STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175158	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN TERRACE AT OVERLAND PARK	**7541 SWITZER ROAD OVERLAND PARK, KS 66214**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 108 residents. The sample included 26 residents. Based on interviews and record review the facility failed to inform a family member of Resident (R) 210's change in condition. Findings included: - R210's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE], documented R210 required total assistance of one to two staff for all Activities of Daily Living (ADLs). The MDS documented severely impaired cognition. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/20/20, documented R210 was unable to make needs known and was in need of total assistance with all ADLs. The Care Plan revised 06/09/20, documented R210 dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. The Care Plan instructed staff to encourage ongoing family involvement. In a telephone interview on 08/25/20 at 11:45 AM, R210's family member stated no knowledge of R210's change in skin condition until her hospitalization on [DATE], when the family observed her in the emergency room . The EMR dated 02/13/20, documented three responsible party/emergency contacts. A Progress Note dated 08/03/20, documented R210 continued to decline and subsequent transfer by ambulance to the emergency department. The EMR lacked evidence of family or responsible party notification. On 08/27/20 at 08:48 AM, Administrative Nurse E verified the lack of evidence in R210's EMR of family notification of change in status. On 08/27/20 at 01:25PM, Administrative Nurse D stated she would expect families would be notified with any change in condition. Upon request, the facility did not provide a Notification of Change policy. The facility failed to notify R210's family of change in condition, placing the resident at risk for inconsistent family involvement with her care.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 108 residents. The sample included 26 residents. Based on observations, record review and interviews, the facility failed to provide a home like environment in the dining room areas for the 17 residents on English Ivy Avenue, for the 15 residents on Forsythia Boulevard and the 16 residents on Geranium Court. Findings included: - On 08/25/20 at 07:30 AM residents sat at the tables in the dining room on English Ivy Avenue with no music, no food or activities noted. Several residents attempted to leave the dining room and staff redirected the residents to return to their seats. The breakfast trays arrived at 08:21 AM, 51 minutes later. On 08/26/20 at 07:33 AM residents sat at the tables in the dining room on Forsythia Boulevard with the TV on in the common area across from the dining room area. The residents did not have any liquids or food offered while waiting for the breakfast cart. The breakfast cart arrived at 08:05 AM, 32 minutes later. On 08/26/20 at 11:33 AM residents sat in the dining room on English Ivy Avenue until the lunch cart arrived at 12:17 PM, 45 minutes later. Some of the residents were offered magazines. On 08/27/20 at 11:45 AM residents sat in the dining room on Geranium Court till the lunch cart arrived at 12:42 PM, 57 minutes later. No activities were noted during that period of time. On 08/27/20 at 10:31 AM Certified Nurese Aide (CNA) M stated the staff started taking the residents to the dining room [ROOM NUMBER] minutes prior to meal times. The independent residents take them selves to the dining room. The staff offer fluids and snacks to the residents. On 08/27/20 at 01:40 PM Administrative Nurse D stated that an acceptable times residents sat and waited for meals in the dining room depended upon the resident. The residents are not allowed to have food or liquids until staff are able to be in the dining room. The facility Meal Service policy revision date of 04/29/19 documented each resident was served a minimum of three well-balanced meals per day. The facility failed to provide, for the 17 residents on English Ivy Avenue, for the 15 residents on Forsythia Boulevard and the 16 residents on Geranium Court, a home like environment in the dining rooms and to de-emphasize the institutional character of the dining experience.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 108 residents. The sample included 26 residents. Based on observation, record reviews and interviews, the facility failed to provide bathing for two dependent Residents (R) 73 and R210. Findings included: - R73's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. The MDS documented R73 required extensive assistance of one staff member for bathing. R73's Cognitive Loss and Dementia Care Area Assessment (CAA) dated 07/10/20 documented he retained the ability to assist with his Activities of Daily Living (ADLs). The Care Plan dated 07/10/20 documented R73 required maximum assistance with bathing. The EMR, under the Tasks tab, documented R73's bath days were scheduled on Tuesdays and Friday's, day shift. The bathing task, reviewed June 1, 2020 through August 23, 2020, revealed R73 had not received a bath on 06/02/20; 06/16/20; 06/23/20, 07/10/20; 07/14/20; 07/21/20; 