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	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab of Kansas City South	8033 Holmes Kansas City, MO 64131

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 09895 Based on interview and record review, the facility failed to ensure written notification to the resident and/or family prior to transfer from the facility for one sampled resident (Resident #10) out of 18 sampled residents. The facility census was 92 residents. Review of the facility Transfer and Discharge policy dated June 2020 showed: -Facility staff will provide the resident with reasonable advance notice of the transfer or discharge before it occurs. 1. Review of Resident #10's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/8/24 showed the resident was moderately cognitively impaired. Review of the resident's Change of Condition progress note dated 12/20/24 showed: -He/She was leaning to his/her right side, his/her mouth also was sliding to his/her right side, he/she was unable to sit upright even after being repositioned and his/her pulse was 105 beats per minute. -His/Her physician was notified, and an order was received to send him/her to the emergency room for evaluation and treatment. -He/She left the facility at 10:30 A.M. in route to hospital emergency room . -There was no mention of written notification to the resident or the resident's family prior to the resident's transfer to hospital. Review of the resident's entire Electronic Medical Record (EMR) showed no written notification to the resident or the resident's family regarding his/her transfer to hospital on 12/20/24. Review of the resident's Change in Condition progress note dated 12/23/24 showed during a telephone call, a facility licensed nurse informed the resident's family member that the resident had gone to an emergency room and was then admitted to the hospital. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning) Dated 1/16/25 showed he/she was cognitively intact. During an interview on 2/20/25 the resident said: -He/She had been admitted to hospital a couple of times in the past couple of months. -He/She could not remember if the facility had given him/her written notification of the reason for his/her hospitalization and the name and address of the hospital. During an interview on 2/26/25 at 12:01 P.M. the facility social worker said: -He/She did not provide written notice to the resident or family when a resident was transferred to hospital. -That would be a licensed nurse responsibility since he/she was usually not in the facility when a resident was transferred to hospital. During an interview on 2/26/25 at 12:17 P.M. Licensed Practical Nurse (LPN) B said: -He/She had worked at the facility for over one year. -He/She had never given a resident or a resident's family a written transfer notification with information about the reason for and location of the resident's transfer prior to sending the resident to a hospital. During an interview on 2/26/25 at 12:15 P.M. the Director of Nursing (DON) said: -The licensed nurse on duty at the time of the resident's transfer was responsible for providing written notification regarding the resident's transfer, including the reason for the transfer and the location of the transfer. -He/She was responsible for monitoring to ensure transfer/discharge notices were given to residents/residents' family prior to a resident's transfer or discharge.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to ensure oxygen equipment such as tubing, nebulizer (a machine that converts liquid medication into a fine mist that could be inhaled through a mouthpiece or mask) and Bilevel Positive Airway Pressure machine (BiPAP- a non-invasive ventilator that helps patients breathe by providing two different air pressure levels for inhaling and exhaling) were stored in a clean plastic bag when not in use for two sampled resident's (Resident #55 and #57) and failed to have a physician's order for two sampled residents to use a nebulizer and/or BiPAP (Resident #55 and #57) out of 18 sampled residents. The facility census was 92 residents. Review of the facility's policy, BiPAP Support, revised 5/2015 showed: -A physician's order is required to initiate BiPAP support and should include BiPAP settings as prescribed. -All BiPAP equipment should be cleaned and stored per general cleaning storage guidelines. Review of the facility's policy, Oxygen Administration, dated 6/2020 showed: -A physician's order was required to initiate oxygen therapy. -All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen would be changed weekly and when visibly soiled. -Oxygen items would have been stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. 1. Review of Resident #55's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe). -Obstructive Sleep Apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). Review of the resident' care plan dated 1/27/25 showed: -He/She had COPD. -Staff was to administer oxygen as ordered if ordered, dated 8/28/23. -Staff was to give aerosol (treatment) as ordered, dated 8/28/23. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 2/3/25 showed: -He/She was cognitively intact. -He/She had COPD. -Respiratory treatment was not checked. Review of the resident's February 2025 Physician's Order Sheet (POS) did not show an order for a nebulizer treatment. Observation on 2/19/25 at 12:27 P.M. showed a nebulizer mouthpiece was sitting on the resident's night stand not in a bag. There was no bag to store the nebulizer mouthpiece in. Observation on 2/20/25 at 9:27 A.M. showed a nebulizer mouthpiece was sitting on the resident's night stand not in a bag. There was no bag to store the nebulizer mouthpiece in. Observation on 2/21/25 at 11:30 A.M. showed a nebulizer mouthpiece was hanging off the side of the resident's night stand not in a bag. There was no bag to store the nebulizer mouthpiece in. 4. Observation and interview on 2/26/25 11:46 A.M. with Licensed Practical Nurse (LPN) A showed: -The nebulizer was on the resident's nightstand and the mouthpiece was not in a bag. -The LPN A said he/she could not find an order for the nebulizer but the resident had COPD. -The nebulizer must have been the roommates. -The LPN A removed the nebulizer from the resident's room. During an interview on 2/24/25 at 1:30 P.M. the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) said: -A nebulizer pipe (mouthpiece) or oxygen equipment should have been in a bag with the date written on it showing when it was changed. -The nebulizer pipe (mouthpiece) should have been cleaned daily and then air dried then put into a bag to keep it clean. -There should have been an physician's order for any type of oxygen. -The nurse was responsible to ensure oxygen equipment was kept in a bag when not in use. During an interview on 2/26/25 at 9:37 A.M. LPN B said: -When oxygen equipment such as the nebulizer was not in use it should have been in a bag to ensure it was kept clean. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There should have been a date on the bag or the tubing indicating when it was changed, it should have been changed weekly. -The nebulizer pipe (mouthpiece) and tubing should not have been hanging off the side of the resident's nightstand. -Nursing was responsible to ensure the oxygen equipment was changed out weekly, kept in a bag with the date it had been changed written on it. During an interview on 2/26/25 at 12:10 P.M. the Director of Nursing (DON) said: -There should have been an order for a resident to have oxygen or oxygen equipment. -The resident did not have an order for the nebulizer. -The oxygen equipment should have been hanging off of the nightstand. -Nursing was responsible to ensure the oxygen equipment was kept in a sanitary condition. -The oxygen equipment when not in use should have been kept in a bag with the date it had been changed written on it. During an interview on 2/26/25 at 1:30 the resident said: -The staff did not put the nebulizer mouthpiece in a bag when not in use, there was no bag in the room. -Someone had stolen his/her nebulizer in the last hour or so. -The nebulizer was his/her personal machine. -He/She still used it. -The nursing staff provided the medication for the nebulizer machine. -He/She had a treatment the day before. -He/She did not know how they got the medication for the nebulizer if they did not have a physician's order for it. 46890 2. Review of Resident #57's Face Sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses: -Abnormalities