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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175557	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Olathe	201 E Flaming Road Olathe, KS 66061

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. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 107 residents. The sample included 26 residents, with five reviewed for dignity. Based on observation, record review, and interviews, the facility failed to provide a dignified care environment for Residents (R) 43 and R20. This deficient practice placed both residents at risk for impaired dignity and unmet care needs.Findings Included:- The Medical Diagnosis section within R43's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, repeated falls, and the need for assistance with personal care. R43's Annual Minimum Data Set (MDS) completed 07/01/25 indicated a Brief interview for Mental Status (BIMS) score of zero (severe cognitive impairment). The MDS noted no upper or lower extremity impairments. The MDS noted she used a wheelchair for mobility. The MDS noted she required substantial to maximal assistance for her activities of daily living (ADL) and supervision during meals. The MDS noted no weight loss. R43's Cognitive Loss Care Area Assessment (CAA) triggered on 05/27/25, indicating she was at risk for a decline in her ADLs related to her memory loss, impaired decision making, and need for assistance. The CAA noted she was at risk for nutritional impairment due to her medical diagnoses and cognitive impairment. R43's Communication CAA triggered on 05/27/25, indicating she was at risk for impaired communication related to her hearing and communication deficits. The CAA noted that a care plan was implemented to minimize the risks associated with her impairments, and staff were to anticipate her needs. R43's Care Plan initiated 07/11/24 indicated she was dependent on staff for meeting her emotional, intellectual, physical, and social needs due to her cognitive impairments. The plan instructed staff to provide a consistent routine and use approaches to ensure her involvement in decision-making. The plan instructed staff to anticipate and meet her needs. On 09/09/25 at 07:50 AM, R43 was wheeled to the dining room area. Her wheelchair lacked foot pedals, and her feet slid on the floor as she was pushed. R43 told staff, I'm hungry, and staff moved her to the table. At 07:55 AM, staff started serving trays two at a time from the kitchen. At 08:00 AM, R43 again informed staff she was hungry as she sat at the table. At 08:10 AM, two other residents had their food at the table she sat at and they ate their food. At 08:15 AM, staff placed a plate of food in the empty seat next to her. At 08:20 AM, the majority of the room had already served their meals except R43. R43 again complained she was hungry and began looking at the meal ticket for the empty seat next to hers. At 08:30 AM, R43 finally received her meal and began eating. The majority of the room had completed their meals before R43 received her plate. On 09/09/25 at 08:45 AM, Administrative Staff B stated the kitchen had to serve the meals two at a time to ensure the food stayed hot. She stated the dishwasher had been down for a week, and the kitchen had to serve the meals on Styrofoam plates. On 09/10/25 at 11:20 AM, Dietary Staff BB stated the dishwasher had been broken for the last week and a half. He stated the facility was waiting for a part and had to use Styrofoam plates. He stated the meals were to be served on the units to ensure they come out at the same time for each resident to enjoy their meals together. On 09/10/25 at 12:32 PM, Certified Nurses Aide (CNA) O stated the residents were to be served their meals around the same time so they could enjoy their meals together. She stated residents should not wait more than five minutes to receive their meals during breakfast. She stated the residents should never be allowed to watch other residents eat while they wait. The facility's Resident Rights policy, revised 12/2018, indicated the facility was to ensure all residents were treated in a dignified manner. The policy indicated the facility was to provide ongoing education and In-service.- The Medical Diagnosis section within R20's Electronic Medical Records (EMR) included diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), major depressive disorder (major mood disorder), and need for assistance for personal cares. R20's Quarterly Minimum Data Set (MDS) completed 06/19/25 indicated a Brief interview for Mental Status (BIMS) score of 15 (intact cognition). The MDS noted no upper or lower extremity impairments. The MDS noted he used a wheelchair for mobility. The MDS noted he had physical, verbal, and other self-directed behaviors observed for one to three days. The MDS noted he was independent for toileting, transfers, bathing, bed mobility, dressing, personal hygiene, and putting on footwear. The MDS noted no behaviors or rejection of care. R20's Functional Ability Care Area Assessment (CAA) was triggered on 09/11/25. The CAA noted he required assistance from staff related to medical diagnoses. The CAA noted that a care plan was implemented to minimize the risks related to his potential decline in activities of daily living. R20's Care Plan initiated

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. The facility had a census of 107 residents. The sample included 26 residents, with four reviewed for accommodation of needs for assistive device. Based on observation, record review, and interview the facility failed to utilize foot pedals during wheelchair transports for Resident (R) 37, R43, R104, and R122. This placed the residents at risk for preventable accidents. Findings Included: - On 09/09/25 at 07:40 AM, R37 (a severely cognitively impaired resident on the secured unit) was wheeled from her room to the dining room table. R37's wheelchair lacked foot pedals, and her feet slid on the ground as she was pushed. On 09/09/25 at 07:50 AM, R43 (a severely cognitively impaired resident on the secured unit) was wheeled to the dining room area from her room. Her wheelchair lacked foot pedals, and her feet slid on the floor as she was pushed.On 09/09/25 at 08:42 AM, R104 (a severely cognitively impaired resident on the secured unit) was pushed from the hallway to the dining room table. R104's wheelchair lacked foot pedals. Her feet touched the floor as she was pushed to the table. On 09/09/25 at 08:15 AM, R122 wheeled to her room from the main dining hall by staff. R122's wheelchair lacked foot pedals, and her feet slid on the ground as she was pushed. On 09/10/25 at 12:22 PM, Certified Nurse's Aide (CNA) O stated foot pedals were to be used on all residents while being pushed in their wheelchairs. She stated that all the wheelchairs had foot pedals available to use. She stated that pushing residents in their wheelchairs without them could cause an injury or fall. On 09/10/25 at 12:34 PM, Administrative Nurse D stated that staff were expected to use foot pedals while pushing the resident's wheelchair. The facility was unable to provide a policy related to assistive devices or accidents as requested on 09/10/25.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 107 residents. The sample included 26 residents, with three reviewed for abuse and neglect. Based on observation, interview, and record review, the facility failed to ensure residents remained free from sexual abuse when cognitively impaired Resident (R) 16, a resident with a history of inappropriate touching, touched R75's genital area against R75's wishes. On 07/18/25, R16 touched a lady in a sexual way, and the facility sent R16 to the hospital for inappropriate behavior. R16 returned to the facility on [DATE], but the facility did not implement interventions to address R16's inappropriate touching. On 08/28/25, R16 exhibited sexual behaviors towards staff, but the facility did not address these behaviors with new interventions. On 08/29/25, R16 touched cognitively impaired R75, a resident unable to consent, in her genital area. R75 screamed at R16 to stop touching her. Staff separated R16 and R75 and placed R16 under one-to-one staff supervision until R16 transferred to an all-male unit in another facility. The facility's failure to identify and implement interventions in response to R16's inappropriate touching and behaviors to prevent sexual abuse placed R75 in immediate jeopardy. Findings Included:- The Medical Diagnosis section within R16's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, repeated falls, and the need for assistance with personal care. R16's 08/02/25 Quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The MDS noted R16 with no upper or lower extremity impairments, and he used a wheelchair for mobility. The MDS noted R16 had physical, verbal, and other self-directed behaviors observed for one to three days. R16's Behavioral Care Area Assessment (CAA) triggered on 05/27/25. The CAA noted he had a history of physical and verbally aggressive behaviors. R16's Care Plan initiated 05/15/25 indicated he was admitted to the secured unit due to his medical diagnoses and risk for elopement. The plan noted staff monitored R16 frequently for safety (05/15/25). The plan noted he had cognitive impairment or impaired thought processes (05/15/25). The plan instructed staff to cue, orient, and supervise him as needed, engage the resident in simple activities, and keep his routine consistent (05/15/25). The plan noted he was dependent on staff for meeting his emotional, intellectual, physical, and social needs (06/20/25). The 09/02/25 care plan update indicated R16 had behaviors related to inappropriate touching. The plan instructed staff to