07/24/20, 08/11/20, and 08/22/20. On 08/25/20 at 03:00 PM R73 ambulated out of his room down the hallway, with his walker, unassisted. Nursing staff approached him and verbally educated him on the use of the call light and the need of staff assistance for safety when he ambulated. On 08/27/20 at 10:31 AM Certified Nurses Aide (CNA) M stated the staff knew who had a bath for that day from the Kardex. R73's bath schedule was on the day shift on Tuesdays and Fridays. On 08/27/20 at 11:45 AM Licensed Nurse (LN) H stated the residents' bath days were listed on the CNA assignment sheets they were given every day. On 08/27/20 at 01:40 PM Administrative Nurse D stated the staff knew to care for the residents from the information in the Kardex. The residents bath days were decided by their room numbers and were given two times weekly. If there were no charted initials on the bath scheduled tasks, then the bath was not given. The facility policy Activities of Daily Living (ADL's), with revision date of 04/22/19, documented a resident who is unable to carry out ADL's received the necessary services to maintain good nutrition, grooming and personal oral hygiene. The facility failed to provide R73's showers consistently accordingly to his schedule. This had the potential for poor hygiene and decreased self-esteem. - R210's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE], documented R210 required total assistance of one to two staff for all Activities of Daily Living (ADLs). The MDS documented severely impaired cognition. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/20/20, documented

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

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.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) R210 was unable to make needs known and was in need of total assistance with all ADLs. The Care Plan revised 06/09/20, documented R210 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. The EMR, under Tasks tab, documented R210's bath days were scheduled twice a week. The Bathing Task reviewed July 01, 2020 to July 31, 2020 documented one shower given on 07/12/20 for the month of July 2020. In a telephone interview on 08/25/20 at 11:45 AM, R210's family member stated R210's toenails were dirty, uncut, crusted with blood, and R210 had an overall unbathed appearance. On 08/27/20 at 07:53 AM, Certified Nursing Assistant (CNA) P confirmed R210 required total assistance with all cares, repositioning, and meals. CNA P confirmed all residents received showers twice a week on the days or evenings they preferred. On 08/27/20 at 01:40 PM, Administrative Nurse D stated the staff knew to care for the residents from the information in the Kardex. The residents' bath days were decided by their room numbers and were given two times weekly. If there were no charted initials on the bath scheduled tasks, the bath was not given. The facility policy Activities of Daily Living (ADL's), with a revision date of 04/22/19, documented a resident unable to carry out ADL's received the necessary services to maintain good nutrition, grooming and personal oral hygiene. The facility failed to provide R210's showers consistently, placing the resident at risk for poor hygiene and decreased self-esteem.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 108 residents. The sample included 26 residents. Based on interviews and record reviews the facility failed to complete wound care as ordered by the physician for one Resident (R) 210 of three residents sampled for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) /injury. Findings included: - R210's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE], documented R210 required total assistance of one to two staff for all Activities of Daily Living (ADLs). The MDS documented severely impaired cognition. The Pressure Ulcer/Injury Care Area Assessment (CAA) dated 02/20/20, documented R210 was unable to make needs known and was in need of total assistance with all ADLs. The CAA documented R210 at risk for skin breakdown due to incontinence and refusal of cares at times. The Care Plan revised 06/09/20, documented R210 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. The Care Plan instructed staff to apply Allevyn (foam dressing used to absorb drainage from wounds) as ordered, low air mattress to the bed, and pressure reducing cushion to her wheelchair. A physician's orders [REDACTED]. This was discontinued on 07/16/20. A physician's orders [REDACTED]. R210's Treatment Administration Record (TAR) dated from 07/01/20 to 07/31/20 lacked documentation of treatment to the right hip. On 08/27/20 at 08:48 AM, Administrative Nurse E verified the TAR lacked documentation of the wound treatment to the right hip. On 08/27/20 at 01:30 PM, Administrative Nurse D stated physician's orders [REDACTED]. The facility's Skin Integrity and Pressure Ulcer/Injury Prevention and Management policy dated 10/03/19, documented the facility staff would provide treatment and care of skin and wounds utilizing professional standards. The facility failed to provide wound care treatment as ordered which placed R210 at risk for inadequate wound healing and the potential for unwarranted complications.
