STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265167	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Rehabilitation & Health Care Center	904 East 68th Street Kansas City, MO 64131

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409 Based on observation, interview and record review, the facility failed to ensure bathing was completed and staff used a specialized shower chair; and to ensure the care plan was updated for the need of a specialized shower chair for one sampled resident (Resident #2) out of 5 sampled residents. The facility census was 136 residents. A policy for bathing or Activities of Daily Living (ADLs-grooming, bathing, hygiene) was requested and not receive at time of exit. 1. Review of Resident #2's Admission Face Sheet showed he/she was admitted to the facility on [DATE] with diagnosis of Cerebral Palsy (CP, is a group of disorders that affect a person's ability to move and maintain balance and posture). Review of the resident's Admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 2/8/24, showed the resident: -Was alert and oriented able to make his/her needs and wishes known. -Had no documentation related to rejection of cares. -Was dependent on staff for dressing, toileting, transferring, hygiene and used a wheelchair for mobility. -Had no documentation related to bathing assistance. Review of the resident's Care Plan revised on 2/21/24 showed the resident: -Had an ADLs self-care performance deficit, limited mobility and range of motion. -Needed the facility staff to clean the resident's nails on bath days. -Provided skin care daily to keep clean and prevent skin breakdown. -Had no documentation related to the resident requiring a specialized shower chair and he/she prefers to have showers. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265167	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Rehabilitation & Health Care Center	904 East 68th Street Kansas City, MO 64131

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's facility Electronic Audit Report from 2/1/24 to 2/29/24 showed: -The documented times the bathing was completed. -The resident first documented bath/shower was on 2/7/24 at 3:25 P.M., the fifth day after his/her admission to the facility. -Had no documentation of shower/bathing was completed on 2/14/24 and 2/17/24. Review of the resident's printed report of the Shower/Bathing Task Sheet documentation from 3/1/24 to 3/16/24 showed: -The resident shower/bath schedule was on Saturdays and Wednesdays during the evening shift. -The resident had bath on 3/2/24. -The resident had no documentation of bath/shower on 3/9/24. -The resident did not have a bath /shower on 3/16/24. -Note: The resident was in the hospital 3/3/24 to 3/14/24. Review of the resident's Nursing Admission Assessment for ADLs dated 3/14/24 showed the resident required a one person assist for bathing and preferred showers. Review of the resident's printed report Shower/Bathing Task Sheet from 3/20/24 to 3/30/24 showed: -The resident did not have a bath/shower on 3/20/24. -Note: The resident was in the hospital 3/22/24 to 3/28/24. Review of resident's Nursing Assessment for ADLs dated 3/28/24 and 4/3/24 showed the resident required a one person assist for bathing and preferred showers. Review of the resident's printed report of Shower/Bathing Task Sheet from 4/3/24 to 4/8/24 showed: -The resident had a bath on 4/3/24. -The resident did not have a bath /shower on 4/6/24. -Note: The resident was in the hospital 3/29/24 to 4/2/24. During an interview and observation on 4/8/24 at 10:30 A.M., showed: -The resident was laying in his/her bed with a hospital gown on. -He/she had no lingering odors noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265167	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Rehabilitation & Health Care Center	904 East 68th Street Kansas City, MO 64131

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-His/her hair was not combed and he/she had brown flakes around his/her neck area. -He/she said that he/she had one shower since admitted to the facility. -He/she preferred showers, not bed baths. Observation of the 4th floor shower rooms on 4/8/24 at 1:50 A.M., showed no specialized shower chair for the resident. During an interview on 4/8/24 at 1:55 P.M., the resident said: -He/she had a shower one time in the specialized shower chair. -The facility had provided bed baths prior to getting him/her the specialized shower chair. -He/she did not receive a shower or bed bath on Saturday 4/6/24. During an interview on 4/8/24 at 10:41 A.M. Certified Nurses Aide (CNA) A said: -He/she was not able to find the resident bathing task schedule in the electronic record. -The CNAs check electronic records daily for resident assigned to them for showers/bathing. -The resident was scheduled for showers/bathes during the evening shift. -CNAs were to document in the electronic record ADLs provided during shift to include bathing. -The Assistant Director of Nursing (ADON) would be responsible for the residents' bathing schedule and monitoring if bathes were being completed. During an interview on 4/8/24 10:45 A.M., with Agency Registered Nurse (RN A) said: -He/she unaware how to access the resident's bath schedule. -CNAs would report to him/her of any refusal of care. During an interview on 4/8/24 at 12:50 P.M., the Director of Nursing (DON) said: -He/she had just completed a shower/bathing audit for the facility and changed the resident's shower days around, so they were more evenly distributed for CNAs able to complete the task. -He/she had reviewed the resident's shower/bath schedule and it showed the bath schedule changed to a shower/bath on Wednesday and Thursday. -The resident was scheduled for shower/bath on 4/6/24 but the resident's bathing task was not documented as completed, documented or refused. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265167	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Rehabilitation & Health Care Center	904 East 68th Street Kansas City, MO 64131

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility had to order a specialized shower chair that leans back, due to the resident unable to sit upright in regular shower chair. -He/she expected the staff to use the specialized shower chair. During an interview on 4/8/24 at 1:35 A.M., CNA C and CNA E said: -They were not aware of the resident having specialized shower chair. -They had not seen the resident's specialized shower chair on that unit. -The resident did get showers/bathing on the evening shift. During an interview on 4/8/24 at 2:00 P.M., CNA C said he/she looked in the shower room on the 400 hallway and did not find the specialized shower chair. During an interview on 4/8/24 at 2:05 P.M., Central Supplies staff said: -The resident had received the specialized shower chair in 2/2024. -He/she had looked in the shower rooms for specialized shower chair on 4th floor and 3rd floor and it was not found. -A tour of the 2nd floor shower room showed no specialized shower chair for the resident. -Recently the specialized shower chair was left in hallway by a shower room. -He/she would search the facility for the specialized shower chair. During an interview and observation on 4/8/24 at 2:26 P.M., Central Supplies staff showed: -Central supplies staff found the resident's specialized shower chair in locked room on 4th floor. -Evening staff had placed the special ized shower chair in that room. -The specialized shower chair should be kept in the shower room when not in use. -The specialized shower chair had a blue netting and the back of the chair was in a reclining position. During a phone interview on 4/8/24 at 2:55 A.M., evening CNA B said: -He/she had no issue be able to complete care task for his/her assigned residents. -When the resident first came to the facility they provided bed baths due to the resident inability to sit in a regular shower chair. -The resident's shower days changed to Wednesday and Saturdays during the evening shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265167	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Rehabilitation & Health Care Center	904 East 68th Street Kansas City, MO 64131

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility had ordered a specialized shower chair for the resident. -The specialized shower chair was in hallway on 4th floor, by the shower room. During an interview on 4/8/24 at 3:35 P.M., the DON said: -He/she was not aware of the resident being left unkept. -The resident had been to hospital several times in 3/2024. -The resident had not voiced any concern to him/her or Administrator related to bathing. -He/she would expect the residents to be offered a shower/bath at least two times a week. -He/she would expect care staff to document in electronic record under CNA task, if type of shower or bath was given, document if the resident had refused or if was unable able to provide care due to the resident out of the facility. -He/she would expect the refusal of care to reported to the resident charge nurse. -He/she would expect the resident care plan to reflect the resident's current needs to include bathing preference and any special equipment to be used. COMPLAINT # MO00233956