anticipate his needs, offer tasks to divert his attention, and provide activities that accommodated his interests (09/02/25). The plan noted staff provided R16 with one-to-one supervision until his departure from the facility, and the facility provided abuse education (09/02/25). R16's EMR under Progress Notes revealed a Nurse's Note completed on 07/16/25. The note indicated R16 was observed holding hands with another resident and using affectionate gestures towards other residents on the secured unit. The note indicated staff provided appropriate redirections to maintain personal boundaries in a respectful manner. The 07/17/25 Nurse's Note indicated R16 wheeled himself around the secured unit and was observed repeatedly touching other residents. The note revealed staff intervened promptly by redirecting him and provided verbal reminders regarding personal boundaries. The note revealed staff had to remove R16 from the immediate area and redirect to an activity table under staff supervision. The 07/18/25 Nurse's Note revealed R16 was observed touching a resident in a sexual way and staff provided several redirections. The note revealed R16 became aggressive upon redirection and wanted to hit the staff. The note revealed staff moved him back to his room and attempted to contact his resident representative. The 07/18/25 Nurse's Note revealed R16 was sent out to an acute medical facility for evaluation. The 07/28/25 acute medical facility summary indicated the facility reported concerns of worsening promiscuity and combativeness. The admission Progress Note completed on 07/28/25 revealed R16 returned to the facility at 04:00 PM following a hospital stay for treatment of inappropriate behaviors and gout. The Social Service Note completed on 08/28/25 revealed the facility notified R16's representative of R16's inappropriate touching. The note indicated he transferred to an all-male unit. The Behavior Note completed on 08/29/25 revealed staff witnessed R16's hands touching another resident's private area. The note documented both residents were immediately separated, and notification of the unit supervisor. The Facility Incident Report #3977 completed on 08/29/25 indicated staff observed R16 placing his hands between R75's (a severely cognitively impaired female resident) inner thighs. The report indicated R75 screamed out, Stop, don't touch me. The report indicated both residents were separated and assessed. The note revealed neither resident had memory recall of the incident, and the facility immediately placed R16

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 107 residents. The sample included 26 residents, with two sampled residents reviewed for hospitalization and one resident reviewed for discharge. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 1 and their representative were provided, as soon as practicable, a written notification of transfer upon their transfer to the hospital. The facility failed to ensure a discharge summary, and a recapitulation of R120's stay was completed upon discharge from the facility. This placed R1 and R120 at risk of miscommunication between the facility and the resident's representative, and the possible missed opportunity for healthcare services.Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), hypertension (HTN- elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R1's Discharge Minimum Data Set (MDS) dated 11/15/24 documented an unplanned discharge to an acute hospital with a return anticipated. R1's Entry MDS dated 11/15/24 documented a re-entry to the facility from an acute hospital. R1's Discharge MDS dated 12/07/24 documented an unplanned discharge to an acute hospital with a return anticipated. R1's Entry MDS dated 12/09/24 documented a re-entry to the facility from an acute hospital. R1's Annual MDS dated 12/19/24 documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required substantial assistance, being dependent on staff for her cares. The overall goal for R1 was to remain in the facility. No active discharge planning was occurring. R1's Discharge MDS dated 05/01/25 documented an unplanned discharge to an acute hospital with a return anticipated. R1's Entry MDS dated 05/03/25 documented a re-entry to the facility from an acute hospital. R1's Functional Abilities Care Area Assessment (CAA) dated 12/30/25 documented she required assistance with her activities of daily living (ADL) and had impaired balance and impaired transition during transfers, and functional impairment in activity. Contributing factors included R1's generalized weakness and decreased safety awareness. R1's risk factors included further ADL decline, falls, incontinence, skin breakdown, and pain. R1's Care Plan, revised 06/09/25, directed staff that due to her daily care needs, R1 wished to remain in long-term care. The Care Plan directed staff to encourage her to express her concerns and feelings. The Care Plan directed staff that R1 would have all her spiritual needs met. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/25 at 09:15 AM, R1 lay in bed with her supplemental oxygen on; R1 voiced no complaints. On 09/10/25 at 01:22 PM, Administrative Nurse D stated that social services typically completed the bed hold and notification of transfers when a resident was sent to the hospital. Administrative Nurse D stated all of R1's bed holds, and notification of transfer should be in her scanned chart. The facility lacked a policy regarding written notification of transfer. - R120's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of traumatic brain injury (TBI- an injury to the brain caused by external forces), insomnia (inability to sleep), and hemiplegia (paralysis of one side of the body). The Entry Minimum Data Set (MDS) dated 07/09/25 documented R120 admitted to the facility. The admission MDS dated 07/14/25 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R120 was independent with bed mobility and toileting. The MDS documented R120 required partial to moderate staff assistance with dressing. R120's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 07/24/25, documented R120 required staff assistance with activities of daily living. R120's Care Plan, dated 07/16/25, documented he required staff supervision during bathing. The Nurses Note on 07/14/25 at 03:52 PM documented R120 discharged to home at 01:30 PM with his personal belongings. The facility was unable to provide a discharge summary, which included a recapitulation of his stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications. R120 was admitted on [DATE] and discharged home on [DATE]. On 09/09/25 at 01:45 PM, Administrative Staff A stated R120 was a respite care resident, and his discharge summary was overlooked at the time of discharge. The facility's Discharge Summary and Plan policy, revised 10/2022, documented that when a resident's discharge was anticipated, a discharge summary and post-discharge plan would be developed to assist the resident with discharge. The discharge summary included a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted The facility identified a census of 107 residents. The sample included 26 residents, with 26 residents reviewed for baseline care plans. Based on observation, record review, and interviews, the facility failed to develop a person-centered baseline care plan for Resident (R) 121 to include her chronic pain. This deficient practice placed R121 at risk of impaired care related to uncommunicated care needs.Findings included:- R121's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Guillain-Barre syndrome (a disorder in which the body's immune system attacks the nerves), fractured toe, fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).The admission Minimum Data Set (MDS) was in progress. R121's Care Area Assessment (CAA) was in progress. R121's Baseline Care Plan dated 09/05/25 documented nursing staff would administer all medication as ordered by the physician. The care plan lacked direction for R121's chronic pain related to a fractured toe, Guillain-Barre syndrome, and fibromyalgia.Review of R121's EMR under the Evaluation tab revealed the Baseline Care Plan e-signed on 09/05/25 lacked documentation related to R121's chronic pain. On 09/10/2025 at 08:01 AM, R121 sat in her electric wheelchair at the dining room table. R121 stated she had to wait for her pain medication after she was admitted to the facility. R121 stated her chronic pain was horrible at times. On 09/10/25 at 12:30 PM, Certified Nurse Aide (CNA) O stated the resident's information for their care and what assistance the resident required for care could be found on their care plan or the Kardex (nursing tool that gives a brief overview of the care needs of each resident). On 09/10/25 at 12:58 PM, Licensed Nurse (LN) K stated the baseline care plan was an under-defined assessment (UDA) in the EMR under the Evaluation tab. LN K stated the admission nurse would answer all the nursing questions on the assessment. LN K stated that for a resident with a diagnosis of chronic pain the information should be included in their baseline care plan.On 09/10/25 at 01:23 PM, Administrative Nurse D stated she expected the baseline care plan to be completed within 24 hours after the resident's admission. Administrative Nurse D stated that chronic pain should be addressed on the resident's baseline care plan with person-centered interventions.The facility's Baseline Care Plans policy, last revised 03/2022, documented the baseline plan of care was to meet the resident's immediate health and safety needs, and was developed for each resident within forty-eight (48) hours of admission. The baseline care plan included instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident.