F 0688 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 108 residents. The sample included 26 residents. Based on observations, interviews, and record review, the facility failed to prevent an avoidable reduction of range of motion (ROM) and/or mobility in Resident (R)70 by inappropriate positioning which resulted in his right shoulder dislocation/subluxation (when the humerus- upper arm bone comes out of the shoulder socket). . Findings included: - The electronic medical record (EMR) under the [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented R70 had a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. He required total assistance from staff of one to two with all activities of daily living (ADLS). He had limited range of motion (ROM) in both side of the upper and lower extremities. He continued to receive occupational therapy (OT) that began on 03/12/20. The Quarterly MDS dated [DATE], documented R70 had a BIMS of zero. He required total assistance of one to two staff with all ADLs. He had limited ROM in both side of the upper and lower extremities. He received OT beginning on 03/12/20. The ADL Care Area Assessment (CAA) dated 06/14/20 documented R70 admitted from the community for total care due to inability to care for himself. No falls occurred this quarter. He used a wheelchair and was unable to stand or walk. He had contractures of all four limbs. He received OT for his posture. The Care Plan last revised on 07/26/20 documented R70 had contractures to the upper and lower extremities and instructed staff to place pillows between R70's knees and ankles, and to put towels between his arms while in bed as tolerated. The care plan further instructed staff not to place pillows under R70's arms due to [MEDICAL CONDITION]; right shoulder immobilizer (a device that is used to hold your arm against your body) in place due to subluxed shoulder. Staff were educated on proper wedge cushion placement, licensed and certified nurse aide (CNA) educated to use a mechanical lift only for transfers. A physician's orders [REDACTED]. Place an immobilizer for right arm/shoulder dislocation dated 07/25/20. May continue orders for 75 days. A Health Status Note in the EMR under the Progress Notes tab dated 07/24/20 at 10:39 AM documented, reported to this nurse by CNA that resident would not lift right arm. Resident will feed himself finger foods and would not lift his arm to bring a banana to his mouth. There is a visual change in his right shoulder compared to his left shoulder. (Physician) was notified and an order for [REDACTED]. (Physician) and family notified. Will send resident to hospital, emergency services called. A Health Status Note under the Progress Notes tab in the EMR dated 07/24/20 01:35 PM documented that the ambulance arrived the resident transferred to a local hospital, and notified the emergency department. A Health Status Note under the Progress Notes tab in the EMR dated 07/24/20 at 07:54 PM documented resident returned to facility. Paperwork with right shoulder dislocation, reduced with a right arm/shoulder immobilizer in place. Keep sling in place, ice, and rest. Follow up with orthopedics. Resident assisted to bed by two ambulance attendants. Right shoulder immobilizer to be worn at all times. May remove immobilizer for bathing and dressing only. An Event Note under the Progress Notes tab dated 07/27/20 at 05:44 PM documented the interdisciplinary team (IDT) met to discuss R70's injury of unknown origin. The resident was not using his right arm, x-rayed done, and shoulder found to be dislocated. The facility conducted an Investigation by facility Administrative Nurse E and notarized by Administrative Staff A on 08/21/20. The summary of the incident documented: On 07/24/20 at approximately 09:00 AM CNA Q entered R70's room and discovered that his right arm was propped away from his body with a wedge cushion. Bed pillows separated the resident's extremities from his torso, and he had contractures that pose a pressure risk to skin integrity, however, the wedge cushion was not intended for this use. Resident was unable to move the utensil to his mouth during breakfast. The licensed nurse, family, and physician were notified. An x-ray showed a dislocation and the resident was sent to the ED for joint reduction. CNA MM worked the night shift before the injury was found and she was promptly contacted for a statement. At that time, it was believed that the wedge cushion was responsible for the dislocation. CNA MM stated that she used the wedge cushion instead of a bed pillow. It was reasonable that the leverage needed to insert the wedge cushion could have caused the dislocation. CNA MM was re-educated on the proper use of wedges and cushions, and may not be used for unintended purposes. The staff member did not act appropriately with wedge cushion use and received re-education to prevent future incidents. A notarized Witness Statement signed on 07/24/20 by CNA MM documented: On Friday the 24th (CNA MM) placed a pillow under resident's arm to relieve pressure from his pressure point elbow. The supervisor informed me that it was the wrong pillow. A Witness Statement signed by CNA Q and notarized by Administrative Staff A on 07/24/20 documented: CNA Q walked into R70's room to find him in bed with foot wedge under right arm/shoulder. When CNA Q removed the wedge from under arm to remove his night clothes, CNA Q noticed that his arm appeared to be more limp than normal. R70 did not appear to show any signs of discomfort during ADLS and transfer. We headed to breakfast, at the time of breakfast CNA Q noticed R70 appeared to not be able to feed himself as usual. At that time, CNA Q notified the charge nurse of concerns for R70. The charge nurse looked at R70's arm and called the doctor . An observation on 08/26/20 at 11:44 AM revealed R70 in his high back wheelchair beside the dining table in the dining area, sling noted to right arm/shoulder. Staff assisted R70 to eat . An observation of R70 on 08/26/20 at 03:45 PM revealed the resident lying in bed on his left side, sling in place to right arm/shoulder, and a pillow placed between his knees. In an interview with CNA MM on 08/26/20 at 03:47 PM she stated she used/put the wrong type of pillow under R70's right arm/shoulder. She could not find any regular pillow in his room, so she used the big pillow to put under his arm to elevate it. She was disciplined and re-educated about the proper types of pillows to be used for

