| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265308 | A. Building<br>B. Wing | 01/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| New Mark Rehab and Healthcare Center | 11221 North Nashua Drive<br>Kansas City, MO 64155 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|

F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Ensure services provided by the nursing facility meet professional standards of quality.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that licensed staff's responsibilities were completed according to acceptable standards of professional clinical practice when two licensed nurses RN-A, LPN-A and the Social Worker (SSD) failed to document a change or update of one resident's condition in the clinical medical record (the clinical medical record is accessible to all facility nursing staff and providers) that would have allowed other clinical staff to know what changes or updates had been done for one Resident (Resident #1), when Resident #1 had a critical potassium lab level and refused to be taken to the hospital for potassium to be replaced, and then unexpectedly died three days later. Additionally, the facility failed to assure staff provided care and treatment in accordance with professional standards of practice for three sampled residents, (Resident #2, #3 and #4) when medications were not administered as ordered by the physician. This affected a total of 4 residents out of 4 sampled. The facility census was 159.Review of the facility's policy Nursing Care and Services, dated [DATE], showed:

-All residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being that enhances quality of life in the long-term care facility.

- The facility staff will provide appropriate and competent services to the residents to ensure safety and highest level of care.

- Licensed nurses and staff will document refusal of treatment, changes in treatment, and changes in the resident's condition in the clinical record. This includes refusal of care and unusual circumstances.

1.Review Resident #1's re-admission MDS (Minimum Data Set) A federally mandated assessment completed by facility staff, for the month of [DATE]., showed:

- Cognition was intact.

- Dependent on nursing staff for all activities of daily living.

- Was on hemodialysis (A machine and process that cleans the blood when kidneys no longer function.) three times a week in an outpatient clinic.

- Was on two IV (Intravenous) antibiotics with hemodialysis three times a week and had infected chronic wounds with osteomyelitis (infection of the bone) and a previous amputation to lower extremity.