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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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 107 residents. The sample included 26 residents, with four residents reviewed for treatment and services to prevent and heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 14's low air loss mattress was at the correct weight setting, and R48's offloading boots were applied to her heels to prevent pressure ulcers. This placed R14 and R48 at increased risk for developing pressure ulcers. Findings Included:- R14's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), hypertension (HTN- high blood pressure), 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), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), major depressive disorder (major mood disorder that causes persistent feelings of sadness), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and pressure ulcer of left buttocks Stage 3 (full-thickness pressure injury extending through the skin into the tissue below).The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R14 had impairment on both sides of her upper body and both sides of her lower body. The MDS documented R14 was dependent on staff for toileting and bathing. The MDS documented R14 was dependent on the staff to roll right to left. The MDS documented R14 was at risk for pressure ulcers and had one stage 3 pressure ulcer. The MDS documented R14 had a pressure-reducing device in her chair and a pressure-reducing device on her bed. R14's Pressure Ulcer/ Injury Care Area Assessment (CAA) dated 07/26/25 documented impaired skin integrity, current pressure ulcers, diabetic foot ulcers, and surgical wounds. The CAA documented the contributing factors, which included osteomyelitis (local or generalized infection of the bone and bone marrow), surgery on the genitourinary system, DM, and paraplegia. R14's Care Plan dated 02/17/23 documented R14 was offered and accepted a low air loss mattress and a foam wedge for positioning; staff were to monitor to ensure proper functioning. R14's plan of care documented R14 was at risk for further alteration in skin integrity related to her medical diagnoses. The plan of care dated 07/17/25 documented R14 had a left lateral (position that was the side) foot, left posterior (back of the body) thigh, right posterior thigh wound, Stage 3 pressure ulcer, and right foot surgical wound. The plan of care for R14 documented staff was to do skin assessments with every care provided and report to the nurse any necessary findings. R14's plan of care lacked direction for staff to monitor her low-air-loss mattress.R14s EMR under the Orders tab revealed the following orders: Left posterior thigh: cleanse all open areas with hypochlorous acid (wound cleaner) or normal saline, pat dry. Apply skin prep (adhesive dressing) to peri-wound (skin surrounding the wound). Cut a collagen (protein-derived wound treatment used to promote wound healing) pad to fit the posterior and medial area and place it over the wound bed. Apply black foam to the base of a large wound and use a wound vacuum device (also known as a negative pressure wound therapy or NPWT), change every day shift on Tuesday, Thursday, and Saturday, dated 08/28/25.R14's EMR under the Weights and Vitals tab document:Weight 213.6 pounds on 09/03/25.R14's Braden Scale for Prediction Pressure Sore Risk dated 08/05/25 documented a score of 14, indicating a moderate risk for pressure ulcers.R14's Weekly Wound Assessment dated 09/02/25 documented R14 had a diabetic foot ulcer on the left foot. On 09/08/25 at 08:25 AM, R14 laid in her bed on her back. R14's low-air-loss mattress was set at 550 pounds. On 09/09/25 at 08:27 AM, R14 laid on her bed on her back. R14 was eating her breakfast. R14's low-air-loss mattress was set at 550 pounds.On 09/10/25 at 12:30 PM, Certified Nurse's Aide (CNA) O stated that CNAs did not do anything with the low air loss mattresses. CNA O stated that she would ensure the bed was working, but did not know anything about the dials. She stated the mattresses were set up by the supply person, and she didn't think the dials needed to be touched after the setup. On 09/10/25 at 12:58 PM, Licensed Nurse (LN) K set the low air loss mattresses according to weight. He stated the mattress should be set close to the resident's weight. He stated that the medical supply set the beds up. He stated there was no place on the Treatment Administration Record (TAR) for the nurse to mark to ensure the bed was set at the correct

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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 0688 Level of Harm - Minimal harm or potential for 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. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 107 residents. The sample included 26 residents with one resident was reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 44 was provided services and treatment to prevent worsening of contractures (abnormal permanent fixation of a joint or muscle) in his left hand. This deficient practice placed R44 at risk for discomfort and decreased range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). Findings included:- R44's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of contracture of the left elbow, contracture of the left hand, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), cerebrovascular accident (CVA- 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), and dementia (a progressive mental disorder characterized by failing memory and confusion).The Annual Minimum Data Set (MDS) dated 05/08/25 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R44 had bilateral lower limitation in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension) and limited ROM on one upper extremity. The MDS documented R44 was dependent on staff's assistance for oral hygiene, transfers, toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS documented R44 had not rejected care during the observation period. The MDS documented R44 had no nursing restorative program. The Quarterly MDS dated [DATE] documented a BIMS score of 10, which indicated moderately impaired cognition. The MDS documented R44 had bilateral lower limitation in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension) and limited ROM on one upper extremity. The MDS documented R44 was dependent on staff's assistance for oral hygiene, transfers, toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS documented R44 had not rejected care during the observation period. The MDS documented R44 had no nursing restorative program.R44's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/22/25 documented she required assistance with activities of daily living.R44's Care Plan dated 08/23/22 documented nursing staff would administer her medication as ordered by the physician. The plan of care documented the nursing staff would notify the nurse of decreased ROM, redness, pressure areas, or increased pain. The plan of care dated 10/02/22 documented R44 refused the use of a left resting splint. The plan of care dated 10/08/24 documented the nursing staff would assist her to maintain proper body position in the bed and when she was in her wheelchair.Review of R44's EMR lacked documentation of a re-evaluation of her current left hand and left elbow contracture. The EMR also lacked documentation of alternative interventions or services provided to R44 to prevent worsening of her contractures. R44's EMR lacked documentation of refusals to wear the left-hand splint. On 09/09/25 at 08:13 AM, R44 laid on the bed with the head of her bed elevated. R44's left elbow was bent and lay against her abdomen with her left hand closed with no splint or device to prevent the worsening of her contractures. On 09/10/25 at 08:01 AM, R44 laid on the bed with her left arm bent at the elbow and her left hand was tightly closed.On 09/10/25 at 12:30 PM, Certified Nurse Aide (CNA) O stated the therapy department would evaluate the residents and determine if the residents required any type of contracture care. CNA O stated the nursing staff would apply the splints if ordered by therapy. CNA O stated the nursing staff would chart the application and removal in the residents' EMR.On 09/10/25 at 12:58 PM, Licensed Nurse (LN) K stated that the therapy evaluated the residents with contractures. LN K stated the nurse would apply the splint and monitor the application of the splint. LN K stated if a resident refused to wear their splint, the nurse would refer them back to the therapy department for re-evaluation. LN K stated the nurse would document the application of the splint or their refusal on the Treatment Administration Record (TAR).On 09/10/25 at 01:23 PM, Administrative Nurse D stated that some of the residents were on therapy maintenance programs. Administrative Nurse D stated the nurse would monitor the application and removal of the splints, and that would be documented on the TAR. Administrative Nurse D stated that if a resident were to refuse to wear their hand splint, that resident would be referred to the therapy department for another assessment.The facility was unable to provide a policy related to quality of care.