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F 0688 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) repositioning. In an interview with CNA LL on 08/27/20 at 11:15 AM, CNA LL stated that at the start of each shift the aides received a report sheet that showed them how a resident transferred, what specific cares they needed, how much assistance each resident required, and if a resident required a lift. An interview with Licensed Nurse (LN) J on 08/27/20 at 12:40 PM stated on the day of the incident she was just coming on to her shift. LN J immediately called the physician. She further stated that staff aides received report of each resident when they began their shift, and also received a printed out report sheet as well as the same information available in the Kardex (tool used to tell staff the specific needs of each individual resident) in the EMR. An interview with Administrative Nurse D on 08/27/20 at 01:21 PM stated that agency staff received a quick orientation packet to go through when they report to work at the facility for the first time. The packet contained a two page check off regarding the packet information. She does not know what competencies agency staff completed when they start working, as that is all taken care of by the Administrator. Currently agency staff get paired with a facility staff CNA to show them how to look in the Kardex that had information directly from the resident care plan and MDS related to cares each resident needed. They also received a printed report that listed specific cares needed for each resident. The agency staff from this incident should not have used the wedge. She was re-educated about the proper use of pillows/wedges and was not allowed to work for a period of time after the incident. In an interview with Consultant Paramedic II on 08/24/20 at 02:38 PM, he stated he felt this incident was odd since the resident had a dislocation to his shoulder and no explanation as to how it happened due to the fact the resident was bed ridden and had contractures. In an interview with Consultant Physician GG on 08/27/20 at 07:45 AM he stated he got the call from the staff nurse about R70's shoulder and ordered an X-ray that confirmed the dislocation. He also stated he thought a staff member tried to lift the resident and his body moved, but his arm didn't. The facility failed to prevent further reduction of R70's ROM and/or mobility when the facility failed to ensure staff followed the care plan as instructed for proper positioning which caused R70's right shoulder dislocation.
F 0689 **Level of harm -** 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** The facility identified a census of 108 residents. The sample included 26 residents, and nine residents sampled for accidents. Based on observations, interviews, and record review, the facility failed to ensure two residents (R) were free from accidents as evidenced by the facility's failure to ensure staff followed R103's care plan for proper transfers which resulted in a 13 centimeter (cm) by 7.5 cm laceration injury while being transferred. The facility also failed to ensure R43 was free from falls and injury when staff failed to use a gait belt for ambulation and R43 fell to her knees resulting in an abrasion. Findings included: - The electronic medical record (EMR) for R103 documented the following under the [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented R103 had Brief Interview for Mental Status (BIMS) score of zero which indicated her cognition was severely impaired. She was totally dependent on one to two staff for all activities of daily living (ADLS). She transferred with use of a Hoyer lift (a total body mechanical lift used to transfer residents) She used a wheelchair for mobility (the ability to move freely and easily). The MDS recorded no falls since admission. The Quarterly MDS dated [DATE] documented R103 had a BIMS score of zero, staff assessment indicated both long-term and short-term memory problems. R103 had severely impaired cognitive skills for daily decision making. She was total dependent on staff assistance of one to two people. She had limited range of motion of both upper and lower extremities. She used a wheelchair for mobility. She transferred with use of a Hoyer lift (a total body mechanical lift used to transfer residents). The MDS recorded no falls since admission. The Care Area Assessment (CAA) dated 12/30/19 documented that R103 admitted with [DIAGNOSES REDACTED]. She was in a wheelchair for ambulation which staff propelled. She had poor trunk control and generalized weakness. The Care Plan last revised on 08/14/20 directed the resident required two staff for transfers. She required a Hoyer only for transfers; she was non-ambulatory and used a wheelchair with positioning devices for safety; R103 required total assistance with wheelchair locomotion, all initiated 12/31/19. The Care Plan recorded on 08/17/20 all staff received re-education on where to find the Kardex and where to