STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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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 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** 45668 The facility identified a census of 54 residents. The sample included 22 residents with four reviewed for resident rights. Based on observation, record review, and interviews, the facility failed to maintain dignified care practices for Resident (R) 47, R12, and R101. This deficient practice placed the residents at risk for embarrassment and decreased psychosocial well-being. Findings Included: - The Medical Diagnosis section within R47's Electronic Medical Records (EMR) included diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dysphagia (difficulty in swallowing food or liquid), and adult failure to thrive. R47's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. The MDS noted that he required extensive assistance from two staff for bed mobility, dressing, and toileting. He wasHe was totally dependent on one staff for personal hygiene, and was totally dependent on two staff for transfers, and bathing. Review of R47's Activities of Daily Living (ADL's) Care Area Assessment (CAA) dated 06/24/22 indicated that he was paraplegic and required total assistance with his ADL's. R47's Care Plan, revised 03/22/22, indicated that he was totally dependent on two staff members to provide bathing opportunities every Wednesday and Sunday. The care plan noted that he was totally dependent on two staff for toileting, personal hygiene, dressing, and bed mobility. The care plan indicated he required a Hoyer lift (total body mechanical lift used to transfer residents) for all transfers. (continued on next page)

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	On 08/17/22 at 08:06 AM, R47 observed being transitioned from his Broda chair (specialized wheelchair with the ability to tilt and recline) to his bed by Certified Nurse's Aide (CNA) PP and CNA M. CNA PP and CNA M completed hand hygiene, donned gloves, and removed the Hoyer Lift from R47's bathroom. CNA PP pulled the room's privacy curtain. CNA PP positioned the Hoyer lift in front of R47's chair and attached the slings. Staff lifted the resident and transitioned him to the bed. Staff removed the Hoyer lift sling from underneath R47 and placed the sling on his chair. CNA PP walked over to R47 and immediately began pulling off R47's pants and incontinence briefs without talking to him and failed to ask his permission to be observed or announcing the intended cares. CNA PP cleaned R47's groin and buttocks before placing a clean incontinence brief on him. R47's pants pulled back up and he was repositioned in bed. Both CNA PP and CNA M wore the same pair of gloves throughout the entirety of the observation and failed to change gloves or complete hand hygiene in between the care tasks. CNA PP and CNA M failed to explain to R47 the tasks being performed on him or engaged R47 in conversation during the cares provided. On 08/18/22 at 01:20 PM, CNA O stated staff should address R47 by his name and staff were to talk to the resident during cares. She stated staff should pull the privacy curtain when changing a resident or providing peri-care (cleaning the private areas of a resident). She stated staff should be asking for his permission and should never perform care task without explaining to the resident first about the procedure. On 08/18/22 at 01:25 PM, Licensed Nurse (LN) H stated each resident's privacy should be respected during bathing and cares. She stated that staff should be talking to the residents by name and ensuring that the residents were comfortable. On 08/18/22 at 05:18 PM, Administrative Nurse D stated staff were expected to address all residents in a dignified manner and ensure each residents' individualized care addressed. Review of the facility's Dignity policy revised 12/2016, revealed each resident shall be cared for in a manner that promotes and enhances their sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. Staff are to explain procedures to the residents before they are performed, and staff are to protect the resident's bodily privacy during assistance with personal cares and during treatment procedures. The facility failed to provide dignified cares for R47. This deficient practice placed him at risk for embarrassment and decreased psychosocial wellbeing. 41037 - R12's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of retention of urine (lack of ability to urinate and empty the bladder), and dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R12 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R12 had an indwelling catheter during the look back period. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 06/22/22 documented he had a suprapubic catheter (urinary bladder catheter inserted through the skin) and required assistance with care and monitoring of the catheter. R12's Care Plan dated 08/16/21 documented he had a 12 French (FR) Foley (tube inserted into the bladder to drain urine into a collection bag) suprapubic catheter. If the catheter becomes dislodged, notify the physician. On 08/15/22 at 08:55 AM observation revealed R12's catheter drainage bag contained dark amber urine with sediment noted in the tubing. The catheter drainage bag was attached to the resident's wheelchair under the seat and lacked a dignity/cover bag. The catheter bag drug along the floor as R12 propelled himself. On 08/22/22 at 08:21 AM, observation revealed R12's catheter drainage bag attached to the wheelchair next to the dignity/cover bag, under the wheelchair seat. The catheter tubing drug along the floor as R12 propelled himself in the dining room. On 08/18/22 at 03:40 PM, Certified Nurse's Aide (CNA) N stated staff should provide catheter care every two hours and when soiled. Staff should place a catheter drainage bag should in a dignity bag below the bladder. On 08/18/22 at 04:15 PM. Licensed Nurse (LN) I stated R12's catheter drainage bag should always be placed in a dignity bag and never be placed on the floor On 08/18/22 at 05:17 PM, AdministrativePM, Administrative Nurse D stated staff should place the resident's catheter drainage bag in a dignity bag. The undated facility policy for Quality of Life-Dignity , documented residents are always to be treated with dignity and respect. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents by helping the resident to keep urinary catheter bags covered. The facility failed to ensure R12 was treated with dignity, when the resident had his catheter collection bag uncovered. This deficient practice placed R12 at risk for negative psychosocial outcomes and decreased autonomy and dignity. - R101's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), pneumonia (inflammation of the lungs), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The staff interview was not completed. The MDS documented R101 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R101 was at risk of development of pressure ulcers. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/05/21 documented a low BIMS related to Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The Quarterly MDS dated [DATE], documented a BIMS score of zero, which indicated severely impaired cognition. The staff interview was not completed. The MDS documented that R101 required extensive assistance of two staff members for ADL's. The MDS documented R101 received oxygen therapy and was at risk of development of pressure ulcers during the look back period. The resident's Care Plan, dated 07/15/19, documented staff would use R101's preferred name. Staff would identify themselves with each interaction. Staff would face R101 when speaking and would make eye contact. R101 understood consistent, simple, directive sentences. Staff would provide 101 the necessary cues. On 08/15/22 at 08:31 AM R101 sat in his wheelchair next to his bed, with his right lower extremity rested on the floor between the leg rests. An unidentified staff entered R101's room and pushed his wheelchair into the hallway without announcing the cares to be provided and continued to propel him without any verbal interaction to inform R101 where staff were taking him. On 08/16/22 at 12:33 PM, R101 sat in a wheelchair in the dining room. R101 slid down in the wheelchair, while his bilateral (both) lower extremities rested on the wheelchair leg rests. Certified Nurse's Aide (CNA) N and CNA Q repositioned R101 to an upright position in the wheelchair. CNA Q sat next to R101 on his right side as she assisted him with lunch. CNA Q did not explain her cares or attempt to engage R101 in conversation at all during the meal from 12:33 PM through 01:24 PM. On 08/17/22 at 08:30 AM, R101 sat in a wheelchair at the dining room table. LN H sat to the right of R101 as she assisted him with breakfast. LN H spoke with other nursing staff and dietary staff as she assisted R101 with his meal. On 08/18/22 at 03:20 PM, CNA O stated she was not aware of the care planned intervention for R101 for face to face and making eye contact with him when communicating. CNA O stated she had not had time yet to review all the care plans. On 08/18/22 at 05:17 PM, Administrative Nurse D stated staff were encouraged to talk to residents face to face and engage the resident during meals. Administrative Nurse D stated in-service training on regarding dignity was provided at least yearly and as needed. The undated facility policy for Quality of Life-Dignity, documented residents are always to be treated with dignity and respect. Staff would inform and orient residents to their environment. Procedures are explained before they are preformed, and residents would be told in advance if they were to be taken out of their usual or familiar surroundings. The facility failed to ensure R101 was treated with dignity. This deficient practice placed R101 at risk for negative psychosocial outcomes and decreased autonomy and dignity.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents with five residents sampled for abuse. Based on observations, record review, and interviews, the facility failed to ensure residents remained free from abuse and failed to protect residents from further abuse. On 03/13/22, Resident (R) 40 pushed R42 out of a chair and caused R42 to fall on the floor. R42 received an abrasion and hematoma (a bad bruise that occurs when an injury causes blood to collect and pool under the skin) to his right temple from the fall. R40 was started on an antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions) on 03/14/22, but the facility did not implement any behavioral interventions related to the incident or protective measures to prevent further incidents. On 03/31/22, R40 approached R6, stood over him, and spoke loudly to him. R40, a former boxer, then punched R6 multiple times in the face. R6 tried to block the punches and threw his coffee cup at R40. R40 went for emergent evaluation for aggressive behaviors on 03/31/22 and returned to facility on 04/06/22. The facility placed R40 on a different unit but failed to implement further interventions to address R40's behaviors. These failures placed the residents in immediate jeopardy. The facility further failed to prevent resident-to-resident abuse when R14, who had a history of aggressive behaviors towards other residents on the unit, shoved R42 causing him to fall. R14 also struck an unidentified resident on the backside, which precipitated a physical altercation between R14 and the unidentified resident. Findings included: - The Diagnoses tab of R40's Electronic Medical Record (EMR) documented diagnoses of diffuse traumatic brain injury (TBI) without loss of consciousness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, psychosis (any major mental disorder characterized by a gross impairment in reality testing) not due to a substance or known physiological condition, schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought] bipolar type (episodes of severe high and low moods), alcohol-induced persisting dementia, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), major depressive disorder (major mood disorder), and drug-induced thyroiditis (inflammation of the gland which controls growth and metabolism due to medication use). The Admission Minimum Data Set (MDS) dated [DATE], documented R40 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. R40 did not have any behaviors in the lookback period. R40 required extensive physical assistance with two staff for bed mobility and transfers; extensive physical assistance with one staff with dressing, toileting, personal hygiene, and bathing; supervision with setup help only with eating and locomotion. R40 received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medications five days and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications six days in the seven-day lookback period. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Quarterly MDS dated [DATE], documented R40 had a BIMS score of nine, which indicated moderate cognitive impairment. R40 had other behaviors not directed towards others one to three days in the lookback period. He required supervision with one staff for bed mobility, transfers, walking, locomotion; extensive physical assistance with one staff with dressing and bathing; limited physical assistance with one staff for toileting and personal hygiene; independent with setup help only for eating. R40 received antidepressant medications seven days in the seven-day lookback period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/07/22, documented R40 triggered for impaired cognition, had a BIMS score of six, and could respond to simple questions. The Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Drug Use CAA dated 02/07/22, documented R4 had been on long term antidepressant and antianxiety medications and was stable at that time with current dosages. The Anti-Psychotic Care Plan dated 03/17/22, documented R40 was at risk for adverse side effects related to use of Geodon (antipsychotic) for schizoaffective disorder, bipolar type, and directed staff approached R40 calmly, attempted to redirect when R40 had a behavior outburst, gave Geodon as ordered, monitored behavior, observed for signs and symptoms either increased or decreased behaviors or adverse effects from the anti-psychotic medication, and spoke with a calming tone to R40. The Behavior Care Plan dated 02/28/19, revised 03/14/22, documented R40 had potential for impaired or inappropriate behaviors and included: verbally aggressive/inappropriate, making threats to others, refusing cares/showers/assessments/medications. R40's occupation was former boxer. The Behavior Care Plan documented the following interventions: staff anticipated and met R40's needs, initiated 02/28/19; staff frequently and closely monitored R40 for unwanted behaviors and when R40 showed aggressive behaviors, staff redirected immediately and kept away from other residents, initiated 10/11/19; staff gave Geodon 20 milligrams one time a day for schizoaffective disorder bipolar type for two weeks, initiated 03/16/22; if R40 approached other residents in unwanted ways, staff intervened and redirected. If approach continued then staff provided ongoing support to redirect until further arrangements were made, initiated 10/17/20; if reasonable, staff discussed R40's behaviors and explained/reinforced why behavior was inappropriate and/or unacceptable to R40, initiated 02/28/19; staff intervened as necessary to protect the rights and safety of others, approached/spoke to R40 in a calm manner, diverted R40's attention, and removed R40 from the situation and took to alternate location as needed, initiated 02/28/19; staff offered food/snacks to calm/distract R40, initiated 07/20/21. The Cognition Care Plan dated 02/18/19, last revised 08/26/21, documented R40 had impaired cognition related to difficulty recalling things short- and long-term secondary to a diagnosis of dementia. The Cognition Care Plan documented interventions, initiated 02/18/19, that staff administered medications per order, asked yes/no questions to determine R40's needs, introduced self frequently, maintained calm and relaxed manner, provided consistency in daily routine, redirected as needed, and reoriented/validated as needed. The Care Plan did not address R40's diagnosis of thyroiditis and/or related complications. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Orders tab of R40's EMR documented an order with a start date of 01/06/22 for memantine (Namenda) 5 mg two times a day for dementia. This order was discontinued on 03/13/22. The Orders tab documented an order with a start date of 03/14/22 for Geodon 20 mg one time a day for schizoaffective disorder bipolar type for two weeks. This order was discontinued on 03/22/22. The Orders tab documented another order with a start date of 03/22/22 for Geodon 20 mg two times a day for behaviors and schizophrenia. This order was discontinued on 04/07/22. R40's Medication Administration Record (MAR) for March 2022 documented R40 had anxious/compulsive behaviors on 03/12/22 night shift. The Notes tab of R40's EMR revealed the following: An Incident Note on 03/13/22 at 03:00 AM documented at 03:00 AM, an unidentified Certified Medication Aide (CMA) sat in the dining room charting. She reported R40 paced and was agitated. She reported R40 had to be watched due to bothering other residents and staff. R40 sat down in one chair to the right of the CMA and started yelling at another resident [R42] to get out of a chair because R40's girlfriend was coming. R40 got up and pushed the other resident [R42] over in the chair. While doing that, R40 lost his balance and fell backwards, hitting the back of his head on the corner of the door jam and fell to the floor. The CMA went to get the nurse and when staff returned, R40 had gotten himself up off the floor and was sitting back in the chair. R40 had a small abrasion on the lower back of his head, with no bleeding noted. Staff asked R40 why the incident happened and R40 stated he did not do anything to anyone. R40 got mad and did not let the nurse obtain vital signs. Staff notified Administrative Staff A, Administrative Nurse E, and the Nurse Practitioner (NP). Staff received an order to send R40 to the emergency room (ER) to be evaluated. R40 refused to go to the hospital and was placed on one-to-one since incident. A Nursing Note on 03/13/22 at 10:05 AM documented R40 was on supervision and denied any pain or discomfort at that time. R40 was calm with no pacing or agitation noted. The staff continued to monitor during the shift. A Nursing Note on 03/13/22 at 01:50 PM documented the NP was called related to a resident-to-resident. R40 received Namenda (medication used to treat dementia) and had a history of TBI, bipolar disorder, schizoaffective disorder, and major depressive disorder. New orders were noted to discontinue Namenda and start Geodon 20 mg, obtain a complete blood count (CBC), basic metabolic panel (BMP), and urinalysis (UA), and attempt to find acute psychological placement for evaluation. A Nursing Note on 03/14/22 at 05:59 AM documented R40 as calm and peaceful throughout the shift. R40 had no signs or symptoms of acute distress noted and no aggression or anxiety noted. The staff continued to monitor. A Nursing Note on 03/15/22 at 11:31 AM documented R40 rested in bed at that time and was complaint with ADLs and cares that morning. R40 had no signs or symptoms of aggressive behavior, was calm, and in good spirits. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a Witness Statement on 03/15/22, Licensed Nurse (LN) K stated on 03/13/22 at about 03:10 AM, the CMA working on 500 hall came to the front and informed her that R40 had knocked R42 over and R40 fell also, when he did it. The CMA informed LN K that both residents were on the floor. The Certified Nurse Aide (CNA) on 500 hall was standing with the residents in the dining room. R42 was lying on the floor, on his right side. R40 sat in a chair next to the entry way into the dining room. R40 got himself up and into the chair . LN K and two staff assisted R42 up. R42 had a hematoma and abrasion on his right temple. R40 had a small scratch and bump on the right backside of his head. R40 denied doing anything and refused to let LN K take vital signs. Staff called the doctor, responsible party, Administrative Nurse E, and Administrative Staff A. R42 was transported to ER, R40 refused to go to ER, and was placed on one-on-one. In an undated Witness Statement, CMA S stated R40 sat in the dining room in a chair when R42 came in and sat down in another chair. R40 told R42 to get up because his girlfriend was going to sit in that chair. R42 kept sitting there, R40 said it again, then got up and pushed R42 out of the chair. As a result, R42 fell forcefully to the ground and R40 fell as well. In an undated Witness Statement, CMA S stated R40 sat in the dining room in a chair when R42 came in and sat down in another chair. R40 told R42 to get up because R40's girlfriend was going to sit in that chair. R42 kept sitting there. R40 said it again, then got up and pushed R42 out of the chair. As a result, R42 fell forcefully to the ground and R40 fell as well. The facility's Investigation dated 03/19/22, documented Administrative Staff A was notified on 03/13/22 of a resident-to-resident incident that occurred at approximately 03:00 AM on 03/13/22, when staff observed R40 push R42 out of a chair. It was reported that R40 sat in a chair and accused R42 of sitting in R40's girlfriend's chair. At that point, R40 pushed R42 out of the chair. Both residents were immediately separated. Staff notified Administrative Nurse E, and R40 was immediately placed on one-to-one following his refusal to go to the hospital. R42 was sent to the hospital for evaluation. The facility investigation recorded that review of the facility camera footage supported the events as described in the facility investigation. A Behavior Note on 03/21/22 at 10:36 AM documented R40 entered another resident's room that morning, started yelling, and tried to walk towards the other resident. Staff intervened and removed R40 from room. R40 then began yelling and cursing at staff. A Behavior Note on 03/21/22 at 10:39 AM documented R40 sat next to another resident and yelled and cursed at that resident. R40 told the other resident he was going to beat him up and was clenching his fist while threatening the other resident. Staff removed the other resident and redirected R40. A Physician Note on 03/22/22 at 02:42 PM documented R40's behaviors continued despite starting Geodon on 03/13/22. R40 initially started on Geodon 20 mg daily, with the dose increased to Geodon 20 mg twice daily due to continued behaviors. Staff continued to monitor R40. UA results came back as possibly contaminated due to multiple organisms identified. Since a urinary tract infection (UTI) could be the cause of R40's behaviors, another UA was ordered. R40's clinical record lacked UA results for UA ordered on 03/22/22. The facility was unable to provide the results, upon request. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nurse's Note on 03/27/22 at 06:52 AM documented R40 was up most of the night, staff redirected him often. R40 denied he was doing anything and got slightly upset. R40 tried to push other residents in their wheelchairs, and he took another resident's stuffed animal from them and wanted to throw it to the other resident. R40 was easily redirected but needed frequent monitoring and redirection. An Incident Note on 03/31/22 at 04:52 PM documented R40 sat in doorway of his room and R6 sat in wheelchair at nurse station, hitting the medication room door with a coffee cup. R40 walked to the nurse station and struck R6. Residents were immediately separated and R40 was placed one-to-one with staff. Upon assessment, R40 had no reddened areas to body, was unable to articulate the event, and denied anything happened. Staff received an order to send R40 to hospital for geriatric psychological (geri-psych) consultation. An Incident Note on 03/31/22 at 07:31 PM documented the nurse was passing medications in the hallway and walked by R40 who laid across his bed in his room. R6 sat in his wheelchair across from the nursing station and the nurse proceeded back to the medication cart. A couple of minutes later, R40 walked out of his room with his walker. R40 talked very loudly at R6. The nurse started walking down the hall to see why R40 was being loud. R40 got closer to R6. R40 stood over R6, talking. R40 then started punching R6 in the head and face and made contact at least four to five times. R6 tried to put his hands up to block the hits. R6 had a cup of coffee that spilled on him, after which R6 threw the cup at R40. The nurse and staff intervened and separated the two residents. The nurse notified Administrative Nurse E who gave an order to send R40 to the hospital for aggressive behaviors and medication evaluation. Police questioned R40, who stated he did not recall hitting anyone. When police walked off, R40 saw R6 and flipped him off (made an obscene hand gesture). Police questioned R6 who did not recall getting hit. R40 was transferred to the hospital for aggressive behavior and medication evaluation. The facility's Investigation dated 03/31/22, documented Administrative Staff A was notified on 03/31/22 of a suspected resident-to-resident incident that occurred on 03/31/22 wherein the LN on the memory care unit witnessed R40 becoming upset as R6 banged a small object against the hallway wall. R40 came out of his room to investigate the cause of the noise, walked over to R6 in the hallway near the medication room door. As the LN began walking over to assist the two residents, R40 was seen on camera swinging his arm and hand towards R6. R6 subsequently was also seen swinging his arms towards R40. The investigation documented it was unclear from the camera angle if contact was made