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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 identified a census of 107 residents. The sample included 26 residents. The facility had one oxygen storage room on the 100 hall and one oxygen storage room on the 200 hall. The facility had a total of six cognitively impaired, independently mobile residents who resided on either the 100 or the 200 hall. Based on observation, record review, and interview, the facility failed to ensure oxygen tanks were stored in a securely locked room. The facility failed to ensure that Resident (R) 28's nothing by mouth (NPO) physician's order was followed. This deficient practice placed residents at risk of possible avoidable injury.Findings included:- On 09/08/25 at 07:14 AM, during the initial tour of the facility, the oxygen storage room on 200 hall was unlocked with 21 unused full oxygen cylinders present. On 09/08/25 at 07:15 AM, the oxygen storage room on the 100 hallway was unsecured with 32 Oxygen E-tanks stored in the room. On 09/08/25 at 09:01 AM, a return to the 200-hall oxygen storage room continued to be unlocked. On 09/08/25 at 07:18 AM, Certified Nurse Aide (CNA) M stated the oxygen storage room should be locked, but the lock was broken. CNA M stated the door had been broken for the past two years. On 09/08/25 at 09:02 AM, Licensed Nurse (LN) G stated that the code for the oxygen storage room had been changed recently. LN G stated that the room should be locked all the time. On 09/10/25 at 01:22 PM, Administrative Nurse D stated that the oxygen storage rooms should always be locked unless a staff member is replacing a used tank with a new one. The facility lacked a policy regarding oxygen storage or accidents. - R28's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), protein calorie malnutrition (a nutritional deficiency where the body doesn't get enough protein and calories (energy) from food), retention of urine, impulse disorder, legally blind, need for assistance with personal cares, and dysphagia (swallowing difficulty) oropharyngeal phase (the second phase of swallowing). The admission Minimum Data Set (MDS) for R28, dated 06/10/25, 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). R28's Nutrition Status Care Area Assessment (CAA) dated 06/10/24 documented impaired nutritional status, internal tube placement, and nothing by mouth (NPO) status. Contributing factors include cerebral palsy, protein-calorie malnutrition, gastrostomy status, colostomy status, legal blindness, congenital malformation, and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). R28's CAA documented staff would anticipate his needs, administer medications and enteral feedings per orders, and monitor for signs and symptoms of aspiration. The CAA documented that the registered dietician would do an evaluation for caloric intake/need and report to the healthcare practitioner as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R28's Care Plan dated 06/05/25 documented R28 required tube feeding related to malnutrition and chronic ileus (a condition where the normal movement of food and waste through the intestines has slowed or stopped) that recently resulted in small bowel obstruction that was surgically repaired. R28's plan of care documented he would maintain adequate nutrition and hydration status and maintain a stable weight. R28's plan of care documented staff should allow R28 to have thin water, five ml of Provale (special water) cup, on a pleasure feeding basis; staff were to limit one cup of water per day. The plan of care for R28 documented he was to have 100 percent staff supervision during intake, and his cup was to be stored with nursing or in the nourishment room when not in use. The plan of care documented staff were to monitor R28 for potential aspiration. R28's plan of care, revised on 06/12/25, documented R28 was NPO, receives all nutrition through his feeding tube, but it was ok to have ice chips as requested. R28's EMR under the Orders tab documented the following physician order: NPO diet, Not Applicable texture, NPO consistency, dated 06/12/25. On 09/08/25 at 11:30 AM, R28 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) outside of the day room. R28 had a cup of crushed ice in a Styrofoam cup with a spoon. There was no nursing staff to monitor R28 for aspiration. On 09/09/25 at 12:30 PM, R28 sat in his Broda chair in hallway 200. R28 had a cup of chunked ice with a spoon; there was no staff monitoring R28 for possible aspiration. On 09/10/25 at 12:30 PM, Certified Nurse's Aide (CNA) O stated the nurse knows how often R28 could have ice chips. She stated the nurse monitored R28 when he received ice chips. On 09/10/25 at 12:58 PM, Licensed Nurse (LN) K stated R28 could have ice chips every hour if he wanted. He stated that the nurse gave him his ice chips, but he should be monitored while receiving the ice. LN K stated there should be an order stating R28 could have ice chips. On 09/10/25 at 01:22 PM, Administrative Nurse D stated staff monitored R28 while he ate his ice chips. She stated there should be an order for ice chips or some documentation stating he was safe to have ice chips. Administrative Nurse D stated that speech therapy had worked with R28. The facility did not provide an accident policy.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 107 residents. The sample included 26 residents. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 24's dialysis (a procedure where impurities or wastes were removed from the blood) physician order was in his orders of the Electronic Medical Record (EMR). The facility failed to ensure R24's care plan provided interventions to direct staff and implement care and services according to the professional standards of practice in order to meet the resident's dialysis care needs. This deficient practice placed R24 at risk for missed dialysis visits and complications related to dialysis.Findings included:- R24's EMR documented diagnoses of osteomyelitis (local or generalized infection of the bone and bone marrow), end-stage renal disease (ESRD- a terminal disease of the kidneys), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and hemiplegia (paralysis of one side of the body).R24's admission Minimum Data Set (MDS) dated 08/20/25 documented he had a Brief Interview for Mental Status (BIMS) score of 13, which indicated an intact cognition. R24 had functional limitation in range of motion with impairment in both upper and lower extremities. R24 used a walker and a wheelchair to assist with mobility. R24 required substantial assistance to total dependence on staff for his functional abilities. R24 required peritoneal dialysis (procedure performed to remove toxins, drugs, or other wastes in the blood normally excreted by the kidney).R24's Functional Abilities Care Area Assessment (CAA) dated 08/25/25 documented he needed assistance with his activities of daily living (ADL) and mobility. Contributing factors include osteomyelitis (local or generalized infection of the bone and bone marrow) of the lumbar vertebra, discitis (inflammation that develops between the intervertebral discs of the spine), ESRD, COPD, and hemiplegia. Staff anticipated his needs and administered his medications as prescribed. Staff assist with his ADLs per the care plan.R24's Care Plan, revised 