find the appropriate way to transfer the resident. Resident was to be a Hoyer lift transfer. The Care Plan directed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, initiated 10/05/18. A physician's orders [REDACTED]. A Facility Investigation completed by Administrative Nurse D dated 08/20/20documented in summary: R103 was alert, but confused, and sustained a laceration with 39 sutures. It was found that on 08/14/20 agency Certified Nurse Aide (CNA) QQ did not follow the care plan/report sheet instructions when transferring R103. Since the resident did not stand, the CNA attempted to stand the resident and she was slouching when transferring. The CNA quickly turned the resident striking her leg on the post area of the wheelchair where the foot pedals attach. As she scraped across the area it caused a large laceration, 15cm by 7.5 cm, that required 39 sutures by the facility physician. CNA QQ received a report sheet each shift with the instructions for transfer for residents on that hall. A Witness Statement on 08/14/20 from LN LL documented: She worked on 08/13/20 on the 11PM-7AM shift. She was charge nurse on second floor. There were two CNA's assigned to the 2400 hall. CNA QQ agency staff told LN LL that he worked on the back-section of 2400 hall many times. The two CNA's split the report sheet they were given. On the report sheet it gave instructions for each resident that included ADLS, transferring, and mobility. CNA QQ used his report sheet to record vital signs he obtained for residents which he handed to her when he was done. After she completed documenting the vital signs, she handed CNA QQ the report sheet. Around 05:10 AM CNA QQ came to nurse's station wearing blue gloves covered in blood, and said he needed her help. When LN LL entered R103's room, resident was sitting in her wheelchair with blood-soaked towels around her leg. CNA QQ told the LN he used a gait belt to transfer R103 and after he transferred her was when he noticed the blood. LN LL's assessment noted a laceration approximately 15 cm on one side and 7.5 cm on the other. She called the physician determined the wound d sutures. Consultant Physician GG instructed LN LL to cover the wound with an abdominal (ABD) pad and wrap with kerlix (gauze used to wrap wounds). When LN LL returned to the nurse's station, she had noticed CNA QQ's report sheet was still lying on the desk. The report sheet under R103's name stated, Hoyer Lift Only. A Witness Statement on 08/14/20 from CNA QQ documented: He was changing and getting R103 up. After getting her dressed he turned R103 toward him in her bed and put the gait belt on the resident, stood her up, turned her toward the wheelchair, and sat her in the chair. He began to lock in place the leg rests of the wheelchair and put her foot on the foot pad. As he did so he noticed that blood running down the left side of R103's calf. He pulled her pant leg up and there was a long laceration. He immediately went to get the charge nurse. The charge nurse wrapped R103's leg and told him to take R103 to the nurse's station. An Event Note on 08/14/20 at 06:36 AM in the EMR under the Progress Notes tab documented: At approximately 05:10 AM, staff called the nurse to R103's room where upon entry the resident had a laceration to her right leg. The resident sat in her wheelchair and CNA reported that after he transferred her in the wheelchair, he noticed the blood running to the floor. The open area was triangle shaped and approximately 15 cm in length on one side and 7.5 cm on the other. Staff cleaned the open area and applied pressure. Staff notified Physician GG and he verbally stated to wrap the wound with an ABD pad, wrap with kerlix. and secure with tape. He would be in to suture the open area if needed. An Event Note on 08/17/20 at 02:28 PM under the Progress Notes tab documented: The interdisciplinary team (IDT) met to discuss the laceration to R103's leg that happened on 08/14/20. Staff transferred the resident with a gait belt and got her leg caught on the attachment point for the leg rest of the wheelchair. Root cause analysis indicated the resident was totally dependent for mobility and required a Hoyer lift for transfers. Because staff failed to use the lift for transfer, the resident's leg hit the chair. All staff received re-education on where to find the Kardex and where in the Kardex to find the way to transfer a resident. An observation of R103's room door on 08/25/20 at 09:45 AM revealed a sign on resident's door stating, Resident is a Hoyer Lift Only. An observation of R103 on 08/25/20 at 12:41 PM noted the resident was in the dining area, reclined back slightly in a high back wheelchair being fed by one staff member. A Hoyer lift sling was underneath of the resident. An observation of R103 on 08/27/20 at 08:58 AM revealed the resident sat in a high-backed wheelcahir reclined back slightly, with non-skid socks on feet. The nurse pulled up the resident's pant leg so her leg wound could be seen. The area had some redness, sutures clean, dry and intact, and open to air. On 08/27/20 at 11:15 AM CNA OO stated that R103 needed a Hoyer lift for transfers, she had a sign on her door, and we also know how to transfer residents by a report sheet received. at the beginning of our shift. It was also on the Kardex or staff can ask the charge nurse. On 08/27/20 at 01:21 PM Administrative Nurse D stated that agency staff read through a quick orientation packet in the Administrators office. She does not know at the time an agency staff was put on the schedule what competencies they have completed, as the Administrator took care of that. If an agency