(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 |
|---|---|---|

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | - Diagnoses: Insulin dependent diabetic, kidney failure, atrial fibrillation (abnormal heartbeat) and congestive heart failure.<br><br>Review of nursing progress notes for the month of [DATE], starting on [DATE] showed:<br><br>-On [DATE] at 6:13 P.M. A one-time order for Potassium Chloride ER 80 mEq (milliequivalent) by mouth was ordered by the facility's Nurse Practitioner for potassium replacement.<br><br>-On [DATE] at 5:46 A.M. resident refused to go to outpatient hemodialysis.<br><br>-On [DATE] at 3:45 A.M. resident was repositioned in bed and provided a drink of water.<br><br>-On [DATE] at 4:52 A.M. resident was found in bed with no respirations and no pulse.<br><br>-On [DATE] at 3:00 P.M. resident's remains where picked up by the county medical examiner.<br><br>Review of the resident's clinical record, including nursing progress notes from [DATE]th through [DATE]th showed the following items were not documented in the resident's facility chart:<br><br>-On [DATE] the resident's code status was updated to a Do Not Resuscitate and was completed with the SSD.<br><br>-On [DATE] labs drawn while resident was at an outpatient clinic doctor appointment. Clinic physician called the facility to report lab results to RN A regarding the critical potassium level and an order was given to RN A to send the resident to the local emergency room for treatment and was not documented.<br><br>-RN A did not document or notify the ordering clinic physician what the resident's wishes were, and that resident refused to be sent to the hospital.<br><br>-RN A did not notify the ordering clinic physician what the plan was as ordered by the nurse practitioner and did not document it.<br><br>-RN A spoke to the resident regarding the lab results and the new order to be sent to hospital, the resident refused to be sent to the hospital and was not documented.<br><br>-RN A notified facility nurse practitioner who ordered immediate dose of 80 mEq potassium with a repeat of STAT (immediate labs) to recheck the resident's potassium level and was not documented.<br><br>-STAT potassium lab results not documented and not documented that provider was notified of the results.<br><br>-On [DATE] no documentation regarding the dialysis clinic had been notified or if the physician was notified that the resident refused dialysis on the 13th. The resident was being treated with IV antibiotics at the dialysis appointments, and this was not documented as being a missed treatment.<br><br>-On [DATE]-indication of a cough and yelling out. No documented assessment of the resident.<br><br>-On [DATE]-found deceased 4:52 A.M.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on [DATE] at 11:35 A.M. RN A said he/she received a phone call from the clinic physician's nurse regarding the resident's critical potassium lab and for the resident to be sent to the hospital for treatment. He/She notified the resident, who refused to be sent to the hospital. He/She notified the facility nurse practitioner and orders were obtained for potassium to be replaced at the facility with repeat lab. The clinic physician's office was not updated on the new plan. The potassium was given that night and labs repeated the next day and called to the nurse practitioner. The resident refused dialysis on the [DATE]th, and the resident was found deceased on the morning of [DATE]. RN A said he/she did not document any of this in the clinical record but should have.<br><br>During an interview on [DATE] at 1:17 P.M. LPN A said he/she received a phone call from an outside clinic wanting to give orders for the resident and informed the clinic the resident had passed away, LPN A did not document the interaction with the provider or review the resident's clinic record to explain how the resident may have come to pass away, but should have.<br><br>During an interview and record review on [DATE] at 12:20 P.M the SSD said she had spent lots of time with resident #1 but had not charted anything regarding their interactions in the resident's chart. She could not recall if she had completed a do not resuscitate (DNR) form with the resident but remembered the resident talking to her about the dialysis nurses discussing the resident changing her code status to a do not resuscitate. She said the resident wished to change her code status to DNR. She said if there was an updated DNR in the chart then it had been done, and that she also kept a notebook to keep her interactions with the resident's in, rather than in the resident's clinical record. A new DNR was completed with the resident on [DATE].<br><br>During an interview on [DATE] at 3:45 P.M. the Administrator said changes in a resident's condition, treatment plan, orders, labs, changes in code status, and resident's wishes should be documented in the resident's chart so other healthcare providers can stay up to date on how the resident is doing. He would expect all licensed providers to document in the resident's progress notes regarding their overall condition.<br><br>The facility did not provide a policy for following physician's orders or medication administration.<br><br>2. Review of Resident #2's physician order sheet (POS), dated [DATE] showed:<br><br>Start date [DATE] - Clopidogrel (Plavix) 75 milligrams (mg.) daily for coronary artery disease (CAD, narrowing or blockage of the coronary arteries which supply oxygen-rich blood to the heart).<br><br>Start date [DATE] - Cyanocobalamin 500 micrograms (mcg.) two tablets daily for supplement.<br><br>Start date [DATE] - Ezetimibe 10 mg. tablet daily for hyperlipidemia.<br><br>Start date [DATE] - Folic Acid 1 mg. tablet daily for deficiency.<br><br>Start date [DATE] - Klor-Con M20 extended-release tablet, two tablets daily for supplement.<br><br>Start date [DATE] - Losartan Potassium 25 mg. on tablet daily for congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body).<br><br>Start date [DATE] - Torsemide 20 mg., two tablets in the morning for CHF.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Start date [DATE] - Dorzolamide HCL ophthalmic Solution 2%, instill one drop in both eyes twice daily for glaucoma.