STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265758	A. Building B. Wing	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab of Kansas City South	8033 Holmes 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accommodate three out of three sampled residents' (Residents # 1, #2, #3) preferences related to showering. The facility census was 91 residents. Review of the facility's Resident Rights - Accommodation of Needs policy, revised 8/2020 showed: -Residents' individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. -In order to accommodate residents' individual needs and preferences facility staff attitude and behavior are directed toward assisting the residents in maintaining independence, dignity, and well-being to the extent possible according to resident wishes. 1. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 10/22/24, showed the resident was: -Cognitively intact. -Dependent (helper does all effort) on staff for toileting hygiene, bathing/showering, and shower/tub transfers. -Incontinent of bowel. -Diagnosed with paraplegia (loss of movement of both legs and generally the lower trunk). Review of the resident's Activities of Daily Living (ADL - dressing, grooming, bathing, eating, and toileting) care plan, revised 10/24/24 did not show any of the resident's bathing/showering needs or preferences. Review of the resident's shower sheets dated 12/2024 showed: -On 12/4/24, 12/11/24, 12/17/24, and 12/19/24 he/she received showers. -On 12/22/24 he/she refused a shower. The form did not document why the resident refused. During an interview on 12/26/24 at 11:20 A.M. Certified Medication Technician (CMT) A said: (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident took showers whenever they were offered. -The resident would speak up if he/she had to go too long without a shower. -As far as he/she knew the resident was getting them. Observation on 12/26/24 at 11:35 A.M. showed the resident had what looked like crumbs and a few dots of stains on the lap area of his/her pants. During an interview on 12/26/24 at 11:35 A.M. the resident said: -There were times he/she had gone a couple of weeks before getting a shower. -He/She hadn't had a shower during the week of Christmas and would have liked to have had one because he/she wanted to feel clean, especially if visitors came. -A weekly shower wasn't enough to keep him/her feeling clean. He/She needed one at least every few days. During an interview on 12/26/24 at 12:42 P.M. Certified Nurse Assistant (CNA) A said the resident did not refuse showers when they were offered. During an interview on 12/26/24 at 2:14 P.M. Licensed Practical Nurse (LPN) A said: -The resident often needed a shower. Anytime they gave residents showers the resident was on the list for one. -He/She was always dropping something on himself/herself. -The resident got a shower at least once a week. 2. Review of Resident #2's quarterly MDS dated [DATE] showed the resident was: -Severely cognitively impaired. -Dependent upon staff for toileting hygiene, bathing/showering, and tub/shower transfers. -Always incontinent of bowel and bladder. -Diagnosed with Hemiplegia/hemiparesis (paralysis/weakness affecting one side of the body). Review of the resident's ADL care plan, revised 10/16/24, showed the resident was dependent on one staff for bathing/showering twice weekly and as needed. A sponge bath would be offered when a full bath or shower cannot be tolerated. Review of the resident's shower sheets dated 12/2024 showed: -On 12/6/24 he/she refused a shower. There was no documentation as to why. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/20/24 and 12/16/4 he/she had a shower. -On 12/20/24 he/she refused a shower. There was no documentation as to why. During an interview on 12/26/24 at 12:00 P.M. the resident said he/she: -Didn't always get to have showers every week. -Wanted more showers than what he/she was getting because he/she felt dirty and thought others could smell him/her. -Would like to get at least a couple of showers a week. 3. Review of Resident #3's quarterly MDS, dated [DATE] showed the resident was: -Cognitively intact. -Dependent on staff for toileting hygiene, bathing/showering, and tub/shower transfers. -Always incontinent of bowel and bladder. -Diagnosed with multiple sclerosis (MS, a neurological disease that attacks the protective covering of the nerves, leading to impaired sensory and motor nerve function, and in most cases some degree of disability) and had upper and lower extremity impairments on both sides of his/her body. Review of the resident's ADL care plan, revised 12/5/24, showed the resident required assistance of two staff for bathing/showering as necessary. It did not mention the resident's bathing/showering preferences related to frequency or time of day. Review of the resident's shower sheets dated 12/2024 showed he/she had showers on 12/2/24, 12/9/24, 12/14/24, and 12/18/24. Observation on 12/26/24 at 12:25 P.M. showed the resident had a body odor. During an interview on 12/26/24 at 12:25 P.M. the resident said: -He/She wasn't getting showers as often as he/she wanted. Sometimes it was only once every two weeks. -He/She had always liked to shower daily, but in the facility setting that probably wasn't possible. -At the very minimum he/she would like to shower at least two or three times a week. -He/She didn't feel clean which affected his/her mood. He/She felt better when he/she was clean. -He/She didn't have any set days of the week for showering and didn't think there was a shower schedule. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was often told there weren't enough staff to shower him/her. -Today he/she asked one of the CNAs for a shower and was told to wait until Saturday (two more days) because staff were too busy. During an interview on 12/26/24 at 12:42 P.M. CNA A said the resident did not refuse showers when they were offered. During an interview on 12/26/24 at 2:14 P.M. LPN A said: -The resident never mentioned to him/her that he/she wanted a shower. -There were four CNAs assigned to the halls on his/her side of the building so a CNA should have been available to give the resident a shower if he/she asked for one. He/she had not heard the resident had refused any shower. 4. During an interview on 12/26/24 at 12:42 P.M. CNA A said: -Residents had scheduled shower days. Lately the nurse just told the CNAs when a resident needed a shower. They hadn't been going by the shower schedule. -Resident showers were documented on shower sheets. During an interview on 12/26/24 at 2:14 P.M. LPN A said: -He/She determined if a resident needed a shower by looking at them. -There was a bathing schedule, and all residents were scheduled to receive two showers a week, but the nurse just determined by looking at residents who actually needed one. -They didn't necessarily get two showers a week since the shower aide had been working as a CNA. During an interview on 12/26/24 at 4:45 P.M. the Acting Director of Nursing (DON)/Regional Nurse Manager said: -Residents should be offered a shower on their scheduled shower days. -If a resident refused a regular bath or shower staff should offer a sponge bath. If they refuse that staff should get the nurse involved to see why the resident was refusing. -If there are four CNAs working on one side of the building staff should shower everyone who is scheduled to get a shower. They can give extra showers as they have time or see if the next shift can get the resident showered. MO00246401

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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** Based on interview, and record review, the facility failed to properly secure one sampled resident (Resident #3) during transport in the facility van out of three sampled residents. The facility census was 91 residents. Review of the facility's Safe Transportation Unloading Procedure, undated, showed: -Always make sure the resident is secure with wheelchair locks engaged and tie down hooks secured to frame of wheelchair. -If transporting multiple residents, ensure other resident wheelchair(s) are fully secured (wheel locks engaged and tie down straps on wheels) until ready for unloading. -If for any reason you must step away from the resident reapply the wheel locks, hook straps and make sure the resident is fully secured. 1. Review of Resident #3's admission Record showed he/she was admitted to the facility on [DATE] with diagnoses that included: -Multiple Sclerosis (MS, a neurological disease that attacks the protective covering of the nerves, leading to impaired sensory and motor nerve function, and in most cases some degree of disability). -Left knee contracture (a shortening of muscles and soft tissue often leading to deformity and rigidity). -Abnormal posture. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 11/14/24 showed the resident: -Was cognitively intact. -Had upper extremity impairments on both sides and lower extremity impairments on both sides. -Was dependent (helper does all the effort) for dressing, transfers, showers, toileting, and repositioning. -Used a motorized wheelchair. Review of the resident's Fall Risk care plan, dated 11/27/24 showed a goal for the resident to be free of falls and injuries. Review of the resident's internal Fall Report, dated 12/12/24 showed: -On 12/12/24 At 3:30 P.M. the resident reported he/she fell inside the van and hit his/her head when returning from an appointment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Transportation Driver (TD) A's written statement showed he/she was bringing the resident and another resident back to the facility when he/she made a turn onto another street and the resident's chair tilted over and the resident said he/she hit his/her head. He/She didn't fall out of his/her seat. -Transportation Escort (TE) A's written statement showed the van turned a corner. The resident's chair was leaned back and he/she tilted over and said he/she hit his/her head. The resident never hit the floor. He/She and TD A tilted the chair back over and the resident rolled back into the facility. -There were no new interventions or plans mentioned in the Fall Report for preventing a similar future accident from happening. During an interview on 12/26/24 at 1:38 P.M. TD A said: -He/She was the driver to take residents to medical appointments. -Before he/she headed home he/she asked TE A if Resident #3 was strapped up and TE A said he/she strapped in Resident #3's wheelchair. -He/She was heading back to the facility from resident medical appointments when he/she made a turn and Resident #3's wheelchair tilted towards the van window. -He/She stopped the vehicle