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) staff member worked when education was being done with facility staff, they will include agency staff. When a resident had an incident, they do an IDT investigation of what happened, the root cause, implement immediate interventions, and encourage nurses to document their note as soon as possible. She expected staff to add new interventions to the care plan by the next day. If a care/special need was on a resident's care plan, then she expected staff to follow the care plan. Staff received a report sheet at the beginning of every shift that listed each resident on the hall and what special care they needed, such as if a Hoyer lift for transfers. Staff can also look on the Kardex in the EMR. Administrative Nurse D stated the facility is currently working a better system when agency staff come to work so they will get paired with a facility staff CNA to show them how to look in the Kardex that gathers information directly from the resident care plan and MDS of cares each resident need as well as making sure they have the printed report that lists specific cares needed for each resident. On 08/27 /20 at 07:45 AM Physician GG stated that R103's wound was a nasty laceration that he sutured himself. He believed that the staff member that transferred R103 that morning should have used the Hoyer lift. The facility's Fall Management policy dated November 2016 documented the facility ensured residents received treatment and care in accordance with professional standard of practice, their environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. The facility implemented interventions, including supervision, consistent with the residents' needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident. The facility failed to ensure that R103 was free from accidents after staff failed to use the proper mechanical device as directed to in the care plan, which caused a laceration requiring sutures to R103's leg . - R43's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Annual Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R43 required extensive assistance of two staff members for Activities of Daily Living (ADL). The Quarterly MDS dated [DATE] documented a BIMS score of 11 which indicated moderately impaired cognition. The MDS documented R43 required extensive assistance of one staff member for ADL's. R43's Fall Care Area Assessment (CAA) dated 01/14/20 documented R43 had a fall at home that resulted in fractures. She was admitted to the facility for long term care related to the need for more assistance with her ADL's. The Care Plan dated 01/31/20 directed staff to assist R43 with ADL's as needed. An intervention dated 05/04/20 directed staff to use a wheelchair for transportation when R43 was overly anxious. On 08/24/20 documentation of verbal education on gait belt usage given by Licensed Nurse (LN) L directed gait belts were used for every transfer and when ambulating with a resident. Certified Nurses Aide (CNA) N signed the education sheet. In a witnessed fall occuring on 08/27/20 at 08:46 AM in the Geranium Court dining room, CNA N ambulated R43 from her bathroom to the dining room using her walker. CNA N held onto R43's waist band of her slacks during the walk and transfer. R43 walked on her tip toesa nd wore tennies shoes. R43 fell in the dining room and sustained an abrasion to her knee, On 08/27/20 at 09:12 AM CNA N stated he absolutely should have used a gait belt on R43, when he ambulated her. He stated he could not find his gait belt and had assisted R43 for another staff person. On 08/27/20 at 11:45 AM Licensed Nurse (LN) H stated CNA N should have used a gait belt while he had ambulated with R43. On 08/27/20 at 01:40 PM Administrative Nurse D stated gait belt usage for residents depended upon the resident. If a gait belt was used for a resident then it should be care planned. The facility Fall Management policy dated November 2016 documented an avoidable accident means occurred because the facility failed to: Implement interventions, including supervision , consistent with a patient's needs, goals, plan of care and current standard of practice in order to reduce the risk of accidents. The facility failed to provide ensure use of assistive devices, including a gait belt, to prevent a fall with injury for R43.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 108 residents. The sample included 26 residents, with six residents sampled for nutrition. Based on observations, interviews, and record reviews the facility failed to monitor weekly weights, consistently monitor the percentages of meals eaten, and provide nutritional supplements to Resident (R) 98 . when she sustained a 11.36 percent (%)weight loss in one month. Findings included: - R98's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. She required extensive staff assistance with her Activities of Daily Living (ADLs). She had no trouble swallowing. She had no significant weight loss or gain. The Quarterly MDS dated [DATE] documented a BIMS score of three, which indicated severely impaired cognition. She required extensive assistance with her ADLs. She had no trouble swallowing. The MDS recorded R98 had a weight gain of five % in the last month or gain of 10% or more in the last six months and was not on a physician prescribed weight gain regimen . The Nutritional Status Care Area assessment dated [DATE] documented R98 received a mechanically altered soft diet with thin liquids to prevent choking and holding food in her mouth. The Care Plan revised on 07/20/20 documented R98 had a swallowing problem and received a mechanically altered diet with pureed meats and thin liquids. She received fortified foods and nutritional supplements. She had an order for [REDACTED]. Speech Therapist services three times weekly for one week for dysphagia (swallowing difficulty) management dated 07/20/20 until 07/27/20. The Order tab lacked orders for any nutritional supplements including the House Shakes referred to in the Care Plan. The EMR lacked evidence the nutritional supplement House Shakes were given and the intake monitored. The Weights tab in R98's EMR documented weights of: 132 pounds (lbs.) on 03/13/20 128 lbs. on 06/01/20 126 lbs. on 07/03/20 128 lbs. on 08/02/20 116 lbs. on 08/07/20 which indicated a 7.94% weight loss in one month 117 lbs. on 08/14/20 There was no weight documented on 08/21/20. The ADL-Eating tab on the EMR reviewed 07/29/20 through 08/26/20 documented the percentages of meals R98 consumed. The documentation lacked percentages for one meal on 07/29/20, 07/31/20, 08/01/20, 08/06/20, 08/08/20, 08/09/20, 08/10/20, 08/11/20, 08/13/20, 08/15/20, 08/19/20, 08/20/20, and 08/25/20. The Tasks tab of the EMR lacked documentation of intake for two meals on 08/07/20, 08/14/20, 08/16/20, 08/18/20, and 08/26/20. The Nutrition Data Collection/assessment dated [DATE] documented R98 had impaired oral food and beverage intake related to her inability to consume regular consistency food. She required mechanically altered soft diet with thin liquids. No nutritional interventions were recommended at the time. The facility continued to monitor nutritional status. A Nutrition/Dietary Note dated 03/24/20 documented R98 weighed 133 pounds. She received a mechanically altered soft diet with thin liquids. Her intake was varied but, averaged around 50%. There were no nutritional interventions recommended. A Progress Note dated 08/07/20 documented R98 had a significant weight loss when weighed that afternoon. She was reweighed with the same weight documented. Staff reported the weight loss to the Assistant Director of Nursing and the Director of Nursing. A message was left with the Medical Director . A Progress Note dated 08/09/20 documented R98 had increased weakness and pillows were placed in her wheelchair to help with her positioning. She had a fair appetite. A Progress Note dated 08/11/20 documented R98 had a fair to poor diet and was fed by staff. A Nutrition/Dietary Note dated 08/27/20 documented R98 triggered for weight loss and had lost 18 lbs. since 08/02/20. She received a pureed diet with thin liquids. Nursing reported R98's intake was poor to fair for most meals. She was offered cheesy eggs and fortified cereal at breakfast. Med Pass (a nutritional supplement) 90 milliliters twice daily and a continuation of weekly weights were recommended . On 08/27/20 at 08:28 AM a staff member fed R98. She received fortified hot cereal, scrambled eggs, yogurt, juice, and water. R98 chewed slowly and held food and fluids in her mouth, a few seconds, before she swallowed. She had no swallowing difficulty. The staff member encouraged R98 to eat, with different approaches and patience. R98 looked down, clamped her lips, and stared at the staff after she ate about 25% of her meal. On 08/26/20 at 01:58 PM Certified Medication/Nurse Aide (CMA/CNA) R stated staff weighed residents monthly unless directed to weigh weekly. They documented meal percentages under the Task/Weights tab in the EMR and when residents had weight loss. On 08/27/20 at 08:00 AM Physician GG stated he did not realize R98 had a significant weight loss. On 08/27/20 at 11:30 AM Administrative Nurse E stated R98 expressed herself by her demeanor, since she could not verbally express herself. The facility ensured residents were monitored for continued weight loss when they were placed on the Residents at Risk (RAR) list. Staff placed R98 on the list during the Covid-19 (an infectious disease caused by severe acute respiratory syndrome) outbreak (around the first part of June) but, there was not a weekly weight done on 08/21/20. He was unsure if any nutritional supplements were ordered. R98's current weight was unknown. On 08/27/20 at 11:42 AM Licensed Nurse G stated weights are taken weekly on residents at risk for weight loss. On 08/27/20 at 1:15 PM Administrative Nurse D stated nutritional assessments were done quarterly by the nursing staff. A significant weight loss existed when there was a 5%

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175158	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN TERRACE AT OVERLAND PARK	7541 SWITZER ROAD OVERLAND PARK, KS 66214

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) weight loss in 30 days or a 10% loss in 180 days. Weights were also discussed weekly in the RAR meetings. Residents were first offered extra portions and higher caloric foods to help weight gain and then nutritional supplements were ordered per physician's orders [REDACTED]. She attended the weekly RAR meetings at the facility. She reviewed the percentages of meals eaten by the residents. Dietary Consultant HH stated weekly weights kept a closer eye on the residents' progress. The facility started a fortified meal program when weight loss appeared and then would add nutritional supplements, such as Med Pass. DC HH did not wish to discuss the particulars in R98's nutritional program. The facility's RAR policy dated 01/22/19 documented residents were reviewed for a significant weight change with a weight loss of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. Those whose meal intake had declined for three consecutive days from their usual intake and whose intake was 25% or less. Diet orders, therapy services, meal fortification, new interventions, and verification of physician notification were discussed. The facility failed to monitor weekly weights, consistently monitor the percentages of meals eaten, and provide nutritional supplements for R98 when weight loss was recorded. These failures had the potential for further weight loss and maintenance of adequate nutritional status to maintain the highest practicable level of her well-being.