by either resident. The residents were immediately separated, and the NP was notified of the incident. R40 was sent out to the hospital for evaluation. R6 was examined for injury with no injuries noted. The facility did not provide Witness Statements regarding incident on 03/31/22. The hospital paperwork filed under the Misc. tab in R40's EMR documented a Case Management Admission assessment dated [DATE] at 04:14 PM which recorded R40 was a long-term care resident from the facility. The note recorded R40 assaulted another resident at the facility and the facility sent R40 to the emergency department. The note recorded the facility requested R40 be placed in a geri-psych facility. The Endocrinology Note in the paperwork hospital on 04/04/22, documented a diagnosis of thyrotoxicosis (condition in which you have too much thyroid hormone in your body) likely amiodarone (medication used to treat heart rhythm problems) induced type. The Discharge Orders dated 04/06/22 recorded diagnoses of hyperthyroidism, dementia, agitation, and schizoaffective disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R40's Medication Administration Record (MAR) for May 2022 documented R40 had the following behaviors: restlessness/nervousness, pacing, anxious/compulsive, and insomnia behaviors on 05/02/22 evening shift; restlessness/nervousness, insomnia, mania/agitation, and biting/kicking/hitting/pinching on 05/12/22; restlessness/nervousness on 05/15/22 night shift, and mania/agitation on 05/17/22 night shift. R40's MAR for June 2022 documented R40 had the following behaviors: pacing on 06/01/22 evening; restlessness/nervousness, mania/agitation, and screaming/yelling on 06/03/22 evening and night; and pacing on 06/04/22 and 06/05/22 night. R40's MAR for July 2022 documented R40 had anxiousness/compulsive, withdrawn, and paranoia/hallucinations/delusions behaviors on 07/25/22 day. On 08/15/22 at 03:20 PM R40 sat on the edge of his bed and conversed with surveyor. He appeared comfortable and without any behaviors. On 08/18/22 at 09:29 AM Activity Staff Z asked R40 in his room if he wanted to join the activity that morning. R40 ambulated independently with walker down hallway to dining room. On 08/18/22 at 09:21 AM, CNA M stated R40 had not had any negative behaviors recently, only wandering and confusion. She stated if he had behaviors, she would tell the nurse. CNA M stated she did not have access to R40's behavior interventions on his care plan. She stated she heard that he had behaviors and altercations in the past, but she did not witness them and could not speak about them. CNA M said sometimes R40 had a tendency to reject care, so she left him alone and reapproached later, which usually worked. She stated if she witnessed a resident-to-resident altercation, she would remove the other resident and get help then report it to the abuse coordinator. On 08/18/22 at 09:40 AM, LN G stated he had not witnessed any resident-to-resident altercations and R40 had not had any behaviors recently. He stated R40 went up to the snack tray and took more snacks than he was supposed to, but he did not get aggressive when he did that. He stated the care plan should have interventions for behaviors in it and behavior monitoring was completed every shift. LN G stated if he witnessed a resident-to-resident altercation, he would intervene between the residents and identify the stimulus of the situation. He would report it to the physician, Administrative Nurse E, and the abuse coordinator immediately. On 08/18/22 at 09:57 AM, Administrative Nurse D stated she started working at the facility in March and since she has been at the facility, R40 had not had any behaviors. She stated since R40 was moved off the memory unit, he did not have any altercations, but had made inappropriate remarks to female staff. Administrative Nurse D stated behavior monitoring was documented every shift on the Medication Administration Record (MAR) and the CNAs might have had some behavior tasks as well. She stated staff had access to the care plan for behavior interventions, the care plans were not totally up-to-date. The staff that have worked at the facility long term know R40's past behaviors, new staff were educated when hired. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/18/22 at 10:05 AM, Administrative Staff A stated when R40 was on the memory unit, he had an incident on 03/13/22, and the camera on the unit showed the incident. She did not recall R40 having any further aggression after that incident, and he had a medication adjustment. One-to-one placement typically lasted for 72 hours and if the resident did not have any further behaviors, they were taken off one-to-one. After the 03/31/22 incident, R40 was sent to the hospital for evaluation and treatment. She stated there was a meeting with R40's family to come up with interventions they could do to address his behaviors, discussed alternate placement but the facility was not sure any other facility would take him. Administrative Staff A stated R40 had done well off the unit, and she had not received any reports about him being aggressive. On 08/18/22 at 02:23 PM in a telephone interview, Administrative Nurse E stated after the 03/13/22 incident, R40 was placed on one-to-one supervision and the NP ordered Geodon and labs. He was on one-to-one for the next four days then was removed because he did not have behaviors. She stated R40 had not had any other behaviors after Geodon was started then stated Geodon was effective the first seven days then was increased due to behaviors. After the 03/31/22 incident, R40 was sent out to the hospital then was moved off the unit when he returned. She stated R40 had not shown any signs of aggression since then but had had some inappropriate behaviors. Administrative Nurse E explained on 03/13/22 at 03:00 AM, R40 wanted R42 to get up because his girlfriend was coming. She stated the CMA should have intervened immediately. Administrative Nurse E stated staff had access to the care plan for behavior interventions. Administrative Nurse E stated on 03/31/22, R6 was making noise, the nurse was at the medication cart and heard R40 speaking loudly and went to check on the noise; the nurse separated the residents immediately. She stated it was determined that R40 was overstimulated and was moved off of the unit. Administrative Nurse E went on to say that the incident on 03/31/22 could not have been prevented because the resident was in a thyroid storm. Administrative Nurse E