Nurse Aide (CNA) N stated the staff reviewed the diet slip when serving the resident their meal tray. CNA N stated the nurse would print the resident's current diet list. On 04/16/25 at 12:32 PM, Licensed Nurse (LN) I stated when a new diet order or a fluid restriction was received from a physician a copy would be sent to dietary. LN I stated the fluid restriction would be documented on the Treatment Administration Record (TAR). On 04/16/25 at 01:10 PM, Administrative Nurse D stated that R28's new diet and fluid restriction order had been entered into R28's EMR incorrectly and was overlooked. Administrative Nurse D stated once the physician entered a new order, a nurse must confirm the new order, and ensure the correct departments were notified of the new order. Administrative Nurse D stated the fluid restriction would be documented and monitored on the resident's TAR. The facility's Nutritional Status Management dated 12/23 documented it was the policy of this facility to assess each resident's nutritional status and needs, including medications and medical conditions to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and other available data, unless the resident's clinical condition demonstrates that this is not possible.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45668 The facility reported a census of 57 residents. The sample included 15 residents. Based on record review and interviews, the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ - Staffing Data Report), when the facility failed to submit accurate weekend staffing hours. This placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - The PBJ provided by CMS for Fiscal Year (FY) 2024 of the fourth quarter (07/01/24 through 09/30/24) indicated the facility was triggered for low weekend staff. The PBJ provided by CMS for Fiscal Year (FY) 2025 of the first quarter (10/01/24 through 12/31/24) indicated the facility was triggered for low weekend staff. A review of the facility's working schedule, time sheets /punches, and posted staffing hours was completed for missed weekend coverages between 07/01/24 to 09/30/24 and 10/01/24 to 12/31/24. The review revealed no missed coverage or gaps. On 04/16/24 at 01:22 PM, Administrative Nurse D stated the facility had no missed licensed nurse shifts and utilized agency staff to fill in the gaps on the schedules. She stated some of the shifts may not have been accurately reported during the PBJ submission hours to reflect agency and administrative nurse shift fill-ins. On 04/16/25 at 01:35 PM, Administrator AA stated the facility had worked hard to cover staffing and believed the triggering was due to an error related to the administrative nurse's hours not being included while filling in the weekend shift. She also stated some agency staff hours may not have been reported. The facility's Payroll Based Journaling policy revised 12/2024 indicated the facility would provide complete and accurate payroll data that could be validated and auditable.

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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. 49634 The facility identified a census of 57 residents. The facility identified 17 residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to store Resident (R) 5, R9, and R37's respiratory equipment in a sanitary manner. The facility additionally failed to store clean linens in a sanitary manner and further failed to ensure R34's Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) remained off the floor. These deficient practices placed the residents at risk for infectious diseases. Included Findings: - On 04/14/25 at 07:10 AM, a walkthrough of the facility was completed, and noted: An inspection of R5's room revealed oxygen nasal tubing wrapped around a standing oxygen canister handle. No sanitary storage was present. An inspection of R9's room revealed a nebulizer mask laid directly on a bedside table. No sanitary storage was present. An inspection of R37's room revealed her wheelchair's supplemental oxygen tank tubing and nasal cannula rested on the seat of her wheelchair. No sanitary storage bag was present. On 04/14/25 at 08:40 AM, R34 sat in her recliner with her feet elevated. R34's catheter bag contained amber-colored urine in the drainage bag. R34's catheter drainage bag laid directly on the floor. The catheter drainage bag did not have a privacy bag cover. On 04/14/25 at 08:46 AM, clean linens were placed on the EBP cart outside R42's room. On 04/16/25 at 07:15 AM, Licensed Nurse (LN) H stated nebulizer mask and nasal oxygen should be stored in a sanitary bag with the resident's name. He stated linens should not be left outside of a resident's room, and urine catheter bags should never be on the floor. On 04/16/25 at 08:15 AM, Certified Nursing Aide (CNA) M stated oxygen tubing could be wrapped around the canister; staff were to ensure the tubing was not on the floor. She stated linens should be placed in the residents' rooms, not outside the rooms. CNA M stated urine catheters should be off the floor and covered. On 04/16/24 at 01:20 PM, Administrative Nurse D stated nasal tubing should be stored in a sanitary bag when not in use and nebulizers should be rinsed and placed on a barrier to dry. She stated linen should not be placed in the hall, catheters should never be on the floor, and should always have a privacy cover. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Infection Control policy dated 10/24 documented the infection prevention and control program was a facility-wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance improvement program. The Infection program would be carried out by the facility's infection preventionist. The goal of the facility was to decrease the risk of infection to residents and personnel. The facility would recognize infection control practices while providing care, and Identify and correct problems related to infection control.