STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 47 residents. The sample included 12 residents, with one sampled resident reviewed for dignity. Based on observation, interview, and record review, the facility failed to preserve Resident (R) 59's dignity when staff failed to ensure that R59's catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) bag was covered with a catheter dignity bag (a bag that conceals urinary drainage bags from public view). Findings included:- R59's Electronic Medical Record (EMR) documented diagnoses of urinary retention (the inability to empty the bladder completely), hypertension (HTN- elevated blood pressure), and radiculopathy (a condition where a nerve root in the spine becomes compressed or irritated).R59 was admitted to the facility on [DATE], the admission Minimum Data Set MDS was not due for completion.R59's Care Plan dated 09/25/25, directed staff that she was dependent on staff for toileting. The care plan directed staff that R59 was incontinent of bladder and had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) due to urinary retention. The care plan directed staff to ensure the drainage bag was below the level of the bladder. The care plan directed staff to empty the catheter drainage bag every shift and as necessary. On 09/29/25 at 07:15 AM, R59 sat in a recliner in her room. R59's catheter bag rested on the floor, and no dignity bag covered the bag. Urine was visible in the urine collection bag.On 09/30/25 at 02:06 PM, Licensed Nurse (LN) I stated that the catheter bag should never be on the floor. LN I stated the catheter bag should be below the level of the bladder but secured off the floor with a dignity bag covering the collection bag.On 09/30/25 at 02:19 PM, Certified Nurse Aide (CNA) M stated the catheter bag should never be on the floor and should always have a dignity bag to cover the collection bag, so the urine was not visible from outside the room.On 09/30/25 at 02:35 PM, Administrative Nurse D stated that the catheter bag should be placed below the level of the bladder and have a dignity bag covering the collection bag. Administrative Nurse D stated the catheter bag should never touch the floor at any time.The facility's Promoting/Maintaining Resident Dignity policy dated 10/21/24 documented it was the practice of the facility to protect and promote resident rights, treat each resident with respect and dignity, as well as care for each resident in a manner and in an environment that maintains or enhances the resident's quality of life by recognizing each resident's individuality. The facility was to maintain resident privacy.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. The facility identified a census of 47 residents. The sample included 12 residents, with one resident reviewed for self-administration of medication. Based on observation, interviews, and record review, the facility failed to ensure safe and appropriate self-administration of medication for Resident (R) 43. Findings included:- R43's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dysphagia (swallowing difficulty), seizure (violent involuntary series of contractions of a group of muscles), major depressive disorder (major mood disorder that causes persistent feelings of sadness), dementia (a progressive mental disorder characterized by failing memory and confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS) dated 07/02/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R43 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on bilateral lower extremities. The MDS documented R43 was dependent on staff assistance for toileting, bathing, bed mobility, and transfers. The MDS documented R43 had received anticonvulsant (a medication that prevents or treats seizures and convulsions) medication during the observation period. R43's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 07/02/25 documented he had some confusion and required assistance with his activities of daily living. R43's Care Plan dated 07/08/25 documented staff would administer his medication as ordered. The plan of care lacked documentation of self-administration of medication. Review of R43's EMR under the Assessment tab lacked an assessment for self-administration of medication. On 09/29/25 at 10:31 AM, R43 laid flat on his bed. R43's a plastic medication cup of unidentified pills sat on the bedside table, an arm's length away from his bed.On 09/30/25 at 02:05 PM, Licensed Nurse (LN) I stated the facility did not have any residents that she was aware of who were assessed to self-administer their own medications. LN I stated the facility would complete an assessment to ensure the resident was safe to administer their own medications, and that assessment would be found under the Assessment tab in the resident's EMR.On 09/30/25 at 02:36 PM, Administrative Nurse D stated a resident would have an assessment to ensure they were safe to self-administer their own medication. Administrative Nurse D stated the nurse should never leave a resident's medication unattended on their bedside table. Administrative Nurse D stated R43 did not have an assessment to administer his own medication. The facility's Resident Self-Administration of Medication policy, revised 04/09/25, documents it is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility had a census of 47 residents. The sample included 12 residents, with two residents reviewed for