acknowledged staff should have identified and intervened when R40 stood over R6 speaking loudly. She said the staff could not get there fast enough. Administrative Nurse E also stated she was unsure if R6 was actually struck, as he could not remember the event. The facility's Abuse Prevention Program policy, last revised December 2016, directed residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The Policy directed administration protected residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. The facility failed to ensure residents remained free from abuse and failed to protect residents from abuse when R40 pushed R42 out of a chair on 03/13/22. The facility failed to implement behavioral interventions to prevent further abuse. On 03/31/22, R40 walked up to R6, who was in a wheelchair, and punched him multiple times in the face. The facility sent R40 to the hospital for evaluation and treatment for behaviors on 03/31/22. The facility moved him off the unit when he returned on 04/06/22 but failed to implement further interventions to address R40's behaviors. These failures placed the residents in immediate jeopardy. On 08/18/22 the facility completed the following actions to remove immediacy: R40 was placed on one -to-one supervision. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff were educated on R40's specific behaviors and interventions for de-escalation. Psych consultation for R40 was completed and recommendations received and reviewed with NP. IDT Team, along with nursing staff, would review and implement new interventions to determine the necessity of ongoing one-to-one supervision. The deficient practice remained at a scope and severity of a G. 45668 - The Medical Diagnosis section within R14's Electronic Medical Records (EMR) included diagnoses of altered mental status, chronic kidney disease, dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement). A review of R14's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interviews for Mental Status (BIMS) score of one indicating severe cognitive impairment. The MDS noted that she had continuous inattention and disorganized thinking, short tempered, and easily annoyed. The MDS noted no behaviors directed towards others but behaviors not directed towards other daily. She rejected cares four to six days during the look back period. R14 required set up and supervision only with walking. A review of R14's Behavior Care Area Assessment (CAA) dated 09/13/21 noted that she frequently wandered around the unit but did not have eloping behaviors. A review of R14's Care Plan for aggressive behavior intervention revealed that on 10/20/21 an intervention was entered requiring staff to be in the dining room at all times when residents were present due to an altercation R14 had with another resident. R14's Care Plan noted that on 07/15/22 R14 walked behind R42 (severely cognitively impaired resident) and forcefully pushed him causing him to fall to the ground. An intervention for this incident were not created until 08/15/22. On 08/15/22 R14's Care Plan was updated to include interventions for her aggressive behaviors. The interventions included giving her medications as ordered, staff observations with residents, assess and anticipate resident's needs, assess and address contributing factors, analyze the time of day and triggers, modify the environment as needed, and report any signs that the resident poses a danger to self or other. A review of R14's Incident Notes on 05/03/22 at 02:45PM noted that while walking down the dementia care hallway R14 struck an unidentified resident's backside. This caused the unidentified resident to become agitated and attempt to hit R14 multiple times. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R14's Incident Notes revealed that on 07/15/22 at 07:05AM R14 forcefully pushed R42 from behind causing him to tumble and fall to the ground. R42 was sent out an acute medical facility for evaluation but returned the same day with no major injuries. A review of R14's Skin Note for 08/02/22 indicated that R14 had a circular 5.6 centimeter (cm) by 6.0 cm bruise on her left hip. R14 was unable to identify the cause of the bruise. On 08/17/22 at 07:11 AM R14 sat at the dining room table waiting for breakfast. R14 attempted to take another residents food but Licensed Nurse (LN) I redirected her and provided her with her own plate On 08/17/22 at 09:53AM Licensed Nurse (LN) I reported that the facility provided both dementia care and abuse in-services annually. She stated that she has not seen any resident encounters since starting a month ago. She noted that staff were required to keep supervision of the resident throughout the day and attempt to keep them busy to prevent behaviors. She stated that staff could view each resident's care plan to see if they have specific triggers or need special supervision while engaged with other residents. She stated staff attempted to supervise residents that gathered in the common areas and during activities. LN I reported that R14 was easily redirected and often engaged in activities when provided something that she is interested in. On 08/22/22 at 10:26AM Certified Nurse's Aide (CNA) P stated that all the residents were monitored while in the common areas. He stated that if a resident became agitated or appeared to have behaviors, staff would intervene and separate the residents. He stated that staff would attempt to find out what is upsetting the resident or move them to an area that is less triggering. He stated that staff were required to take both dementia care and abuse training annually. He stated that staff keep the residents engaged in activities and social to help prevent resident altercations. He stated that he has not seen any resident altercations at the facility. On 08/18/22 at 05:05PM Administrative Nurse D stated that all suspected abuse or injuries of unknown origins must be investigated by the facility A review the facility's Recognizing Signs and Symptoms of Abuse policy revised 01/2011 indicated that all suspected signs of physical abuse must be reported immediately. The policy noted that signs of abuse may include cuts, bruises, paranoia, inconsistent injury explanation, lacerations, leaving someone unattended that required supervision, and injuries of questionable origin. A review of the facility's Abuse Prevention Program policy revised 12/2016 indicated that residents have the right to be free from abuse. The policy noted that residents will be protected from abuse from staff, family, volunteers, and other residents. The policy noted that the facility will identify and assess all possible incidents of abuse. The policy noted that suspected abuse will be reported within timeframes as required by federal law. The facility failed to ensure the residents were free from abuse. This placed the residents at risk for injury and decreased psycho-social wellbeing. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to prevent resident-to-resident abuse when R14, who had a history of aggressive behaviors towards other residents on the unit, shoved R42 causing him to fall. R14 also struck an unidentified resident on the backside, which precipitated a physical altercation between R14 and the unidentified resident.