09/04/25, directed staff that he received hemodialysis. R24's Care Plan directed staff to check and change his dressing daily at the access site in the left upper arm. The Care Plan directed staff not to draw blood or take blood pressure in the left arm. R24's Care Plan lacked staff direction on his dialysis days, the location of his dialysis clinic, the contact information of the dialysis clinic, and how information would be communicated between the facility and the dialysis clinic.R24's EMR lacked a physician's order for dialysis.On 09/08/25 at 01:49 PM, R24 laid in his bed resting.On 09/10/25 at 12:59 PM, Licensed Nurse (LN) K stated that when a resident was admitted , the admitting nurse was responsible for entering orders in the EMR. LN K stated that the unit manager would review his order the next day to make sure everything was entered correctly. LN K stated R24's EMR should have his dialysis order entered. LN K stated R24's care plan should direct staff on which days he goes to dialysis, as well as any special care needed regarding care before and after his dialysis treatment.On 09/10/25 at 01:22 PM, Administrative Nurse D stated that R24's order for his dialysis should have been entered into the EMR at the time of his admission on [DATE]. Administrative Nurse D stated that the unit manager should have caught that during her audit that the order was not in the EMR. Administrative Nurse D stated she expected R24's care plan to reflect which days and times he went to dialysis, as well as the dialysis clinic name, and other special instructions.The End-Stage Renal Disease, Care of a Resident policy, dated February 2022, documented that staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care would be managed, including: how the care plan would be developed and implemented; how information will be exchanged between the facilities; and responsibility for waste handling, sterilization, and disinfection of equipment; and the resident's comprehensive care plan would reflect the resident's needs related to ESRD/dialysis care.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 107 residents. The sample included 26 residents, with three residents reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to assess and identify trauma-based triggers related to R11's post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The facility failed to implement individualized interventions to prevent re-traumatization to R11. These deficient practices placed R11 at risk for decreased psychosocial well-being and ineffective treatment. Findings included:- R11's Electronic Medical Record (EMR) documented diagnoses of PTSD, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and hydronephrosis (a condition where urine backs up into the kidney, causing it to swell).R11's Annual Minimum Data Set (MDS) dated 03/20/25 documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R11 required only supervision from staff for her cares. R11 had an active diagnosis of PTSD. R11's Psychotropic Drug Use Care Area Assessment (CAA) dated 03/02/25 documented the use of psychotropic meds to manage psychiatric illness/condition. A licensed nurse monitored for side effects every shift, and the physician/psychiatrist was to be notified of any abnormal findings. A pharmacist consultant would review medications monthly, and the physician would review medications with each visit. R11's CAAs lacked her PTDS being addressed.R11's Care Plan, revised on 08/05/25, directed staff that she had adjustment issues related to recent losses and changes. The Care Plan directed staff to allow R11 the opportunity to communicate her feelings. The Care Plan directed staff to encourage R11 to participate in conversations with staff and other residents daily. The Care Plan lacked staff direction on her PTSD triggers and interventions to prevent re-traumatization.On 09/10/25 at 11:15 AM, R11 sat in her wheelchair near the entrance of the building, visiting with a staff member.On 09/10/25 at 12:59 PM, Licensed Nurse (LN) K stated he knew that some residents' care plans did address a PTSD diagnosis, but was not certain R11's care plan did. LN K stated staff should be made aware of past trauma and what might be triggers.On 09/10/25 at 01:22 PM, Administrative Nurse D stated that social services did an initial evaluation on each resident at admission and then quarterly. Administrative Nurse D could not say if the evaluation addressed PTSD. Administrative Nurse D stated she would expect R11's care plan to address past traumas and have interventions to prevent re-traumatization.The Trauma-Informed and Culturally Competent Care policy, dated October 2023, documented the purpose was to guide staff in providing care that was culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Trauma-informed care was an approach to delivering care that involved understanding, recognizing, and responding to the effects of all types of traumas. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. The policy documented the performance of universal screening of residents, which included a brief, non-specialized identification of possible exposure to traumatic events. Utilize screening tools and methods that were facility-approved, competently delivered, culturally relevant, and sensitive. Screening may include information such as trauma history, including type, severity, and duration; depression, trauma-related or dissociative symptoms; risk for safety (self or others); concerns with sleep or intrusive experiences; behavioral, interpersonal, or developmental concerns; historical mental health diagnosis; substance use; protective factors and resources available; and physical health concerns. Utilize initial screening to identify the need for further assessment and care. Assessment involved an in-depth process of evaluating the presence of symptoms, their relationship to trauma, and the identification of triggers. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments. Use assessment tools that are facility-approved and specific to the resident population. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. Identify and decrease exposure to triggers that may re-traumatize the resident. Recognize the relationship between past trauma and current health concerns (e.g., substance abuse, eating disorders, anxiety, and depression). Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms, and values.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 107 residents. The sample included 26 residents, with two reviewed for dementia (a progressive mental disorder characterized by failing memory and confusion). Based on interviews, record reviews, and observations, the facility failed to provide consistent dementia-related behavioral interventions for Resident (R) 16 to promote the resident's highest practicable level of well-being. This deficient practice placed R16 at risk for decreased quality of life, isolation, and impaired dignity.Findings Included:- The Medical Diagnosis section within R16's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, repeated falls, and the need for assistance with personal care. R16's Quarterly Minimum Data Set (MDS) completed 08/02/25 indicated a Brief interview for Mental Status (BIMS) score of three (severe cognitive impairment). The MDS noted no upper or lower extremity impairments. The MDS noted he used a wheelchair for mobility. The MDS noted he had physical, verbal, and other self-directed behaviors observed for one to three days. The MDS noted he required substantial to maximal assistance from staff for toileting, transfers, bathing, bed mobility, dressing, personal hygiene, and putting on footwear. R16's Behavioral Care Area Assessment (CAA) triggered on 05/27/25. The CAA noted he had a history of physical and verbally aggressive behaviors. R16's Care Plan initiated 05/15/25 indicated he was admitted to a secured unit due to his medical diagnoses and risk for elopement. The plan noted he was monitored frequently for safety (05/15/25). The plan noted he required substantial assistance from staff for transfers, bathing, toileting, dressing, personal hygiene, and oral hygiene (05/15/25). The plan noted he had cognitive impairment or impaired thought processes (05/15/25). The plan instructed staff to