of breathing. -Heart failure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Electronic POS dated 2/2025 showed he/she had no orders for BiPAP. During an observation and interview on 2/19/25 at 9:46 A.M., showed: -The resident had a BiPAP at least a couple of weeks. -The resident had not seen staff clean or cover the mask. -The mask was observed in the resident's top dresser drawer uncovered. Review of the resident's quarterly MDS dated [DATE] showed: -He/She was cognitively intact. -He/She was not using BiPAP. Review of the resident's care plan on 2/25/25 showed: -His/Her care plan was last reviewed/revised on 12/19/24. --Note: The care plan had not addressed BiPAP. Review of the resident's Electronic Medical Record on 2/25/25 showed he/she had a physician consult sheet dated 1/15/25 that showed new BiPAP and pressure setting ordered by his/her physician. During an interview on 2/26/25 at 9:39 A.M., Certified Nursing Assistant (CNA) A said: -Resident masks should be placed in a plastic bag when not in use. -Charge nurses are responsible for resident BiPAP machines. -If a resident has a BiPAP it should be in his/her care plan that is located at the nursing station. -He/She was not aware that Resident #57 had a BiPAP. During an interview on 2/26/25 at 9:46 A.M., Certified Medication Technician (CMT) A said: -He/She has worked at the facility for three years. -Masked should be covered when not in use. -The charge nurse is responsible for the resident BiPAP machines. -BiPAP's should have orders. -The Unit Managers are responsible for updating resident care plans. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 10:07 A.M., LPN A said: -Residents who have BiPAP's should have physician orders for settings and care for the machine. -The charge nurses are responsible obtaining BiPAP orders. -The MDS nurse is responsible to update the resident care plans. -He/She is updated in daily nursing report of any resident changes. -He/She was not aware that Resident #57 had a BiPAP. During an interview on 2/26/25 at 10:12 A.M., the MDS nurse said: -He/She had worked at the facility for five years. -He/She was responsible for the resident care plans. -He/She reviews new orders and updates the care plans. -He/She was not aware that Resident #57 had a new order for BiPAP. -Physician consults are reviewed during morning meetings for any new orders. During an interview 2/26/25 at 12:10 P.M., the DON said: -He/She would expect there would be orders including care if the BiPAP. -All new orders are reviewed in morning meetings and care plans updated. -He/She is responsible that orders are written and the care plans are updated. -He/She was not aware that Resident #57 did not have BiPAP orders written related to a physician consult from 1/2025.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09895 Based on observation, interview, and record review, the facility failed to ensure documentation related to attending the dialysis (a procedure that filters the blood when the kidneys were no longer able to do so) unit and coming back from the dialysis unit was completely filled out and accurate for four sampled dialysis residents, (Residents #10, #23, #32, and #33), and failed to document assessments in the computer in a consistent manner for two sampled resident, (Resident# 23, Resident #32) out of 19 sampled residents. The facility census was 92 residents. Review of the facility Dialysis Care policy dated June 2022 showed: -The facility was responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each dialysis treatment, and providing for all non-dialysis needs off the residents including during the time period when the resident was receiving dialysis. -The facility maintained a contract with a dialysis service provider which addresses communications between the facility and the provider. -The facility would provide a method of communication between the dialysis provider and the facility. -Nursing staff would communicate pertinent information in writing to the Dialysis staff which might include medication changes, recent changes in condition and the resident's tolerance of dialysis. -The dialysis provider would communicate in writing to the facility the resident's current vital signs (temperature, heart rate, breathing rate, and blood pressure), pre and post dialysis weight and any problems encountered while the resident was at the dialysis provider. -The nursing staff would keep the resident's attending physician, the resident and the resident's family informed of any change in the resident's condition. -(The Facility) would inspect the shunt site (a surgical connection of an artery and a vein for dialysis) area for color, warmth, redness, tenderness, pain, edema, drainage, and bruit (the whooshing sound) one per shift. -(The Facility) would check for a bruit (a pulsation felt of blood flowing through the ateriovenous anastmomosis (shunt site). -Place your fingertip slightly over the vein and feel for the thrill. -Place the stethoscope over the vein and listen for the buzz or bruit. -Document the findings in the medical record. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The dialysis provider and the resident's attending practitioner (medical professional including physicians and nurse practitioner with advanced education and licensed to diagnose and treat health conditions) must be notified of a canceled or postponed dialysis treatment and responses to the change in treatment must be documented in the resident's medical record. -If dialysis was canceled or postponed, the nursing staff and dialysis provider should provide or obtain ongoing monitoring and medical management for changes such as fluid gain, respiratory issues, reviews of relevant lab results, and any other complications until dialysis can be rescheduled based on resident assessment, stability and need. -Nursing staff were to use the Nurses Dialysis Communication Record or comparable form to convey information to the dialysis provider. -All documentation concerning dialysis services and care of the dialysis resident would be maintained in the resident's medical record. Review of the facility Dialysis and Nursing Home Handoff Communication Tool, undated showed: -A section for Information to be completed by nursing home and sent with the resident for each dialysis treatment. -A section to be completed by dialysis and returned with the resident for each dialysis treatment that included pre-dialysis weight, post-dialysis weight, problems during dialysis, amount of fluid removed, post dialysis vitals, labs drawn yes/no, copy of lab results attached yes/no, updated physician (MD) orders attached yes/no. did dietitian make recommendations, did social worker make recommendations, food/fluid consumed during dialysis, percentage meal consumed, fluids consumed, medications given during dialysis - anemia (low red blood cell count) medications, other medications, vascular access (where the dialysis machine connects to the bloodstream during dialysis treatments) condition, dialysis nurse's signature and date. 1. Review of Resident # 10's electronic medical record on 2/19/25 through 2/26/25 showed: -He/She was admitted to the facility on [DATE]. -He/She had a physician's order for dialysis on Tuesday, Thursday and Saturday. -There were a total of four Dialysis and Nursing Home Handoff Communication Tools dated 1/30/24, 2/4/25, 2/8/25 and 2/11/25. Review of the resident's Dialysis and Nursing Home Handoff Communication Tool dated 1/30/25, 2/4/25 showed: -The section to be completed by dialysis had only the resident's pre-dialysis weight and a post-dialysis weight, pulse and blood pressure. -No additional information was documented by the dialysis staff and/or facility staff. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the residents Dialysis and Nursing Home Handoff Communication Tool dated 2/11/25 showed: -The section to be completed by dialysis had only the resident's pre-dialysis but not the resident's post-dialysis weight, temperature, respiratory rate and blood pressure and the area for problems showed he/she was taken off dialysis early. -No additional information was documented by the dialysis staff and/or facility staff. Review of the resident's Nursing Progress Notes dated 1/1/25 through 2/26/25 showed: -No documentation of facility licensed nurse follow-up with dialysis regarding any missing dialysis communication forms. -No documentation of facility licensed nurse follow-up with dialysis regarding any missing information on the resident's 1/30/25 2/5/25, and 2/11/25 dialysis communication forms. During an interview on 2/25/25 at 3:55 P.M. the Director of Nursing (DON) said: -The resident had been going to dialysis three times a week, there should be more dialysis communication forms than the three in his/her EMR. -There might be more dialysis communication forms waiting to be uploaded to the resident's EMR. -He/She would check with medical records to see if there were additional dialysis communication forms not in the resident's medical record and would bring any dialysis communication forms found in medical records to the surveyor. -Note: At the time of the survey exit on 3/5/25 no additional dialysis communication forms for the resident were provided to the survey team. 39469 2. Review of Resident #23's face sheet showed he/she was readmitted to the facility on [DATE] with a diagnosis of End Stage Renal Disease (ESRD - a permanent condition in which the kidneys are no longer able to function), dated 6/26/24. Review of the resident's care plan dated 1/7/25 showed: -He/She received dialysis on Monday, Wednesday, and Friday. -Staff was to auscultate Bruit and palpate Thrill to fistula/shunt every shift. Notify physician of abnormalities or absence, dated 7/11/24. -Staff was to monitor site as ordered. Review of the Entry Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 1/21/25 showed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was moderately cognitively impaired. -He/She had ESRD. Review of the January 2025, Dialysis Communication Tool received by the facility on 2/21/25 at 8:37 A.M. showed: -No documentation before 1/17/25 was in the resident's chart. -The Communication Tool dated 1/17/25 showed: -The Pre dialysis weight was 81.1. -The Post dialysis weight was 81.1. -462 milliliters of fluid was removed. -No fluid was added. -There was no other Dialysis Communication Tools for January (missing 12). --NOTE: The facility did not have this documentation at the time of survey. The facility contacted the dialysis center for the information after it was requested during survey. Review of the resident's January Nurses' Administration Record showed: -Staff was to assess the resident's dialysis right arm shunt site every shift for signs/symptoms of infection, bleeding, pulsation or aneurysm dated 1/21/25. -Out of 30 opportunities the staff documented: -(n) 27 times. -(no/-) twice. -NA once. -None of the above were in the chart code (approved abbreviations to have been used by the nursing staff in documentation). Review of the resident's February 2025 Physician's Order Sheet (POS) showed the following orders: -Assess the resident's dialysis device graft/fistula in right arm. Monitor for bruit/thrill every shift related to ESRD, dated 1/22/25. -Assess dialysis right arm shunt site every shift for signs/symptoms of infection, bleeding, pulsation or aneurysm every shift, dated 1/22/25. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dialysis treatment on Tuesday, Thursday, and Saturday. Review of the February Nurses' Administration Record showed: -Staff was to assess the resident's dialysis right arm shunt site every shift for signs/symptoms of infection, bleeding, pulsation or aneurysm dated 1/21/25. -Out of 61 opportunities the staff documented: -(n) 50 times. -(m) twice. -NA six times. -(no/-) three times. -None of the above were in the chart code. Review of the February 2025, Dialysis Communication Tools received by the facility on 2/21/25 at 8:37 A.M. showed: -No documentation for the following days; 2/3, 2/5, 2/14, and 2/19. -Documentation on 2/17 was not completed by dialysis unit. -There was no documentation the dialysis unit had been contacted to retrieve the information. --NOTE: The facility did not have this documentation at the time of survey. The facility contacted the dialysis center for the information after it was requested during survey. During an interview on 2/21/25 at 1:30 P.M. the DON said: -There was no Communication Tool from the Dialysis unit before 1/17/25 for this resident. -They must have done something different at the dialysis unit for the weight to have been the same before and after treatment. -He/She would not have expected the facility staff to have question the weight being the same before and after treatment. -Documentation from the dialysis unit did not show the resident had any extra treatments. -He/She would have expected there to have been a Communication Tool to have came back with the resident after every treatment and that it was completely filled out. -The Communication Tool should have been downloaded into the resident's chart every week. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She would have expected nursing staff to have ensured the Communication Tool came back with the resident and if that was not done staff should have called the dialysis unit to have them fax the document, this has not been done. 3. Review of Resident #32's face sheet showed he/she had been admitted to the facility on [DATE] with a diagnosis of Acute Kidney Failure. Review of the resident's January 2025, Dialysis Communication Tools received by the facility on 2/21/25 at 8:37 A.M. showed: -There were two Dialysis Communication Tools dated 1/1/25 by the facility. -(A) showed the date on the facility's section was 1/1/25. -The date on the dialysis section was 12/30/24. -(B) showed the date on the facility's section was 1/1/25. -The date on the dialysis section was 1/1/25. -Documentation on 1/8/25 did not show a code status (a person's predetermined medical instructions regarding the use of life-saving measures in the event they stop breathing) on the facility's section. -Documentation on 1/10/25 was a different form. The form did not have a place for the resident's code status, nor was it documented anywhere on the facility's section. -Documentation on 1/13/25 did not show a code status on the facility's section. -Documentation on 1/13/25 was a different form. The form did not have a place for the resident's code status, nor was it documented anywhere on the facility's section. -Documentation on 1/15/25 did not show a code status on the facility's section. -Documentation on 1/15/25 was a different form. The form did not have a place for the resident's code status, nor was it documented anywhere on the facility's section. --The pre dialysis weight was documented by the dialysis unit as 119/68. --The post dialysis weight was documented by the dialysis unit as 119/68. -Documentation on 1/17/25 did not show a code status on the facility's section. -Documentation on 1/17/25 was on a different form. The form did not have a place for the resident's code status, nor was it documented anywhere on the facility's section. -There was no documentation on 1/20/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab of Kansas City South	8033 Holmes Kansas City, MO 64131

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Documentation on 1/27/25 was not completed by the facility or the dialysis unit. -There was no Dialysis Communication tool on 1/29/25. -There was no Dialysis Communication tool on 1/31/25. --NOTE: The facility did not have documentation from 1/1/25 -1/27/25 at the time of survey. The facility contacted the dialysis center for the information after it was requested during survey. Review of the resident's January 2025 Nurses' Administration Record showed: -Upon return from dialysis palpate the resident's right arm shunt for thrill and listen for the bruit. Repeat twice within eight hours post dialysis. -If either was absent notify the physician and document findings. -Check the bruit and thrill every shift routinely, every Monday, Wednesday, and Friday. -Document Y for audible bruit and thrill. -Document N if there were no audible sound and notify the physician immediately, dated 4/10/24. -Out of 93 opportunities (three times 31 days) there was no Y or N they were marked with an X. -X was not in the chart code. Review of the resident's quarterly MDS dated [DATE] showed: -He/She was cognitively intact. -He/She had ESRD. -He/She was on dialysis. Review of the resident's February 2025 Nurses' Administration Record showed: -Upon return from dialysis palpate the resident's right arm shunt for thrill and listen for the bruit. Repeat twice within eight hours post dialysis. -If either was absent notify the physician and document findings. -Check the bruit and thrill every shift routinely, every Monday, Wednesday, and Friday. -Document Y for audible bruit and thrill. -Document N if there were no audible sound and notify the physician immediately, dated 4/10/24. -Out of 70 opportunities (three times 31 days) 43 times they were marked with an X. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-X was not in the chart code. -N was marked 23 times, there was no documentation the physician was notified. -There were four Vs. Review of the resident's February 2025 POS showed the following orders: -Dialysis on Monday, Wednesday, and Fridays, dated 7/1/24. -Upon return from dialysis palpate right arm shunt for thrill and listen for the bruit. Repeat twice within eight hours post dialysis. -If either was absent notify the physician and document findings. -Check the bruit and thrill every shift routinely, every Monday, Wednesday, and Friday. -Document Y for audible bruit and thrill. -Document N if there were no audible sound and notify the physician immediately, dated 4/10/24. Review of the resident's care plan dated 2/5/25 showed: -He/She was to receive dialysis three times a week on Monday, Wednesday, and Friday. -Staff was to Auscultate the Bruit and palpate the Thrill to the right arm shunt every shift. -Staff was to notify the physician of abnormalities or absence. -Monitor the dialysis site as ordered. -Monitor vital signs before and after Dialysis. Review of the resident's February 2025, Dialysis Communication Tools received by the facility on 2/21/25 at 8:37 A.M. showed: -There was no Dialysis Communication Tool on 2/3/25. -Documentation on 2/5/25 was blank (not completed by the dialysis unit). -Documentation on 2/7/25 was blank (not completed by the dialysis unit). -There was no Dialysis Communication tool on 2/10/25. -Documentation on 2/12/25 was blank (not completed by the dialysis unit). -Documentation on 2/14/25 did not include vital signs taken by the facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--NOTE: The facility did not have this documentation at the time of survey. The facility contacted the dialysis center for the information after it was requested during survey. 4. Review of Resident #33's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of ESRD. Review of the resident's care plan dated 1/13/25 showed: -He/She had a behavior problem and would refuse to go to dialysis. -He/She received dialysis. Review of the quarterly MDS dated [DATE] showed: -He/She was cognitively intact. -He/She had ESRD. -He/She was on dialysis. Review of the resident's January 2025, Dialysis Communication Tools received by the facility on 2/21/25 at 9:37 AM. showed: -There was no documentation showing that the resident went to dialysis or refused to go to dialysis from 1/2/25 to 1/15/25, missing five dates. -Documentation on 1/17/25 was a different form. The form did not have a place for the resident's code status, nor was it documented anywhere on the facility's section. -There was no documentation showing that the resident went to dialysis or refused to go to dialysis from 1/18/25 to 1/31/25, missing six dates. --NOTE: The facility did not have this documentation at the time of survey. The facility contacted the dialysis center for the information after it was requested during survey. Review of the resident's February 2025, Dialysis Communication Tools received by the facility on 2/21/25 at 9:37 A.M. showed: -On 2/5/25 there was no documentation showing that the resident went to dialysis or refused to go to dialysis. -On 2/12/25 there was no code status on the facility's part of the Dialysis Communication Tool. -There was no post dialysis weight documented by the dialysis unit. -There was no documentation showing that the resident went to dialysis or refused to go to dialysis on 2/14/25 or 2/17/25. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--NOTE: The facility did not have this documentation at the time of survey. The facility contacted the dialysis center for the information after it was requested during survey. Review of the resident's February 2025 POS showed a physician order for Dialysis three times a week on Monday, Wednesday, and Friday, dated 12/9/24. During an interview on 2/19/25 at 11:15 A.M. the resident said: -He/She has a Peripherally Inserted Central Catheter (PICC a long think flexible tube inserted into a person vein in the arm) line on his/her chest. -Staff did not look at the PICC site when he/she would return from dialysis. -The resident some times refuses dialysis. -The staff was supposed to have sent a sheet with his/her vitals on it to the dialysis unit and he/she was supposed to have brought the sheet back from the dialysis unit with the dialysis information on it. He/She would give the dialysis staff the notebook when he/she went to dialysis, but he/she did not look in the notebook. -He/She did not look in the notebook, so he/she may have taken an empty notebook back and forth. During an interview on 2/21/25 at 10:30 A. M .,Licensed Practical Nurse (LPN) A said: -The resident had a PICC line in her chest and they did dialysis through that line. -This resident was his/her own person and often refused to go to dialysis. -If the resident refused, they were to document on his/her medical record as well as the Dialysis Communication Record that the resident had refused. -He/She ensured the resident's refusal had been documented but did not think other staff did. -On the Dialysis Communication Record should have been completely filled out with the vital signs, code status and the other information on the sheet. -The dialysis unit was to completely and accurately complete their part of the Dialysis Communication Record. -The dialysis unit should have ensured the resident's pre and post weights as well as vital signs and any difficulties. -There should have been a Dialysis Communication Sheet filled out completely by the facility and the dialysis unit that was accurate every time the resident went to dialysis. -If a Dialysis Communication Sheet did not come back from the dialysis unit the receiving nurse should have called the dialysis unit to have it faxed back to the facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-That did not always happen. -The receiving nurse should have seen that the resident's weight was the same before and after dialysis there might have been a reason but there was no not stating why the weight was the same. -The nursing staff should have documented the dialysis site assessment the same way and it was not being done. -He/She could not tell what the documentation concerning the dialysis site meant. -He/She said maybe they need some education. -The DON was ultimately responsible for ensure documentation was done correctly and accurately every time. -The resident had a dialysis notebook that he/she was to take to dialysis and had them fill out, bring it back and upload the information weekly. -They have called the dialysis center to notify them the notes have not been coming back with the residents and they were still not sending the notebook with documentation back as they should. 5. During an interview on 2/24/25 at 1:30 P.M. the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) said: -The receiving nurse should have looked at the dialysis notes from the dialysis unit to ensure that they were completely filled out and were accurate. -He/She could not think of a reason that the pre and post dialysis weights would have been the same. -If the dialysis unit did not send a note back or it was incomplete the nurse should have called the dialysis unit back to retrieve the note. -If a resident refused to go to dialysis then it should have been documented in the Nurses' Notes. -The assessment of the dialysis site on the Nurses' Administration record should have been recorded as Y (yes there was an infection or bleeding at the site) or N (no bleeding or infection) the staff has not been doing that. -The DON was ultimately responsible for ensuring there was complete and accurate documentation that went to the dialysis unit and came back from the dialysis unit every time. During an interview on 2/26/25 at 9:37 A.M. LPN C said: -There are several residents that go out to dialysis. -If a resident declined to go out to dialysis it should have been charted in the Nurses' Notes. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident should have received education and the physician should have been notified. -The note from the facility should have included vital signs and code status. -The note when it came back from dialysis should have been viewed by the receiving nurse to ensure it was filled out completely and correctly. -The note should have included pre and post weights and vital signs as well as anything unusual. -The dialysis unit did not always send the note back. -The receiving nurse would have then contacted the dialysis unit to retrieve the documentation. -It has been a struggle to get the note from the dialysis unit. -The weights should never have been the same as they take fluid off of the resident. -The dialysis shunt should always have been assessed to ensure there was not bleeding or infection. -The documentation would have been on the progress notes not the nurses' notes. -The thrill should have been document as (+) if it was felt. -If the thrill was not felt then it should have been documented as (-). -The staff was documenting the assessments many different ways and was not able to understand their documentation. -The DON was ultimately responsible for ensuring staff was documenting correctly and documentation came back from the dialysis unit every time a resident went to dialysis. During an interview on 2/26/25 at 12:10 P.M. the DON said: -The facility should have had written communication with the dialysis unit. -There was a sheet that was started at the facility then went to the dialysis unit in a binder with the resident. -The sheet should have been filled out by both the facility and the dialysis unit then it would have been sent to Medical Records to have been downloaded into the resident's medical record. -The sheet should have included vital signs and weights before and after dialysis. -The facility licensed nurse on duty at the time of the resident return from dialysis assesses the resident's vital signs and dialysis access and reviews the resident's dialysis communication form and if there is missing information, the licensed nurse should then contact the dialysis center and obtain the missing information and should confirm any information regarding the resident's pre and post-dialysis weights as needed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The DON should have been notified if a resident did not have three completed sheets from dialysis every week. This has not been done. -If a resident refused to go to dialysis then it should have been document in their chart. -The sheet the facility filled out should have included a code status. -If the resident's weight was the same pre and post dialysis he/she would have expected the nurse to have called the dialysis unit to find out why. -They have had a lot of issues with the dialysis unit sending the sheets back with the resident. -Staff should have documented the shunt assessment in the same way not three or four different ways. They should have all charted the same way. -He/She was ultimately responsible for ensuring staff was documenting the same way. -He/She had not audited the dialysis notebooks or assessments.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 43345 Based on observation, interview and record review, the facility failed to post staffing information that consistently included the facility name, daily census, and the actual hours worked per shift for each of the three categories of nursing employees: Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs)/Certified Medication Technicians (CMTs) directly responsible for resident care. The facility census was 92 residents. Review of the facility's Nurse Staffing Posting Policy, revised June 2020 showed: -The facility would post the staffing on a daily basis and would have included: --Facility name. --The current date. --The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: ---RN's. ---LPN's. ---CNA's. --Resident Census -The facility would post the nursing data specified above, on a daily basis at the beginning of each shift. -Data must be posted in a clear and readable format and in a prominent place accessible to residents and visitors. 1. Observations on 2/19/25 at 11:15 A.M., 2/20/25 at 9:30 A.M., and 2/21/25 at 9:50 A.M., showed the posted staffing sheet did not show the total number worked for RN's, LPN's, or CNA's. During an interview on 2/24/25 at 1:16 P.M., Staffing Coordinator said: -He/She filled out the form the facility used for staffing. -The form did not have a space for actual hours worked for all staff by job title. -If the form had that spot he/she would have filled it in. -He/She did not know that he/she needed total hours worked per job title. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 11:05 A.M., the Administrator said: -He/She the Staffing Coordinator filled out and posted the form. -The Staffing Coordinator was responsible for filling out the staffing form. -He/She was unaware that the form needed total hours worked per job title. During an interview on 2/26/25 at 12:11 P.M., the (Director of Nursing) DON said: -He/She did not fill out the daily staffing form. -He/She did not verify that this was done. -It was his/her expectation that the staffing would be posted daily with the required information. -He/She did not realize the facility had been using the wrong form without all the required information.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to ensure medications were not left at the bedside unattended for three sampled residents (Residents #53, #57, and #23), out of 19 sampled residents, failed to ensure medication carts were maintained and locked when unattended by staff, failed to maintain cleanliness in the medication room, and failed to maintain the medication refrigerator temperatures within recommended ranges. The facility census was 92 residents. Review of the facility's policy, Storage of Medications, dated 8/2020 showed: -Medications and biologicals were to have been stored safely, securely, and properly, following manufacturer's recommendations. -The medication supply was accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. -Medication rooms, carts, and medication supplies were to have been locked when they were not attended by persons with authorized access. -Medication storage areas were to have been kept clean, well-lit, and free of clutter and extreme temperatures and humidity. -Medication storage conditions were to have been monitored on a regular basis by the consultant pharmacist and corrective action was to have been taken if problems were identified. -All medications were to have been maintained within the temperature ranges noticed in the United States Pharmacopeia and by the Centers for Disease Control (CDC). -Refrigeration was to have been 36 degrees Fahrenheit (F) to 46 F degrees, with a thermometer to allow temperature monitoring. -The facility should have checked the refrigerator in which vaccines were stored at least two times a day, per CDC guideline. Policy for medication administration was requested and was not provided. Review of The Nursing Drug Handbook 2017 retrieved on 3/6/25 showed: -Insulins: Store unopened insulin lispro (a rapid acting insulin) pens between 36 degrees F to 46 degrees F. Do not freeze. Do not use if frozen. --Insulin Lispro pens included: Admelog and Humalog. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Insulins: Store unopened insulin glargine (a long acting insulin) pens between 36 degrees F to 46 degrees F. Do not freeze. Discard if frozen. --Insulin Glargine pens included: Semglee and Lantus. 1. Observation on 2/24/25 at 7:15 A.M. of the medication pass on the south hallway with Licensed Practical Nurse (LPN) A showed: -He/She went into a resident's room to wash his/her hands. -He/She had left the medication cart facing outward in the hall, unlocked while in the room. -An unidentified resident rolled by the unlocked medication cart in his/her wheelchair. Observation on 2/24/25 at 7:20 A.M. of the medication pass on the south hallway with LPN A showed: -He/She came out to the medication cart to obtain the equipment to check the resident's blood sugar. -He/She left the cart unlocked facing outward in the hall while he/she went into the room to take the resident's blood sugar. -An unidentified resident walked by the outward facing in the hall unlocked cart. Observation on 2/24/25 at 7:48 A.M. of the nurses' medication cart on the south hallway with LPN A showed: -There was a large pink stain in the bottom of the first drawer which contained residents prescribed medications. -There was one round pink pill loose in the bottom of the medication drawer. -There was one half of a round blue pill loose in the bottom of the medication drawer. -In the top drawer with resident's prescribed medication there were the following items: --A used hair clip. --A lighter. --Two sets of car fobs to an unknown person's car. --A pair of used