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	175176	A. Building B. Wing	08/22/2022

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents; five residents were sampled for abuse. Based on observations, record reviews, and interviews, the facility failed to report an occurrence of potential abuse and/or neglect, for Resident (R) 37 who had a fracture of unknown origin, to the State Agency (SA) as required. The facility further failed to report resident to resident abuse involving R14. This deficient practice placed the resident at risk for unresolved and ongoing abuse, a decrease in psychosocial well-being, and further injuries. Findings included: - The Diagnoses tab of R37's Electronic Medical Record (EMR) documented diagnoses of fracture of lower end of right femur subsequent encounter for closed fracture with routine healing, generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal cares. The Annual Minimum Data Set (MDS) dated [DATE], documented R37 had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. R37 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; total physical dependence with one staff for locomotion; total physical dependence with two staff for bathing; and independent with setup help only for eating. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/14/22, lacked an analysis of findings. The ADL Functional/Rehabilitation Potential CAA dated 07/22/22, documented R37 had limitation to lower extremities and was non-ambulatory. She had a wheelchair for mobility and required total assistance with transfers via Hoyer (total body mechanical lift used to transfer residents). The Care Plan dated 03/4/15, revised 08/16/22, documented R37 had an ADL self-care performance deficit related to impaired physical mobility. The Care Plan documented an intervention, last revised 08/11/22, for bed mobility with extensive assistance with one to two staff to turn and reposition R37 in bed; an intervention, last revised 02/02/19, for dressing with extensive assistance with one staff to complete upper and lower dressing; an intervention, last revised 02/02/19, for physical assistance with incontinence cares, check and change in bed; and an intervention, last revised 02/02/19, for transfers of total assistance with at least two staff via Hoyer lift. A Transfer to Hospital Summary on 07/27/22 at 11:09 AM documented the ambulance was called due to R37 hollering in pain. R37 screamed upon staff trying to provide care. A Advanced Registered Nurse Practitioner (ARNP) Progress Note on 07/27/22 at 09:11 PM documented R37 complained of right knee pain. R37's knee was noted to be warm to touch and swollen. R37 refused for provider to move leg. R37 was known to have chronic right hip dislocation. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Progress Note on 08/14/22 at 11:42 AM documented R37 had chronic comorbidities including pathological fractures (break in the bone that is caused by an underlying disease). Verbal orders were given to the facility nurse to continue all diet/fluid orders, mobility, weight-bearing status orders, medication orders, and follow-up appointment orders as prescribed by the hospital. A History and Physical Note from the acute care hospital on 07/27/22 documented R37 was brought to the emergency room (ER) for evaluation of right-sided knee pain. R37 reported severe right knee pain with an intensity of 10 out of 10 and minimal movement relieved with rest and pain medication. R37 could not further clarify the duration of the pain or any recent fall or trauma. Computed Tomography (CT) scan showed an acute impacted transfer fracture of the distal femur. A Consults Note from the acute care hospital on 07/28/22 documented R37 presented to theER on [DATE] with a history of right knee pain which began approximately a week ago. R37's family reported that she suddenly started reporting right leg pain when they visited her in the facility. R37 could not recall an injury and facility staff reported no trauma. R37 had been non-weightbearing or ambulatory for several years. CT scan in the ER demonstrated a chronic dislocated hip that was asymptomatic for R37 and a right distal femur fracture with slight impaction. On 08/18/22, upon request, the facility was unable to provide an investigation related to R37's fracture of unknown origin. On 08/17/22 at 08:31 AM R37 laid in bed and finished eating breakfast. She smiled and appeared comfortable R37 had a knee immobilizer in place on her right knee. On 08/22/22 at 08:13 AM R37 stated she did not know what happened to her right leg, just that it was sore. She did not remember getting dropped during a transfer or any staff getting rough during cares with her. On 08/22/22 at 09:30 AM R37's representative stated R37 had a broken leg and he/she wanted to know how that was possible when R37 did not walk. He/she stated the facility reported there was no facility injury, R37 did not fall off the bed, and she did not get hit. He/she asked if R37 had been abused and facility reported she had not been abused. He/she just wanted to know how the leg became broken. On 08/18/22 at 09:21 AM, Certified Nurse Aide (CNA) stated if she witnessed abuse, she reported to the facility's abuse coordinator. On 08/18/22 at 09:40 AM, Licensed Nurse (LN) G stated if he witnessed any abuse, he reported it to the physician, Assistant Director of Nursing (ADON) and Administrative Staff A immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/18/22 at 05:17 PM, Administrative Nurse D stated R37 did not have a fall or any known accident. She stated that R37 had complained of hip pain so an x-ray was completed which did not show anything, but she continued to complain of pain. Administrative Nurse D stated R37 was sent to the