accidents and/or hazards. Based on observation, interview, and record review, the facility failed to ensure rooms containing hazardous materials were kept locked and kept them out of reach of the eight cognitively impaired /independently mobile residents. Findings Included: - On 09/29/25 at 07:04 AM, an initial walkthrough of the facility was completed. An inspection of the 200 Hall revealed an unsecured Telephone room with empty boxes and a wire panel that was unlocked.An inspection of the R14's room revealed an uncontained oxygen cylinder sitting directly on the floor. On 09/29/25 at 07:17 AM, Housekeeper Staff U stated the room should be locked. He stated there had been folks at the facility working on the phone lines. Housekeeping Staff U locked the Telephone room. On 09/30/25 at 02:06 PM, Licensed Nurse (LN) I stated the telephone had wires in it and should always be locked. She stated the oxygen cylinders should never be left in a room without a stroller, or the cylinder should be placed on the back of a wheelchair. She stated the cylinders should always be contained. On 09/30/25 at 02:34 PM, Administrative Nurse D stated oxygen cylinders should never be left directly on the floor in a resident's room. She stated the Telephone room should always be locked. The facility's Accidents and Supervision policy, revised 02/15/25, documented the resident's environment would remain as free of accident hazards as possible. Each resident would receive adequate supervision and assistive devices to prevent accidents. The facility would establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. - R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN- elevated blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, need for assistance with personal care, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), displaced fracture sixth cervical vertebra (the seven bones that make up the neck region of the spine), fracture of scrum (the large, triangular-shaped bone at the very bottom of the spine, located between the two hip bones), displaced intertrochanteric (part of the proximal (upper) end of the left femur (thigh bone), and repeated falls. The Quarterly Minimum Data Set (MDS) for R6, dated 06/30/25, recorded a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R6 had an impairment to one side of her lower body. The MDS documented R6 needed setup or cleanup for oral hygiene and eating. The MDS documented R6 was dependent on staff for toileting, bathing, and dressing. The MDS documented R6 was at risk for falls and had a fall with fracture before admission or entry. R6's Fall Care Area Assessment (CAA), dated 01/31/25, documented R6 triggered for falls related to a history of falls. The CAA documented R6 was in the facility for a fall at home and a urinary tract infection. The CAA documented R6 had a fall risk of eight, which indicated a moderate risk for falls, and requires a Hoyer (total body mechanical lift) for transfers due to cognition. The CAA documented R6 had no falls since admission. R6's Care Plan dated 02/10/25 documented that R6 was at risk for falls due to confusion, knee pain, and a recent fall with a fracture. The plan of care for R6 documented staff would place a bright yellow tape on R6's brake handle to help remind her to lock her brakes before transferring. The plan of care for R6 documented that the staff were to ensure R6's call light was in reach and orient her to her call light. R6's plan of care documented staff were to ensure R6 wore nonskid socks or shoes with each transfer. The plan of care for R6 documented staff would arrange R6's room to accommodate physical limitations. R6's care plan, dated 04/28/25, documented that staff would assist with wheelchair locomotion on and off the facility unit. On 09/29/25 at 07:14 AM, R6 laid (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in her bed on her right side. R6's call light was clipped to her privacy curtain. R6's call light was out of her reach. On 09/29/25 at 11:35 AM, R6's call light was at the top of her bed. R6's was by the bottom of her bed in her wheelchair. R6's call light was out of her reach. On 09/30/25 at 02:06 PM, Licensed Nurse (LN) I stated call lights should always be within the resident's reach. She stated all of the nursing staff were responsible for ensuring the residents had their call light within reach. On 09/30/25 at 02:19 PM, Certified Nursing Aide (CNA) M stated call lights should either be clipped to the resident or put in the resident's hand. CNA M stated the nursing staff should always let the resident know where the call light is placed. On 09/30/25 at 02:34 PM, Administrative Nurse D stated call lights should always be placed within the resident's reach. She stated the staff should orient the resident to the call light before leaving the resident's room. The facility's Accidents and Supervision policy, revised 02/15/25, documented the resident's environment would remain as free of accident hazards as possible. Each resident would receive adequate supervision and assistive devices to prevent accidents. The facility would establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. The facility identified a census of 47 residents. The sample included 12 residents, with one resident reviewed for tube feeding complications. Based on observation, interviews, and record review, the facility failed to ensure Resident (R) 33's water for tube feeding (administration of nutritionally balanced liquefied foods or nutrients through a tube) bag was marked with the date, time, and the facility further failed to ensure R33's syringe was marked with a date.Findings Included:- R33's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN- elevated blood pressure), traumatic brain injury (a disruption in the normal function of the brain caused by an external force, such as a blow, bump, jolt, or penetrating injury to the head), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), muscle spasms, need for personal care, and hemiplegia (paralysis of one side of the body) effecting right and left sides of the body.The Quarterly Minimum Data Set (MDS) for R33, dated 07/14/25, recorded a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented eating was not applicable and was dependent on staff for all activities of daily living (ADL). R33's Tube Feeding Care Area Assessment (CAA) dated 07/14/25 documented R33 triggered for tubing feeding secondary to the presence of a percutaneous endoscope gastrostomy tube (PEG- a tube inserted through the wall of the abdomen directly into the stomach) while a resident in the facility. The CAA documented R33 was nothing by mouth (NPO), and the estimated nutrition needs from the dietitian included calories and protein to promote a healthy weight. R33's Care Plan dated 02/15/22 documented R33 was at risk for altered nutrition and hydration related to the use of a feeding tube. R33's plan of care documented staff were to use personal protective equipment (PPE) when performing peg tube care. The plan of care for R33 documented nursing staff would check tube placement per protocol before administering feedings or medications. R33's plan of care dated 09/18/22 documented she was NPO and received her nutrition through a peg tube. The EMR under the Orders tab documented the following physicians' orders:Per feeding pump, flush 100 milliliters (ml) of water every four hours. May use water flush for medication administration every four hours for hydration/nutrition, dated 12/11/24. Enteral Feed Order every shift. Administer Osmolyte (feeding formula) at 1.2 mL per hour (hr) continuously via a feeding pump. May turn off two hours a day for showers/personal care. May administer G side of GJ tube, dated 08/07/25.GJ Tube- left lower abdomen. Cleanse with wound cleanser, apply a drain sponge, every day shift for skin integrity, dated 08/23/25. R33's EMR lacked direction for staff as to when to change out the syringe for R33's water flush.On 09/29/25 at 07:50 AM, R33 laid in his bed, with his head elevated. R33 was receiving internal feeding and water. R33's internal water bag was not marked with a date, and the syringe placed in a graduated cylinder (a container for measuring) was not dated. On 09/30/25 at 08:11 AM, R33 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline). R33 was receiving internal feeding and water. R33's internal water bag was not marked with a date, and the syringe placed in a graduated cylinder was not dated. On 09/30/25 at 02:06 PM, Licensed Nurse (LN) I stated that a tube feeding bag and water bag should be labeled with the date, the resident's name, and the time. She stated the syringe should be dated. LN I stated she thought the syringe was changed out weekly. On 09/30/25 at 03:34 PM, Administrative Nurse D stated she did not believe the facility required the syringe and water bag to be dated. She stated the syringe and water bags were changed daily.The facility's Medication Administration via Enteral Tube policy, revised 04/09/25, documented it was the policy of the facility to ensure the safe and effective administration of medications via enteral feeding tubes by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	utilizing safe practice guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 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** The facility identified a census of 47 residents. The sample included 12 residents, with one resident reviewed for respiratory care. Based on observation, interviews, and record review, the facility failed to ensure Resident (R) 19's continuous positive airway pressure (CPAP- a ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) was stored in a sanitary manner. Findings included:- R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), fluid overload (occurs when there is an excessive amount of fluid in the body), pneumococcal (type of bacterial infection), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), cellulitis (a common bacterial infection of the skin and underlying tissues) of left limb, and hemiparesis/hemiplegia (weakness and paralysis on one side of the body). The admission Minimum Data Set (MDS) dated [DATE] was in progress. R19's Base Line Care Plan dated 09/22/25 lacked direction for staff to care for R19's respiratory equipment, including his CPAP. R19‘s EMR under the Orders tab revealed the following physician orders: CPAP with home settings at night, at bedtime for sleep apnea (a disorder of sleep characterized by periods without respirations), dated 09/18/25.On 09/28/25 at 08:36 AM, R19 sat in his wheelchair, R19's CPAP mask laid on his bedside table. R19's CPAP mask was not stored in a sanitary manner. On 09/29/25 at 02:06 PM, Licensed Nurse (LN) I stated all respiratory equipment should be placed in a bag; the bag should have the last changed date. She stated that all nursing staff were