cue, orient, and supervise him as needed (05/15/25). The plan instructed staff to engage in simple activities and kept his routine consistent (05/15/25). The plan noted he was dependent on staff for meeting his emotional, intellectual, physical, and social needs (06/20/25). On 09/02/25, R16's plan was updated, indicating he had behaviors related to inappropriate touching. The plan instructed staff to anticipate his needs, offer tasks to divert his attention, and provide activities that accommodated his interests (09/02/25). The plan noted he was placed on one-to-one supervision until his departure from the facility, and facility staff provided abuse education (09/02/25). The plan lacked interventions related to his inappropriate touching or boundary concerns prior to 09/02/25. R16's EMR under Progress Notes revealed a Nurse's Note completed on 07/16/25. The note indicated R16 was observed holding hands with another resident and using affectionate gestures towards other residents on the secured unit. The note indicated staff provided appropriate redirections to maintain personal boundaries in a respectful manner. R16's EMR under Progress Notes revealed a Nurse's Note completed on 07/17/25. The note indicated R16 wheeled himself around the secured unit. The note revealed R16 was observed repeatedly touching other residents. The note revealed that staff intervened promptly by redirecting him and provided verbal reminders regarding personal boundaries. The note revealed staff had to remove R16 from the immediate area and redirect to an activity table under staff supervision. R16's EMR under Progress Notes revealed a Nurse's Note completed on 07/18/25. The note revealed R16 was observed touching a resident in a sexual way and provided several redirections. The note revealed R16 became aggressive upon redirection and wanted to hit the staff. The note revealed that staff moved him back to his room and attempted to contact his resident representative. R16's EMR under Progress Notes revealed a Nurse's Note completed on 07/18/25. The note revealed R16 was sent out to an acute medical facility for evaluation. R16's EMR under Miscellaneous revealed an acute medical facility summary from 07/28/25. The summary indicated the facility report concerns of worsening promiscuity and combativeness. R16's EMR under Progress Notes revealed an admission Progress Note completed on 07/28/25. The note indicated he returned to the facility at 04:00 PM following a hospital stay for treatment of inappropriate behaviors and gout. R16's EMR under Progress Notes revealed a Social Service Note completed on 08/28/25. The note revealed R16's Resident representative was notified that R16 had been touching and being inappropriately with staff. The note indicated he was being transferred to an all-male unit. R16's EMR under Progress Notes revealed a Behavior Note completed on 08/29/25. The note revealed that staff witnessed R16's hands touching another resident's private area. The note revealed that both residents were immediately separated, and the unit supervisor was notified. A Facility Incident Report #3977 completed on 08/29/25 indicated R16 was observed by staff placing his hands between R75's (a severely cognitively impaired female resident) inner thighs. The report indicated R75 screamed out, Stop, don't touch me. The report indicated that both

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility identified a census of 107 residents. The sample included 26 residents, with five medication carts and three medication rooms. Based on observation, record review, and interviews, the facility failed to ensure an accurate reconciliation of controlled drugs at the end of daily work shifts and maintain the staff count sheets for the controlled drugs. This placed residents at risk for misappropriation of medications and/or diversion of controlled substances. Findings included:- On 09/09/25 at 07:30 AM, a review of the September 2025 Narcotic Shift Count Sheet on the 200 hall from 09/01/25 to 09/09/25 (nine days) revealed a missing signature either for the on-coming nurse or the off-going nurse on the following dates: 09/01/25, 09/02/25, 09/03/25, 09/04/25, 09/05/25, 09/06/25, 09/07/25, 09/08/25, and 09/09/25. On 09/09/25 at 07:33 AM, Licensed Nurse (LN) K stated that each shift should count the narcotics at shift change with the oncoming nurse and the off-going nurse. LN K stated it was the expectation of the facility that reconciliation of the narcotics was expected when the shift started and ended. On 09/10/25 at 01:23 PM, Administrative Nurse D stated she expected the narcotics to be counted between the oncoming nurse and the off-going nurse. The facility's Controlled Substances policy, last revised April 2019, documented the facility complied with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Controlled medications were counted at the end of each shift. The nurse coming on duty and the nurse going off duty determined the count together. Any discrepancies in the controlled substance count were documented and reported to the director of nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175557	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Olathe	201 E Flaming Road Olathe, KS 66061

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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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Azria Health Olathe		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E Flaming Road Olathe, KS 66061	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 107 residents. The sample included 26 residents, with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 25's insulin (a hormone that lowers the level of glucose in the blood) was given before meals according to the physician-ordered parameters related to blood glucose monitoring. This deficient practice placed R25 at risk for hypoglycemia (less than normal amount of sugar in the blood), delayed treatment, and unnecessary medication complications. Findings included:- R25's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses hypertension (HTN high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), fracture of shaft of left tibia (the inner and typically larger of the two bones between the knee and the ankle), quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), need for assistance with personal care, muscle weakness, cognitive (relates to all the mental processes involved in knowing, thinking, learning, remembering, and understanding things), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R25 needed setup or cleanup for eating and oral hygiene. The MDS documented R25 was dependent on staff for toileting and needed substantial to maximal assistance for bathing. The MDS documented R25 had DM and received insulin during the look-back period. R25's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 07/09/25 documented R25's need for assistance with activities of daily living (ADL) and mobility. Contributing factors include displaced fracture with routine healing, quadriplegia, DM, HTN, anxiety, and depression. The CAA documented staff would anticipate R25's needs, administer medications as prescribed, prepare and serve his diet as ordered.R25's Care Plan dated 07/11/25 documented R25 had DM and he would have no complications related to diabetes through the review date. The plan of care for R25 documented staff would check his body for breaks in skin and treat promptly as ordered by the physician, and give diabetes medication as ordered. R25's care plan documented the dietician would discuss mealtimes, portion sizes, dietary restrictions, snacks allowed in the daily nutritional plan, and compliance with nutritional regimen.R25's EMR under Orders revealed the following physicians' orders:Insulin Glargine Subcutaneous (beneath the skin) solution pen injector 100 units/milliliter (ml) (insulin Glargine- long-acting insulin), inject five units subcutaneously at bedtime for diabetes, dated 07/04/25.Humalog (fast-acting insulin) Mix 75/25 Kwik Pen Subcutaneous suspension pen injector (75-25) 100 unit/ml (insulin Lispro Protamine (intermediate-acting insulin) and Lispro (fast-acting insulin)), inject three units subcutaneously with meals for diabetes hold if blood sugar < (less than) 200 