<br><br>Start date [DATE] - Metoprolol tartrate 25 mg., give 0.5 mg. twice daily for high blood pressure. Hold for systolic blood pressure less than 110, and diastolic less than 50 or hear rate less than 60.<br><br>Start date [DATE] - Ensure or equivalent supplement with meals for at risk of malnutrition.<br><br>Start date [DATE] - Tramadol 50 mg. one tablet three times a day for pain.<br><br>Review of the resident's medication administration record (MAR) dated [DATE] showed on [DATE], the following medications were documented with a 9 (a 9 indicated to see the progress notes):<br><br>Clopidogrel (Plavix) 75 mg. daily for CAD.<br><br>Cyanocobalamin 500 mcg. two tablets daily for supplement.<br><br>Ezetimibe 10 mg. tablet daily for hyperlipidemia.<br><br>Folic Acid 1 mg. tablet daily for deficiency.<br><br>Klor-Con M20 extended-release tablets, two tabs daily for supplement.<br><br>Losartan Potassium 25 mg. on tablet daily for CHF.<br><br>Torsemide 20 mg., two tablets in the morning for CHF.<br><br>Dorzolamide HCL ophthalmic Solution 2%, instill one drop in both eyes twice daily for glaucoma.<br><br>Metoprolol tartrate 25 mg., give 0.5 mg. twice daily for high blood pressure. Hold for systolic blood pressure less than 110, and diastolic less than 50 or hear rate less than 60.<br><br>Ensure or equivalent supplement with meals for at risk of malnutrition.<br><br>Tramadol 50 mg. one tablet three times a day for pain.<br><br>Review of the resident's progress notes dated [DATE] showed staff did not document why the medication was not administered.<br><br>3. Review of Resident #3's POS dated [DATE] showed:<br><br>Start date [DATE] - Brexpiprazole (antipsychotic used to treat schizophrenia and depression) 0.5 mg. tablet daily for prophylaxis.<br><br>Start date [DATE] - Cetirizine 5 mg tabled daily for allergies.<br><br>Start date [DATE] - Cranberry oral tablet 450 mg. daily to reduce the risk for a urinary tract infection (UTI).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Start date [DATE] - Magic cup in the afternoon for weight loss.<br><br>Start date [DATE] - Pantoprazole Sodium delayed release 40 mg. tablet daily for gastroesophageal reflux disease (GERD).<br><br>Start date [DATE] - Senna Plus oral tablet 8.6-50 mg. one tablet daily for constipation.<br><br>Start date [DATE] - Sertraline HCL 50 mg. one tablet daily for dementia with behaviors related to major depression disorder.<br><br>Start date [DATE] - Trazodone HCL 50 mg., give 0.5 mg. tablet every morning and at bedtime for restlessness and depression.<br><br>Start date [DATE] - Acetaminophen oral tablet 325 mg. two tablets twice daily for pain not to exceed (NTE) 3 grams in 24 hours.<br><br>Start date [DATE] - Ativan 0.5 mg. one tablet twice daily for agitation until [DATE].<br><br>Start date [DATE] - Carvedilol oral tablet 6.25 mg one tablet three times a day for high blood pressure. Hold if systolic blood pressure is less than 100 or pulse is less than 60.<br><br>Start date [DATE] - Gabapentin capsule 300 mg. one capsule twice daily for anxiety.<br><br>Start date [DATE] - Memantine HCL 10 mg. one tablet twice daily for dementia.<br><br>Start date [DATE] - Quetiapine Fumarate 50 mg. one tablet twice daily for dementia.<br><br>Start date [DATE] - Trazodone HCL 50 mg. give 0.5 mg. tablet every morning and at bedtime for restlessness and depression.<br><br>Start date [DATE] - Buspirone HCL 10 mg. one tablet three times daily for anxiety.<br><br>Start date [DATE] - Med Pass 2.0 120 milliliters (ml.) three times a day for supplement.<br><br>Review of the resident's MAR dated [DATE] showed on [DATE], the following medications were documented with a 9:<br><br>Brexpiprazole 0.5 mg. tablet daily for prophylaxis.<br><br>Cetirizine 5 mg tabled daily for allergies.<br><br>Cranberry oral tablet 450 mg. daily to reduce the risk for a UTI.<br><br>Magic cup in the afternoon for weight loss.<br><br>Pantoprazole Sodium delayed release 40 mg. tablet daily for GERD.<br><br>Senna Plus oral tablet 8.6-50 mg. one tablet daily for constipation.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Sertraline HCL 50 mg. one tablet daily for dementia with behaviors related to major depression disorder.<br><br>Trazodone HCL 50 mg., give 0.5 mg. tablet every morning and at bedtime for restlessness and depression.<br><br>Acetaminophen oral tablet 325 mg. two tablets twice daily for pain NTE 3 grams in 24 hours.<br><br>Ativan 0.5 mg. one tablet twice daily for agitation until [DATE].<br><br>Carvedilol oral tablet 6.25 mg one tablet three times a day for high blood pressure. Hold if systolic blood pressure is less than 100 or pulse is less than 60.<br><br>Gabapentin capsule 300 mg. one capsule twice daily for anxiety. Staff did not document it as administered at 8:00 A.M or 2:00 P.M.<br><br>Memantine HCL 10 mg. one tablet twice daily for dementia.<br><br>Quetiapine Fumarate 50 mg. one tablet twice daily for dementia.<br><br>Trazodone HCL 50 mg. give 0.5 mg. tablet every morning and at bedtime for restlessness and depression.<br><br>Buspirone HCL 10 mg. one tablet three times daily for anxiety. Staff did not document it as administered at 8:00 A.M or 2:00 P.M.<br><br>Med Pass 2.0 120 milliliters (ml.) three times a day for supplement. Staff did not document it as administered at 8:00 A.M or 2:00 P.M.<br><br>Review of the resident's progress notes dated [DATE] showed staff did not document why the medication was not administered.<br><br>4. Review of Resident #4's POS dated [DATE] showed:<br><br>Start date [DATE] - Diltiazem HCL 30 mg. one tablet three times daily for high blood pressure.<br><br>Start date [DATE] - 2 Cal four times a day for supplement.<br><br>Review of the resident's MAR dated [DATE] showed on [DATE], the following medications were documented with a 9:<br><br>Diltiazem HCL 30 mg. one tablet three times daily for high blood pressure.<br><br>2 Cal four times a day for supplement.<br><br>Review of the resident's progress notes dated [DATE] at 3:07 P.M., showed neither the medication or the supplement had been administered.<br><br>During an interview on [DATE] at 2:14 P.M., the Staffing Coordinator said:<br><br>(continued on next page) |