responsible for ensuring respiratory equipment was stored in a sanitary manner. On 09/29/25 at 02:19 PM, Certified Nurse's Aide (CNA) M stated she was unsure how to store a CPAP. On 09/29/25 at 02:34 PM, Administrative Nurse D stated all respiratory equipment should be contained in a bag when not in use. The facility's Storage and Maintenance of Respiratory and Medical Equipment policy, reviewed 03/25/25, documented to ensure respiratory and medical equipment was stored in a manner that minimizes the risk of contamination and maintains compliance with infection prevention and control standards. All respiratory therapy equipment and other reusable medical devices must be stored properly when in active use to protect against contamination, ensure resident safety, and maintain readiness for use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. The facility identified a census of 47 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, interviews, and record review, the facility failed to ensure dosing instructions for Voltaren (an anti-inflammatory class of medication used to reduce inflammation and treat pain) gel for Resident (R) 31. Findings included:- R31's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of chronic pain, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), contracture (abnormal permanent fixation of a joint or muscle), and multiple sclerosis (MS-progressive disease of the nerve fibers of the brain and spinal cord). The Significant Change Minimum Data Set (MDS) dated 07/24/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R31 had frequent pain during the observation period. R31's Pain Care Area Assessment (CAA) dated 08/05/25 documented nursing staff would monitor her pain. R31's Care Plan dated 04/13/22 documented nursing staff would address her complaints of pain promptly with pain medications as ordered. R31‘s EMR under the Orders tab revealed the following physician orders: Diclofenac sodium external gel one percent (%) (Diclofenac Sodium (Topical)) apply to the right hip topically every six hours as needed for pain, dated 09/17/25. The order lacked a dose. On 09/30/25 at 01:05 PM, R31 sat upright in her wheelchair at the front desk as she waited for transportation for a doctor's appointment to have her pain medication refilled.On 09/30/25 at 02:05 PM, Licensed Nurse (LN) I stated all medication should have dosage ordered by the physician to be administered.On 09/30/25 at 02:36 PM, Administrative Nurse D stated she would expect every medication should have an indication for administration.The facility's Unnecessary Drugs policy, last reviewed 02/25/25, documented it was the facility's policy that each resident's entire drug/medication regimen was managed and monitored to promote or maintain the resident' s highest practicable mental, physical, and psychosocial well-being free from unnecessary drugs. Adequate Indications for use refers to the identified, documented clinical rationale for administering a medication that was based upon an assessment of the resident' s condition and therapeutic goals and after any safer treatments have been deemed clinically contraindicated. Also, adequate indication for use means that the medication administered was consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 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. The facility identified a census of 47 residents. The facility had three medication rooms. Based on observation, interview, and record review, the facility failed to, in accordance with state and federal guidelines, ensure that a vial of tuberculin (a substance used in the tuberculin skin test to detect an immune system response to the bacteria that causes tuberculosis) was labeled properly after being opened. Findings included: - On 09/30/25 at 07:32 AM, upon inspection of the rehabilitation unit medication room an open and undated multi-use vial of tuberculin was located in the medication refrigerator. The vial cap was removed. The prescription tag on the box documented an order date of 08/29/25.On 09/30/25 at 07:35 AM, Licensed Nurse (LN) G stated that the vial should have been dated when opened. LN G stated he would discard the vial and obtain a new vial to have available.On 09/30/25 at 02:35 PM, Administrative Nurse D stated that LN G had reported to her that he had not dated the tuberculin vial when he opened it for use. Administrative Nurse D stated the tuberculin vial should be dated upon being opened and then discarded after 28 days.The facility's Multidose Medication Storage and Labeling policy dated 04/06/25 documented each multidose medication must be labeled with the date opened and the beyond-use in accordance with manufacturer instructions or facility policy (e.g., not to exceed 28 days if not otherwise specified).