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** The facility identified a census of 108 residents, The sample included 26 residents. Based on observations, record review, and interview the facility failed to ensure staff possessed the skills necessary to provide necessary care and services to Resident (R) 70, R103 and R43 when staff failed to use the appropriate positioning devices and assistive devices which resulted in injuries to R70, R103, and R43. Findings included: - Based on observation, record review and interview, staff failed to prevent further reduction of R70's range of motion (ROM) and/or mobility when the facility failed to ensure staff followed the care plan as instructed for proper positioning which caused R70's right shoulder dislocation. See F688. Based on observation, interview and record review, the facility failed to ensure R103 was free from accidents after agency CNA staff failed to use the proper mechanical device as directed to in the care plan for use to safely transfer resident, which caused a laceration requiring sutures to R103's leg. See F689. Based on observation, record review and interviews, the facility failed to provide ensure staff use of assistive devices, including a gait belt, to prevent a fall with injury for R43. See F689. An interview with Administrative Nurse D on 08/27/20 at 01:21 PM stated that agency staff are given a quick orientation packet to go through when they report to work at the facility for the first time. The packet contains a two page check off what the packet talked about. She does not know what competencies agency staff have completed when they start working here, that is all taken care of by the Administrator. The facility is currently working a better system when agency staff come to work so they will get paired with a facility staff CNA to show them how to look in the Kardex that gathers information directly from the resident care plan and MDS of cares each resident need as well as making sure they have the printed report that lists specific cares needed for each resident. The facility did not provide a policy on staff training. The facility failed to ensure staff possessed the necessary skills and training required to provide care and services to residents in accordance with the resident's plan of care which resulted in injuries to R70, R103 and R43 and placed the residents residing on the units where those staff were assigned at risk of injuries.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 108. The sample included 26 residents. Based on observations, record review, and interviews, the facility failed to ensure the use of standard infection control precautions for the proper use and handling of wound care supplies for Resident (R) 65 and the proper food handing for R43. Findings included: - On 08/26/2020 at 07:15 AM Licensed Nurse (LN) I donned gloves and placed a plastic bag with a Santyl tube (a sterile enzymatic [MEDICATION NAME] ointment used to treat wounds) and an unopened Kerlix (gauze bandage dressing) package on the floor. LN I did not clean R65's wound. LN I then placed the Santyl on the wound and placed it back in the plastic bag, on the floor. The wound was then wrapped with the Kerlix. After the procedure LN I placed the Santyl bag in the medicine cart without cleaning it. LN I stated she washed her hands prior to the procedure. On 08/27/20 at 11:42 AM Licensed Nurse LN G stated wound treatment supplies are placed on a clean barrier prior to wound treatments. On 08/27/20 at 01:15 PM Administrative Nurse D stated wound treatment supplies are placed on a clean barrier and soiled items were placed on a separate barrier. Wound treatment supplies were not placed on the floor. The facility's Infection Prevention and Control Program (IPCP) and Plan revised 07/25/19 documented the IPCP Program implemented methods to reduce the risks associated with procedures including the appropriate storage, cleaning, disinfection, and/or disposal of supplies and equipment. The facility failed to ensure the use of standard infection control precautions for the proper use and handling of wound care supplies. This had the potential for transmission and/or development of infection among the residents and staff. - On 08/27/2020 at 08:59 AM Certified Nurse Aide (CNA) N picked up a half- opened banana without gloves and opened it completely before he placed it back on the resident's plate. He then placed a piece of toast, spread jam onto the toast and placed it back onto the plate, without gloves on. On 08/27/2020 at 11:28 AM, CNA O stated staff were not supposed to wear gloves when they served meals but if a resident needed jelly on toast staff used hand sanitizer before and after touching the food. On 08/27/2020 at 11:46 AM, LN J stated staff wore gloves to put jelly on toast and staff did not touch the food without gloves . On 08/27/2020 at 01:38 PM, Administrative Nurse D stated staff should have worn gloves if they touched the food. The Food and Nutrition Services Policy last revised 05/20/2020 documented staff fingers were kept out of food for proper food handling. The facility's Infection Prevention and Control Program (IPCP) and Plan revised 07/25/19 documented the IPCP Program implemented applicable precautions, as appropriate, based on the potential for transmission, the mechanism of transmission, and the care, treatment, and services setting. The facility failed to use standard infection control precautions for the proper handling of food items for R43. This had the potential for the transmission and/or development of infection among the residents and staff.