tweezers. Observation and record review on 2/24/25 at 8:13 A.M. of the medication room on the south hallway with LPN A showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no documentation of the medication refrigerators temperature on the Temperature log for the last two days. -The temperature documented the previous six days was at 32 F degrees or lower. -The Temperature Log said to maintain refrigerator temperature at 36 to 41 degrees F. -In the medication refrigerator there were the following medications: -Three vials of Tuberculin (TB - a sterile liquid used in a skin test to help diagnose tuberculosis -a serious bacterial infection that infects the lungs). -On the TB box it showed to not freeze, and was to have been stored at 36 to 46 F degrees. -Five Semglee unopened insulin pens. -Five unopened Admelog solostar insulin pens. -Four unopened Humalog insulin pens. -Four unopened Lantus insulin pens. -There was one round tan pill on the floor. -The only sink in the medication room was dirty with rust. -There was no paper towels so staff could wash and dry their hands. During an interview on 2/24/25 8:15 A.M., LPN A said: -The medication carts should always have been locked if you were not in front of it using it. -There should not have been a pink stain in the drawer it was probably from an old medication that had spilled. -There should not have been any loose pills in the drawers or on the floor. -There should not have been any personal items in the medication cart. -Whoever had used the medication cart should have ensured it was cleaned at the end of their shift. -Dietary was in charge of checking the refrigerator temperatures. -The temperature of the medication refrigerator should have been checked daily by the night nurse. -The temperature of the medication refrigerator should not have been below freezing, 32 F degrees. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pharmacy should have been notified that the medications had been stored at a temperature less than freezing to see what they recommended and that had not been done as far as he/she knew. -If the temperature was out of range maintenance should have been notified and that had not been done. -Housekeeping should have ensured the sink in the medication room was clean and that there were paper towels so nursing staff could wash their hands, they had been out of paper towels several days. -He/She did not think that the sink had been cleaned for a while. 2. Observation on 2/24/25 at 8:50 A.M. of the Certified Medication Technician (CMT) cart on the south hallway with CMT A showed: -The following loose pills were found in the drawers of the medication cart: -One white round pill. -One peach colored oblong pill. -One red capsule. -One white oblong pill. During an interview on 2/24/25 at 9:00 A.M. CMT A said: -Whoever was on the medication cart should have kept it clean. -There should not have been any loose pills in the drawers or on the floor. -Twice in the last month he/she had seen pills on the floor. -He/She would tell the nurse then pick up the pills from the floor and throw them away. -The medication carts should have been locked if you were not in front of it as there were some residents who would have tried to take something out of it. -There should not have been any personal items in the medication cart. -The housekeeper should have ensured the medication room sink was cleaned daily and that there were paper towels so you could have dried your hands after washing them. -The Unit Manager should have ensured the medication refrigerator was kept within the temperature range. During an interview on 2/24/25 at 1:30 P.M. the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) said: (continued on next page)

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	265758	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab of Kansas City South	8033 Holmes Kansas City, MO 64131

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There should not have been any loose pills or other objects in the medication cart with the residents medications. -There should not have been any pills on the floor. -The nurse was responsible for ensuring the temperature of the medication refrigerator was within range and checked every night. -If it was not within the range 36 to 46 degrees maintenance should have been notified. -The medication cart should not have been unlocked if he/she was not using it. -The nurse was responsible for ensuring the temperature of the medication refrigerator was within range and checked every night. -If it was not within the range 36 to 46 degrees maintenance should have been notified. -The medication cart should not have been unlocked if he/she was not using it. During an interview on 2/26/25 at 12:10 P.M. the Director of Nursing (DON) said: -There should not have been any medication found on the floor. -There should not have been any loose pills in the medication carts. -There should not have been any personal items in with the residents' medications. -The medication cart should have been cleaned after each shift by the staff member who used it. -The medication cart should have been locked if staff was not directly in front of it. -The nursing staff was responsible for ensuring the medication room was clean and that they had supplies such as the paper towels in it. -The nursing staff should have checked the medication refrigerator at least daily to ensure the temperature was within range and that none of the medications had been frozen. -The Charge Nurse was responsible for ensuring the medication refrigerator was checked to ensure it was within range and not below 32 degrees F. -If the medication refrigerator was out of range the DON should have been notified, he/she had not been told it had been out of range. -He/She could have readjusted the temperature and rechecked to ensure it was within range. -If medication such as insulin had been frozen it should have been thrown away and new insulin ordered from the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 2/26/25 at 9:45 A.M., north nursing station medication cart showed: -Left unlocked facing outwards toward the hallway and unattended by staff. -One resident observed to roll by in his/her wheelchair past the medication cart while unlocked. 4. Review of Resident #23's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain). -Heart failure (a condition in which the heart does not pump blood as well as it should). -Hemiplegia and Hemiparesis following cerebral infarction affecting right non-dominate side (a condition that causes weakness or paralysis (loss of muscle function) on on side of the body after blood flow to the brain was reduced. -Dysphagia (a difficulty swallowing foods or liquids). -Altered mental status (a change in a person's level of consciousness, awareness, and cognitive function). -Muscle weakness. Review of the resident's care plan dated 1/7/25 showed: -He/She was able to feed self once the meal tray was set up. -There was nothing about the resident able to self administrate their own medications. Review of the resident's entry Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 1/21/25 showed: -He/She was moderately cognitively impaired. -He/She was impaired on one side. -He/She needed set up assistance to eat. Review of the February 2025 Physician's Order Sheet showed the following orders: -Crush oral medications or open capsules and mix all medications together for administration with medium of resident's choice, dated 12/4/24. -There was order to leave medications at bedside. Observation on 02/19/25 at 9:53 A.M. showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was not in the room. -There was a pill cup toppled over on the resident's bedside tray table. -There were two white oblong pills and one round blue pill under the resident's bed. -The roommate was severely cognitively impaired. Observation on 2/21/25 at 12:28 P.M. showed: -The resident was not in the room. -There was a cup with four pills in it sitting on the resident's bedside tray table. -One tan oblong pill, one dark brown capsule, one round white pill, one round blue pill. During an interview on 2/24/25 at 8:13 A.M. LPN A said: -The resident was most likely at dialysis. -There should not have been any medications left at bedside. -None of the resident's had a physician's order stated that medications could have been left at bedside. -Nurses were responsible to ensure the residents took their medications and that the medication was not left at the bedside. -Staff was to watch to make sure the residents took the medication and did not choke. -The facility had provided education on ensuring residents took their medications and staff did not just leave the medications at bedside. -This resident did not have an order to leave any medications at bedside. -His/Her medications were to have been crushed and put in applesauce or pudding. 