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 - Some	Provide and implement an infection prevention and control program. The facility identified a census of 47 residents. The facility identified 14 residents on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care). Based on record review, interviews, and observations, the facility failed to ensure Resident (R) 19's ventilator mask was stored in a sanitary manner, failed to implement adequate hand hygiene, and further failed to ensure R59's catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) was not on the floor. Findings included:- On 09/29/25 at 07:15 AM, R59 sat in a recliner in her room. R59's catheter bag rested on the floor, and no dignity bag was noted to cover the bag. Urine was visible in the urine collection bag.On 09/29/25 at 08:36 AM, R19 sat in his wheelchair. R19's CPAP mask laid on his bedside table. R19's CPAP mask was not stored in a sanitary manner. On 09/30/25 at 07:12 AM, Certified Medication Aide (CMA) R served R6's Carnation milk and Miralax (bowel medication) in disposable cups. CMA R touched the rims of each cup when handing the cups to R6.On 09/30/25 at 07:26 AM, Licensed Nurse (LN) H prepared R25, R41, and R52's Voltaren (topical pain reliever medication) gel and placed the medication into a plastic cup with each resident's name. LN H placed three plastic medication cups into a white plastic tray. LN H exited the medication room, entered R25's room, failed to perform hand hygiene, and applied a pair of clean gloves. LN H placed the white tray with the resident's medication onto R25's bedside table. LN H assisted R25 with her blankets, placing R25's pajama pant legs above her knees. LN H applied the Voltaren gel to R25's knees. LN H removed her gloves without performing hand hygiene upon removal. She removed the white tray with R41 and R52's medication. LN H entered R41's room, failed to perform hand hygiene, applied a pair of clean gloves, and set the white tray onto R41's bedside table. LN H applied the Voltaren gel onto R41's neck and shoulders. LN H removed her gloves, failed to perform hand hygiene after the removal of her gloves, and removed the white tray from the bedside table. LN H failed to perform hand hygiene. LN H entered R52's room, failed to perform hand hygiene, applied a pair of clean gloves, and set the white tray with R52's Voltaren gel onto the bedside table. LN H applied the gel onto R52's knees, removed her gloves, and failed to perform hand hygiene upon removal of her gloves. LN H returned to the medication room with the white tray. On 09/30/25 at 07:45 AM, LN H prepared R33's medication for gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) administration. LN H placed the plastic medication cups into a white tray. LN H exited the medication room with the white tray and entered R33's room with the white medications. LN H applied clean gloves but failed to perform hand hygiene. LN H placed the white tray with R33's medication onto her roommate's bedside table. LN H retrieved an undated clear syringe from an empty water pitcher from R33's bedside table. LN H inserted the clear syringe into R33's G-tube and attempted to administer a water flush without success. LN H removed the syringe with water from the G-tube and placed the syringe into the white tray, with the open tip directly onto the bottom of the white tray. LN H removed the syringe from the white tray and flushed R33's G-Tube. On 09/30/25 at 02:06 PM, LN I stated urinary catheter bags should never be on the floor. LN I stated all respiratory equipment should be placed in a bag; the bag should have the last changed date. She stated that all nursing staff were responsible for ensuring respiratory equipment was stored in a sanitary manner. LN I stated hand hygiene should be performed after each glove change or when gloves were dirty or soiled, and between residents. She stated that staff should never touch the rim of a cup before handing the cup to anyone. LN I stated the syringe for the peg tube feeding should be stored in a sanitary manner, dated, and covered.On 09/30/25 at 02:17 PM, Certified Nurse Aide (CNA) M stated that urinary catheter bags should never (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175257	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Lane Health and Rehabilitation	10315 Johnson Drive Shawnee, KS 66203

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 - Some	touch the floor. CNA M stated she was unsure how to store a CPAP. CNA M stated staff should wash hands between residents, and from clean to dirty. On 09/30/25 at 04:31 PM, Administrative Nurse D stated the catheter bag should never touch the floor at any time. She stated respiratory equipment not in use should be in a dated bag. Administrative D stated hand hygiene should be performed between residents, and between dirty and clean. She stated staff should never hand a resident a cup with the rim or touch the rim of a cup. She was unsure if the syringe for the peg tube should be dated. She stated the syringe for a peg tube was changed daily and placed in a graduate cylinder (a collection cylinder). The Infection Prevention and Control policy dated 02/15/25 documented the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.The Hand Hygiene policy dated 02/15/25 documented all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The facility's Storage and Maintenance of Respiratory and Medical Equipment policy, revised 03/25/25, documented to ensure respiratory and medical equipment was stored in a manner that minimizes the risk of contamination and maintains compliance with infection prevention and control standards. All respiratory therapy equipment and other reusable medical devices must be stored properly when in active use to protect against contamination, ensure resident safety, and maintain readiness for use.The facility's Medication Administration via Enteral Tube policy, revised 04/09/25, documented it was the policy of the facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing safe practice guidelines.