ml/dl, dated 07/04/25.Insulin Glargine subcutaneous solution pen-injector 100units/ml (insulin Glargine), inject ten units subcutaneously at bedtime for diabetes, dated 07/14/25.R25's EMR under the Treatment Administration Record (TAR) recorded the following blood glucose levels under 200 milligrams per deciliter (ml/dl). R25's TAR that lacked evidence, R25's insulin was held.08:00 AM Blood glucose readings:07/08/25 113 ml/dl07/11/25 165ml/dl07/12/25 123ml/dl07/13/25 140 ml/dl07/16/25 108 ml/dl07/17/25 123 ml/dl07/21/25 132 ml/dl07/22/25 150 ml/dl07/28/25 178 ml/dl07/30/25 160 ml/dl12:00 PM Blood glucose readings:07/16/25 170 ml/dl07/21/25 196 ml/dl07/22/25 137 ml/dl07/30/25 160 ml/dl05:00 PM Blood glucose readings:07/12/25 196 ml/dl07/16/25 113 ml/dl07/17/25 135 ml/dl07/22/25 120 ml/dl08:00 AM blood glucose readings:08/03/25 106 ml/dl05:00 PM blood glucose readings:08/29/25 125 ml/dl08/30/25 152 ml/dlR25 admitted to the facility on [DATE] and discharged to the hospital on [DATE].On 09/10/25 at 12:58 PM, Licensed Nurse (LN) K stated it was the nurse's duty to ensure the nurse double checked the TAR before nurses would give insulin. He stated nurses waited until the resident had his meal tray or would give the insulin after the resident had eaten.On 09/10/25 at 01:22 PM, Administrative Nurse D stated the facility needed to do a better job at oversight of insulin given. She stated nurses should ensure they are giving the correct amount of insulin to a resident. She stated that if a resident should be given insulin with meals, the insulin should be given when the meal arrived, or while the resident was eating.The facility did not provide a policy for unnecessary medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Azria Health Olathe		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E Flaming Road Olathe, KS 66061	

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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 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 107 residents. The facility had three medication rooms and five medication carts. Based on observation, record review, and interview, the facility failed to ensure the medication cart was kept locked and secured with cognitively impaired and independently mobile residents on the hall. This placed the residents at risk of accidental ingestion of medication and adverse reactions.Findings included:- On 09/08/25 at 07:14 AM, the nurse's medication cart on the 200 hall was left unlocked and unattended by staff. The medication cart contained two insulin pens and two vials of insulin.On 09/08/25 at 07:18 AM, Licensed Nurse (LN) H stated that she had stepped away from the cart briefly to assist another nurse, but the cart should always be locked when she was away from it. On 09/10/25 at 01:22 PM, Administrative Nurse D stated that the medication carts should not ever be left unlocked when staff are away from the cart. The facility's Security of Medication Cart policy, dated January 2023, documented that the medication cart shall be secured during medication passes. The nurse or certified medication aide must secure the medication cart during the medication pass to prevent unauthorized entry. The medication cart should be parked in the doorway of the resident's room during the medication pass. The cart doors and drawers should be facing the resident's room. When it's not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. Medication carts must be securely locked at all times when out of the nurse's view. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility identified a census of 107 residents, with one kitchen and two dining rooms. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to storage, preparation, and meal service. This deficient practice placed the residents at risk of food-borne illnesses and food safety concerns. Findings Included: - On 09/08/25 at 07:05 AM, a walkthrough of the facility's kitchen was completed. An inspection of the main kitchen area revealed:The floor was heavily dirty with old food debris and trash in the food prep and stove area. A soiled towel was on the floor next to the stove top ovens. Dessert saucers and plates were stored upwards in the dishware storage rack. An inspection of the dry food storage area revealed dirty floors and a soiled Band-Aid in the center of the dry food storage room floor. A dented 6.56-pound (lb.) can of fruit cocktail was on the canned storage rack. An inspection of the walk-in refrigerator revealed a metal tray of five packaged turkey cold cut meat underneath the walk-in refrigerator's air blower. The tray had liquid dripping on the turkey packages and pooling in the tray, dripping from a pipe coming from the air conditioner. On 09/11/25 at 12:01 PM, Dietary Staff BB stated that food was not to be placed underneath the air conditioner in the walk-in units. He stated the food was moved and thrown out. He stated that staff were expected to clean after every meal service.A review of the facility's Food Services and Nutrition policy, dated 10/2017, indicated the facility would promote a system that identified proper service, cleaning, and food storage. The policy noted that all surfaces within the dining room and kitchen were to be cleaned and sanitized per professional standards. The policy indicated food would be labeled/dated and stored in a manner that is safe and maintains nutritional value. The policy indicated staff were to ensure safe food handling practices to prevent cross-contamination and food-borne illness. The policy indicated staff should complete hand hygiene in between touching surfaces related to direct food preparation, handling, and serving. The policy noted that all kitchen and dining equipment be stored in a manner that prevents soiling or contamination of clean items.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 107 residents. The sample included 26 residents, with two residents reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Residents (R) 4 and R5. This placed the resident at risk for inadequate end-of-life care. Finding Included:- R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN-elevated blood pressure), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), epilepsy (brain disorder characterized by repeated seizures), psychosis (any major mental disorder characterized by a gross impairment in reality perception), dementia (a progressive mental disorder characterized by failing memory and confusion), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), repeated falls, need with assistance with personal cares, muscle weakness, encounter for palliative care, and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 99, which indicated severely impaired cognition. The MDS documented R4 was dependent on staff for toileting, bathing, dressing, and eating. The MDS documented R4 received hospice services. R4's The Functional Abilities Self-Care and Mobility Care Area Assessment (CAA), dated 08/12/25, documented R4's activities of daily living (ADL) function CAA triggered secondary to assistance required in ADLs, impaired balance, transitions during transfers, and functional impairment in activity. R4's contributing factors include generalized weakness and decreased safety awareness. R4's risk factors included further ADL decline, falls, incontinence, skin breakdown, and pain. The CAA documented R4's care plan would be initiated/reviewed to improve/maintain current ADL status and functional ability, maintain continence status, decrease pain, and decrease fall and pressure ulcer risk. R4's Care Plan dated 09/05/24 documented R4 was admitted to hospice due to a terminal diagnosis, cerebral atherosclerosis (a condition where fatty deposits build up in the arteries that supply blood to the brain). R4's plan of care documented comfort would be maintained, and staff would adjust the provision of ADLs to compensate for the resident's changing abilities. R4's plan of care documented that staff were to encourage participation to the extent the resident wished to participate and encourage the support system of family and friends. R4's plan of care documented to keep the environment quiet and calm, keep linens clean, dry, and wrinkle-free. R4's plan of care documented staff were to keep the lighting low and familiar objects nearby. The plan of care for R4 documented the hospice provider would review the resident's living will and ensure it was followed. The plan of care for R4 documented staff were to involve the family in the discussion. R4's plan of care documented Vitas hospice would provide durable medical equipment (DME), and staff would work cooperatively with hospice team to ensure R4's spiritual, emotional, intellectual, physical, and social needs were met. A review of the hospice-provided communication binder revealed R4 was admitted to hospice services on 09/05/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Azria Health Olathe		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 E Flaming Road Olathe, KS 66061	