and the resident said he/she hit the right side of his/her head on the window during the turn. At the time the resident said his/her head hurt a little bit, but later told him/her he/she was OK. -The resident had a motorized wheelchair and the back of the wheelchair was found reclined instead of all the way up when they stopped. Another resident was in a manual wheelchair to Resident #3's right and the other resident's wheelchair stopped Resident #3 from falling to the van floor. Resident #3's wheelchair was leaning on the other resident's wheelchair when he/she stopped. Resident #3 didn't hit the other resident, just his/her wheelchair. -TE A strapped Resident #3 in on the day of the accident. He/She had shown TE A how to strap in wheelchairs using four straps per wheelchair, attaching them just under the resident's seat. -On the day of the accident they were transporting two residents. TE A had difficulty getting Resident #3 and the other passenger in because TE A's motorized wheelchair was so large. All the motorized wheelchairs tended to be larger than the manual wheelchairs. -He/She didn't know if TE A used all four straps, but TE A said he/she did. -When he/she stopped the van after Resident #3 tilted to his/her right he/she saw that the two straps on the left side of Resident #3's wheelchair were not attached. He/She had never known wheelchair straps to come off and out of the floor slot before. Either TE A didn't have the straps on securely or they weren't on right. -He/She thought Resident #3 was just so scrunched up with the other resident in the van TE A couldn't put the straps on like he/she normally did. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-As the driver he/she was responsible for ensuring all wheelchairs were strapped down appropriately. He/She should have double checked the wheelchairs were strapped in correctly. During an interview on 12/26/24 at 3:30 P.M. Resident #3 said: -He/She was not strapped in correctly. They put straps on one side, but not the other so he/she was only half-way buckled in. -He/She tipped over while the van was in motion and the right side of his/her head hit the window hard. It really hurt at the time. -He/She called an ambulance when they got back to the facility and went to the hospital to have it checked out. He/She wanted to make sure he/she was alright. During an interview on 12/26/24 at 3:50 P.M. TE A said: -Resident #3 and another resident were in the back of the van. -He/She attached three straps onto Resident #3's wheelchair. He/She was supposed to put anywhere from two to four straps on the wheelchair. -The previous Transportation Driver, who was no longer working at the facility, had shown him/her how to attach the straps to the wheelchairs. -When he/she got the residents in the van the back of Resident #3's wheelchair was positioned upright. -On the way back from the medical appointments he/she heard a little scream. -The driver pulled over immediately. -They found Resident #3's wheelchair tipped over onto the back section of another resident's wheelchair and the back of Resident #3's wheelchair was reclined. Neither resident was hurt. -The front left strap that had been attached to Resident #3's wheelchair came up off the van floor. -Once before one of the wheelchair straps came up out of the van floor when they were transporting a different resident. That resident wasn't hurt either. -He/She wasn't aware of any protocol he/she needed to follow to prevent a similar accident from happening again. -It was fine to use anywhere from two to four straps to secure wheelchairs in the van. During an interview on 12/26/24 at 4:10 P.M. the MDS Coordinator said: -The resident used an outside transportation company as well as the facility van for appointments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The driver should make sure the resident's wheelchair was locked and he/she was strapped down correctly before transporting. During an interview on 12/26/24 at 4:25 P.M. the Maintenance Director said: -He/She supervised the Transportation Driver. -He/She was told the resident tipped in his/her wheelchair during transport. -Without having seen it, he/she didn't know if the resident was strapped in correctly. -He/She had never been told straps had come up off the van floor. -He/She hadn't spoken to or provided education to TD A or TE A since the resident's accident. -The driver was always supposed to use four straps to secure each wheelchair. -After TD A was hired, he/she trained TD A to always use four straps to attach the front and back of each side of the wheelchair, and to ensure straps were securely latched. -Drivers were supposed to make sure straps were attached correctly. -TE A is the escort. He/She didn't train TE A because the driver was supposed to always secure the wheelchairs. During an interview on 12/26/24 at 4:33 P.M. the Administrator said: -Residents other than Resident #3 also have power (motorized) wheelchairs. -He/She re-educated the driver the day of the accident on making sure all strap latches were secure. He/She also told TD A and TE A to make sure all wheelchairs were in remained in an upright position. -The Maintenance Director was responsible for educating drivers on latching the straps to the wheelchairs. -He/She held the driver responsible for ensuring wheelchairs were secure.