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

He/She did not cover any shifts but was responsible to get staff to cover the shifts when call ins happened.

When a staff member called in, he/she would attempt to get the in-house staff to cover the shift. If the in-house staff were unable to cover the shift, then he/she would reach out to an agency to cover the shift.

On Sunday, [DATE], the Certified Medication Technician (CMT) called in for the 100 halls. The Registered Nurse (RN) passed the medications.

He/She attempted to get in-house staff to cover the shift, and no one was able to. He/She attempted to get agency to work and was unable to get anyone to pick up the shift. He/She notified the unit managers. Unit Manager A was unable to work, and Unit Manager B was working another job. He/She notified the Regional Associate who approved the premium shifts (higher rate of pay), but he/she was unable to get any staff to cover the shift until 2:00 P.M.

During an interview on [DATE] at 4:40 P.M., RN B said:

He/She worked on [DATE] on the 100 halls.

When the CMT had not shown up for work, he/she contacted the staffing coordinator who said to go ahead and start passing the medications and he/she would try to get coverage.

He/She had never passed medications in a long-term care facility before. He/She did not know which residents' medications should be crushed, placed in applesauce or pudding.

He/She had a resident with a medical emergency, had to complete wound care and monitor the residents on the unit to ensure they did not fall or have any resident-to-resident altercations.

He/She did get some medications passed but did not get them all passed. When the CMT arrived at 2:00 P.M., the CMT said he/she would not pass them because they were overdue, and the RN should document not administered.

RN B said if the medications were not passed, he/she should have documented in the progress notes why the medications were not administered.

Normally agency staff pick up any extra shifts.

During an interview on [DATE] at 5:36 P.M., the Administrator and the Regional Nurse Consultant said:

When the facility has a call in, the Staffing Coordinator is notified. The Staffing Coordinator calls the in-house staff first then calls for agency staff. The unit managers are also notified to see if they can cover the shift.

The Administrator would expect to be notified if there was an emergency staffing issue.

The Administrator said the medications should have been administered, even if the staff had to notify the physician and get an order for the medications to be administered late.

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The nurse should have reached out to the physician to see if the medications should have been administered late or held.<br><br>The Regional Nurse Consultant said she would expect the medications to be administered as ordered and/or the physician to be notified.<br><br>Intakes 2707044 & 2706879 & 2706685 |