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/25 at 08:35 AM, R4 sat in the dining area waiting for her breakfast, holding her doll. On 09/09/25 at 08:50 AM, R4 sat in the dining room with staff assisting her with breakfast. On 09/10/25 at 12:30 PM, Certified Nursing Aide (CNA) O stated she was unsure what hospice provided for the residents. She stated the hospice aides would let the staff know if the hospice provider left any supplies or gave a shower. CNA O stated she didn't think that what hospice provided, the CNAs could see. On 09/10/25 at 12:58 PM, Licensed Nurse (LN) K stated he was unsure what hospice provided. He stated he did not do the care plans; the MDS coordinator did the care plan. LN G stated he did not think what hospice provided would need to be on the facility's care plan. LN G stated that hospice aides and nurses were good at letting the facility know what equipment and supplies they brought to the resident. He stated if there was something specific the facility needed to know, they could look in the hospice binder specific to each resident. On 09/10/25 at 01:22 PM, Administrative Nurse D said she knew the hospice providers had detailed care plans and staff would know specific services by those. She stated she thought everything hospice provided should be on the care plan. The facility's Hospice Program policy, dated 07/17, documented hospice services were available to residents at the end of life. The facility had an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so. Upon admission and periodically during their stay, residents were informed of the availability of hospice services coordinated through the facility. - R5's Electronic Medical Record (EMR) documented diagnoses of malignant neoplasm (cancer- an abnormal growth of cells that can invade and spread to other parts of the body) of lung, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and hemiplegia/paresis (weakness and paralysis on one side of the body). R5's admission Minimum Data Set (MDS) dated 08/25/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R5 required substantial/maximal assistance to being dependent on staff for his activities of daily living (ADL) care. R5 was on hospice care. R5's Functional Abilities Care Area Assessment (CAA) dated 08/27/25 documented his need for assistance with his ADLs and mobility due to his lung cancer, need for palliative care, and failure to thrive. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Care Plan initiated on 08/19/25 directed staff that he had a terminal prognosis and elected hospice care. The Care Plan directed staff to adjust provisions of his ADLs to compensate for his changing abilities. The Care Plan directed staff to encourage participation to the extent the resident wished to participate. The Care Plan directed staff to encourage the resident to express his feelings and listen with non-judgmental acceptance and compassion. The Care Plan directed staff to encourage a support system of family and friends. The Care Plan directed staff to keep the environment quiet and calm, keep linens clean, dry, and wrinkle-free, keep the lighting low, and keep familiar objects nearby. The Care Plan directed staff to observe R5 closely for signs of pain and administer pain medications as ordered and notify the physician immediately if there was breakthrough pain. The Care Plan directed staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. R5's Care Plan lacked staff direction on who the hospice provider was and the contact information. R5's Care Plan lacked staff direction on what hospice provided for the resident as far as supplies, durable medical equipment (DME), medications, and hospice staff information (who would visit and the frequency of the visits). On 09/09/25 at 01:15 PM, R5 lay resting on his low air loss mattress, the bed in low position, and the call light within reach. On 09/10/25 at 12:30 PM, Certified Nurse Aide (CNA) O stated that the nurses would usually tell staff when a resident was on hospice. CNA O stated that the hospice aide would come a couple of times a week, and the hospice nurse came to the facility weekly and would usually ask if a resident needed any supplies. CNA O stated that the items/equipment supplied had the hospice name on them. CNA O stated she was not certain if R5's care plan had all that information in it or not. On 09/10/25 at 12:59 PM, Licensed Nurse (LN) K stated the hospice information was at the nurse's station and the hospice plan of care was in the resident's hospice books. LN K could not say for certain if R5's care plan had all the information about hospice in it as far as the contact information and what hospice supplied, but would expect that the care plan should have that information on it. On 09/10/25 at 01:22 PM, Administrative Nurse D stated they had been working on improving the resident care plans. Administrative Nurse D stated R5's care plan should document the hospice provider and contact information as well as what hospice provided and when hospice staff would visit. Administrative Nurse D stated she would ensure R5's care plan was revised to reflect that information. The Hospice Program policy, dated January 2024, documented coordinated care plans for residents receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) to maintain the resident's highest practicable physical, mental, and psychosocial well-being. The coordinated care plan would reflect the resident's goals and wishes, as stated in his or her advance directives and during ongoing communication with the resident or representative, including palliative goals and objectives, palliative interventions, and medical treatment and diagnostic tests.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Olathe	201 E Flaming Road Olathe, KS 66061

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility had a census of 107 residents. Five Certified Nurse Aides (CNA) were sampled for required in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for decreased quality of life and/or inadequate care. Findings included:- Review of the information facility's in-service records revealed the following CNAs were employed with the facility for more than 12 months: CNA MM, hired on 06/26/24, had not completed the required in-services in the past 12 months. CNA NN, hired on 09/29/24, had not completed the required in-services in the past 12 months. CNA OO, hired on 09/22/22, had not completed the required in-services in the past 12 months. CNA PP, hired on 11/22/23, had not completed the required in-services in the past 12 months. CNA QQ, hired on 10/25/23, had not completed the required in-services in the past 12 months. On 09/10/25 at 12:30 PM, Certified Nurse Aide (CNA) O stated the facility did have monthly meetings. CNA O stated she could not remember the last time she had a dementia (a progressive mental disorder characterized by failing memory and confusion) in-service. On 09/10/25 at 12:58 PM, Licensed Nurse (LN) K stated the facility did provide monthly in-services. LN K stated he could not remember the last dementia care in-service. LN K stated we are provided abuse and neglect in-services often. On 09/10/25 at 01:23 PM, Administrative Nurse D stated the facility human resource department, and the administrative staff were responsible for ensuring the direct care staff received the required 12 hours of in-services. The facility's In-Service Training, All Staff policy, last revised 08/2022, documented all staff must participate in initial orientation and annual in-service training.