46890 5. Review of Resident #57's quarterly MDS dated [DATE] showed the resident was cognitively intact. Observation and interview on 2/19/25 at 9:46 A.M., showed: -The resident was sitting on side of his/her bed. No facility staff present. -Showed he/she had a medication cup with pills inside not dated or marked on top of his/her dresser. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She said that it was his/her morning medication and staff had always left at his/her bedside before he/she took it. 6. Review of Resident #53's quarterly MDS dated [DATE] showed the resident was cognitively intact. Observation and interview on 2/25/25 at 10:10 A.M., showed: -The resident was in his/her bed asleep. His/Her breakfast tray on over the bed table with medication cup of pills on tray not marked or dated. No staff present. -He/She had woke up and said that it was his/her morning medication and had fallen back to sleep before taking. -He/She said that staff often left his/her medication on the meal tray. 7. During an interview on 2/24/25 at 8:00 A.M. CMT A said: -None of the residents had an order to leave medications at their bedside. -There would have had to had a physician's order to leave the medication at bedside. -He/She had seen pills left at the bedside from the previous shift twice this month. -He/She had told the nurse and then threw the pills away. -The Charge Nurse was responsible for ensuring medication were not left at bedside. -You need to watch the residents swallow the pills to ensure they don't choke. -He/She had seen other residents roam into other resident's rooms so you needed to ensure pills were not left at bedside because a different resident might have taken them. During an interview on 2/24/25 at 1:30 P.M. with the ADON said: -There should not have been any pills left at bedside or on the floor. -Staff needed to watch to ensure the residents took their medications. During an interview on 2/26/25 at 9:39 A.M., Certified Nursing Assistant (CNA) A said medication should not be left at resident bedside and if he/she saw them he/she would have thrown them in the trash and told the nurse. During an interview on 2/26/25 at 9:46 A.M., CMT A said medication should not be left at the bedside. He/She would take to the nurse if found. During an interview on 2/26/25 at 10:07 A.M., LPN A said: -Medication should not be left at bedside unless there is a physician order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She would be responsible make sure staff are not leaving medication unattended. -Medication administration competencies are done yearly During an interview 2/26/25 at 12:10 P.M., the DON said: -He/She would expect medication not to be left at resident bedside if no physician orders. -He/She would be responsible for medication administration training and audits are completed. -Staff was to have watched the residents take their medications. -There should never have been any pills left at bedside or spilled on the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to ensure three sampled dialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidney were not functioning properly) residents (Resident #23, Resident #32, and Resident #33) and one supplemental resident who had a feeding tube (a medical device that delivers liquid nutrition directly to the stomach through a surgically created opening in the abdominal wall), (Resident #42) were on Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) out of 18 sampled residents and one supplement resident, failed to adequately educate the staff about EBP, and failed to have EBP or isolation signs on the door and isolation carts (a container that contained Person Protective Equipment (PPE - clothing and other equipment designed to protect the wearer from the risk of injury of infection) at the resident's rooms or in the hallway. The facility census was 92 residents. Review of the facility's policy, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multi-Drug Resistant Organisms (MDROS) dated July 12, 2022 showed: -EBP may be indicated for residents with any of the following: -Wounds or indwelling medical devices. -Infections. -Effective implementation of EBP requires staff training on the proper use of personal protective equipment and the availability of PPE and hand hygiene supplies at the point of care. 1. Observation on 2/19/25 at 9:30 A.M. of 300 and 400 hallways did not show: -Any signs on the following residents' doors (Resident #23, Resident #32, Resident #33 or Resident #42), which showed the staff was to use EBP when doing cares with the residents on those hallways. -Any isolation equipment at any of the residents' rooms or in the hallway. Observation on 2/19/25 at 1:30 P.M. of 300 and 400 hallways did not show: -Any signs on the following residents' doors (Resident #23, Resident #32, Resident #33 or Resident #42), which showed the staff was to use EBP when doing cares with the residents on those hallways. -Any isolation equipment at any of the residents' rooms or in the hallway. Observation on 2/20/25 at 9:15 A.M. of 300 and 400 hallways did not show: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Observed the two CNAs as they entered the resident's room and closed the curtain around the resident to change the resident's brief without wearing a gown. -There was no sign on the resident's door indicating EBP precautions were to have been used with the resident. -There was no isolation cart with PPE in the hallway or in the resident's room. During an interview on 2/19/25 at 2:30 P.M. the resident said: -When the staff performed cares such as changing his/her brief or assessing his/her dialysis shunt, they wore gloves but no gown. -He/She had not seen a sign on his/her door about EBP or an isolation cart outside the room. 3. Review of Resident #33's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Periorbital cellulitis (infection of the skin surrounding the eye). -ESRD. -Other bacterial infections. -He/She resided on the 400 hallway. Review of the resident's quarterly MDS dated [DATE] showed: -He/She was cognitively intact. -He/She was occasionally incontinent of urine. -He/She was frequently incontinent of stool. -He/She was on dialysis. -Wound infections was not checked. Review of the resident's care plan dated 1/13/25 showed: -He/She needed the assistance of one staff member for bathing. -He/She had a genital infection. -Staff was to maintain universal precautions when providing resident care. -He/She received renal dialysis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff was to auscultate Bruit and palpate Thrill to shunt every shift and notify physician of abnormalities or absence, dated 5/7/24. -Staff was to change dressing daily at access site as ordered, dated 5/7/24. -Did not show the resident was to have been on EBP. Review of the resident's February 2025 POS showed the following orders: -Assess dialysis shunt site (right chest) every shift for signs/symptoms of infection, bleeding, pulsation or aneurysm, dated 12/9/24. -Dialysis on Monday, Wednesday, and Fridays, dated 12/9/24. -EBP when dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting, dated 2/14/25. -Apply Vaseline or Aquaphor (an ointment that enhances skin healing) four times a day on eyelid until follow up appointment at the eye clinic, dated 2/27/24. -Cleanse legs with soap and water pat dry. Apply Calcium Alginate (a natural absorbent biodegradable substance used in wound dressings)to right lower leg. Cover with ABD (abdominal pads - used do help keep wounds dry) pads. Wrap and secure with kerlix (bandage rolls which provide absorbency). Dressing to have been changed twice a day for Osteomyelitis (a bone infection) dated 2/20/25. -Miconazole 7 Vaginal (used to treat vaginal infections) Cream 2% insert one application vaginally every 12 hours for Candida (a yeast infection), dated 12/7/24. -Nystatin (a powder used to treat yeast infections) External Powder 100000 unit/gram to apply to bilateral pannus folds (an abnormal extra layer of skin on the abdomen) topically every six hours as needed for skin condition, dated 12/7/24. -There was no order for the resident to have been on EBP. During an observation and interview with the resident on 2/20/25 at 9:10 A.M.: -He/She said: --The staff had not been using EBP (gown or gloves) when checking his/her dialysis site. --The staff did wear gloves but not a gown when they applied a cream to his/her genital area. --The staff did not wear a gown when they put an ointment on his/her eye. --The staff did not wear a gown or gloves when they bathed him/her. --He/She had the toes on both feet surgically removed in the fall of last year. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--He/She was not able to see if the surgical sites had healed. --He/She said there was no sign on his/her door nor any isolation cart. --He/She had open areas on his/her legs that weeped from cellulitis (skin infection). --He/She had a surgical site on left eye was open to air (where they had surgically removed extra skin). --He/She had a dialysis access was a PICC (a Peripherally inserted central catheter, a thin flexible tube inserted into a vein and threaded into a large vein in the heart) line on the right side of his/her chest. -There was no sign outside of his/her door indicating staff was to wear PPE. -There was no isolation cart at the door of the resident's room. -Observation showed the resident had a surgical site under his/her left eye. -Observation showed the resident had a PICC line on the right side of his/her chest. -Observation showed the resident had several open areas on his/her legs that were weeping. -Observation showed an open area on both of the resident's feet from old surgery where his/her toes had been amputated. During an interview on 2/21/25 at 10:30 A.M. Licensed Practical Nurse (LPN) A said: -He/She knew the resident had a PICC line in her chest and they did dialysis through that line. -They check the site for redness or warmth or drainage every shift and is on the Treatment Administration Record (TAR). -He/She did not know what EBP was. -They just started to put signs on the doors saying to See Nurse and putting isolation containers on the doors since survey started. 4. Review of Resident #42's quarterly MDS dated [DATE] showed: -He/She was moderately cognitively impaired. -He/She had a feeding tube. -He/She resided on the 300 hallway. Review of the resident's February 2025 POS while on site showed the following orders: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Aquaphor (ointment used to apply to dry skin) to have been applied four times a day on the resident's left eyelid. -Staff was to follow EBP, dated 2/14/25. -Staff was to assess dialysis shunt site (PICC) right upper chest daily. Observation of tube feeding administration on 2/24/25 at 9:00 A.M. with LPN A showed: -The nurse entered the room set up supplies and started to flush the resident's feeding tube with water. -The nurse was stopped and asked twice if he/she had forgotten anything and he/she responded no. -The nurse was wearing gloves but not an isolation gown. -There was a sign on the resident's door that said See Nurse. -There was an isolation container with gowns and gloves hanging on the door to the resident's room. During an interview on 2/24/25 at 9:25 A.M. LPN A said: -They had just started using the isolation carts after survey started. -The ADON had talked about EBP a couple of weeks ago but he/she forgot what they were supposed to have done. -He/She did not know why a resident would have been on EBP. 5. Review of Resident #32's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnosis: -Acute kidney failure. -He/She resided on the 300 hallway. Review of the resident's quarterly MDS dated [DATE] showed: -He/She was cognitively intact. -He/She was on dialysis. Review of the resident's February 2025 POS showed the following orders: -Dialysis on Monday, Wednesday, and Friday. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-EBP when dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting every shift, dated 2/14/25. -Upon return from dialysis palpate right arm shunt for thrill and bruit. Repeat twice within eight hours post dialysis. Check bruit and thrill every shift routinely. -May apply Barrier cream as needed to redness or excoriation (skin that has been scraped away which resulted in scratches or wounds) after incontinent episodes every morning and night for skin breakdown dated 11/30/23. Review of the resident's care plan dated 2/5/25 showed: -He/She needed the assistance of one staff member for bathing/showering and dressing. -He/She received dialysis three times a week. -Staff was to auscultate the Bruit and palpate Thrill to right arm shunt every shift. -The care plan did not include using EBP with the resident. During an interview on 2/20/25 at 1:59 P.M. the resident said: -He/She goes out to dialysis. -He/She declined allow wound care/dialysis shunt cares to be observed. -The staff did not always check his/her dialysis shunt like they were supposed to. -When they checked his/her dialysis shunt they did not wear a gown or gloves. -When they checked his/her heel they did not wear gloves or a gown, he/she frequently had open heel sores. -Staff had just put up a sign on his/her door which said to see Nurse. -Staff had just put a isolation station at his/her door today. -He/She had not received education from the nursing staff about why there was a sign on his/her door or why staff was wearing PPE. 6. During an interview on 2/24/25 at 1:30 P.M. LPN/Infection Preventionist (IP) said: -EBP had started in the building on 2/14/25. -He/She had provided education with the staff about EBP by doing 1:1 education. -There had not been signs which showed the staff or visitors were to see the nurse on the third or fourth hallways. (continued on next page)

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	02/26/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The nurse would have told the staff or visitors to wear EBP if doing cares with the residents. -The staff should have been told in report that EBP was needed on which residents and why. -There should have been an order for EBP from the physician. -It should have been in a resident's care plan that EBP was needed by the MDS Nurse. -If a resident had open areas on their skin, had a foley, a PICC line, dialysis shunt, or a feeding tube, they should have had EBP. -He/She did not put the isolation containers or signs on the door of the third and fourth hall until the second day of survey. -He/She was responsible for ensuring that staff were educated on EBP, that there were signs on the residents door for those who needed EBP, there were isolation containers at the residents door, and should have done spot checks to ensure staff was following EBP protocol. -There were many residents at the facility that were on EBP. During an interview on 2/26/25 at 9:37 A.M. LPN B said: -They had education provided by the ADON about two weeks ago but he/she could not recall what the education included. He/She did not know what PPE should be included for EBP or when to use EBP. -They just started to put signs on the resident's doors which said See Nurse, and have isolation containers on some of the residents doors on Tuesday after the survey started. -They were to wear gloves and gowns when working with a resident who had a foley (tube that goes into the bladder to drain urine), peg tube, open wound, dialysis shunt, or PICC line. During an interview on 2/26/25 at 10:25 A.M. Certified Medication Technician CMT B said: -There might have been education about a month ago that the ADON provided 1:1 with the staff about EBP, but he/she could not recall what the education included. He/She did not know what PPE should be included for EBP or when to use EBP. -They had just put out the signs and isolation carts after survey started. -He/She did not know why a resident would have been on EBP. During an interview on 2/26/25 at 12:10 P.M. the Director of Nursing (DON) said: -If staff were to use EBP on a resident there should have been a sign on the door stating staff was to wear PPE when working with the resident. -An isolation container with PPE was to have been available at the resident's doorway. (continued on next page)

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	02/26/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-EBP was not put in place until after the start of survey. -Education about EBP had been provided by the IP maybe 2/14/25. -No education had been provided to the residents or family about EBP. -Any resident who had a foley, PICC line, Dialysis shunt, feeding tube, or an open wound should have been on EBP. -