hospital, the hospital then called and reported the fracture to the facility. She stated that Administrative Nurse E interviewed the CNAs and the CNAs stated R37 did not have any falls. Administrative Nurse D stated that because the physician stated it was a pathologic fracture, the fracture was not reported or looked at from an abuse perspective as there was no indication or any abuse or neglect. She stated that injuries of unknown causes were reportable because the origins were not known. Administrative Nurse D refused to answer any further questions regarding injuries of unknown origins. On 08/22/22 at 10:07 AM, Certified Medication Aide (CMA) R stated R37 was a total assistance with transfers and bed mobility. R37 had complained of pain for two to three weeks after the hip x-ray was obtained. CMA R stated she had requested an increase in pain mediation for R37 but facility was concerned it would make R37 sleepy. She stated R37 was yelling out in pain, so the facility sent her to the hospital. On 08/22/22 at 10:13 AM, Social Services X stated he would have found out about R37's fracture in a group text after diagnosis in the hospital. He stated he did not know anything about her fracture. Social Services X stated if a resident alleged abuse or neglect, he obtained further details then reported it to Administrative Staff A. He stated if an injury of an unknown cause occurred, he reported it to the charge nurse then the ADON. On 08/22/22 at 10:26 AM, LN L stated if a resident had an injury of unknown origin, she reported it immediately to the Director of Nursing (DON), ADON, and primary care physician (PCP). She stated she conducted a head-to-toe assessment to ensure no other injuries were present then reported the event to Administrative Staff A within two hours of the assessment. On 08/22/22 at 10:35 AM, CNA P stated any injuries were reported to the nurse and if there was abuse then he reported it to Administrative Staff A who is the abuse coordinator. He stated he reported injuries or abuse immediately when he became aware of the situation. On 08/22/22 at 10:45 AM, LN G stated Administrative Staff A was the abuse coordinator and any abuse was reported to her within two hours of the occurrence. He stated for any injury that was grossly evident, the resident was sent to the hospital for treatment. LN G stated he did work with R37 when she was having pain and she was reportedly tolerating the Tylenol. He stated when R37 no longer responded to Tylenol, she was sent out to the hospital. On 08/22/22 at 11:08 AM, Administrative Staff A stated that the day R37 was sent to the hospital, therapy staff reported to her that R37 seemed like she was in a lot of pain. She stated Administrative Nurse E knew about R37's pain and nursing had sent R37 to the hospital. Administrative Staff A stated when the clinical management team discussed R37, they could not identify there was a fall and could not tell at that time that anything had happened. She stated she was not sure anyone ever reported to her that R37 had a fracture and she expected fractures or injuries to be reported to her as the abuse coordinator. Administrative Staff A stated that any allegations of abuse and injuries of unknown cause were reported then investigated to rule out or substantiated any abuse. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/22 at 12:12 PM, Consultant HH stated R37 was on therapy prior to her hospital discharge on 07/27/22. She was participating in therapy for transfers, bed mobility, and self-care. Consultant HH stated R37 slowly began participating less and less with physical therapy then refused to get out of bed. She stated nursing gave R37 pain medication prior to therapy but she yelled out with any movement and occupational therapy reported the pain to nursing. She was not sure which nurse it was reported to or if an assessment had been completed by nursing. The facility's Abuse Prevention Program policy, last revised December 2016, directed residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The Policy directed administration protected residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. The facility's Recognizing Signs and Symptoms of Abuse/Neglect policy, last revised January 2011, directed to aid in abuse prevention, all personnel were to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. The following were some examples of actual abuse/neglect and signs and symptoms of abuse/neglect that were promptly reported: fractures, dislocations, or sprains of questionable origin. The facility's Abuse Investigation and Reporting policy, last revised July 2017, directed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source were promptly reported to local, state and federal agency and thoroughly investigated by facility management. Findings of abuse investigations were also reported. All alleged violations including injuries of unknown source were reported immediately but no later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. The facility failed to ensure R37 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility failed to report a fracture of unknown origin as potential abuse or neglect to the SA. This deficient practice placed the resident at risk for unresolved and ongoing abuse, a decrease in psychosocial well-being, and further injuries. 45668 - The Medical Diagnosis section within R14's Electronic Medical Records (EMR) included diagnoses of altered mental status, chronic kidney disease, dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R14's Quarterly Minimum Data Set (MDS) noted a Brief Interviews for Mental Status (BIMS) score of one indicating severe cognitive impairment. MDS indicated diagnoses of diabetes mellitus, Alzheimer's disease, dementia, anxiety disorder, and depression. The MDS noted that she had continuous inattention and disorganized thinking, short tempered, and easily annoyed. The MDS noted no behaviors directed towards others. A review of R14's Behavior Care Area Assessment (CAA) dated 09/13/21 noted that she frequently wandered around the unit but did not have eloping behaviors. A review of R14's Care Plan for aggressive behavior intervention revealed that on 10/20/21 an intervention was entered requiring staff to be in the dining room at all times when residents are present due to an altercation R14 had with another resident. A review of the care plan revealed no new behavior interventions between 10/20/21 and 08/15/22. R14's Care Plan noted that on 07/15/22 R14 walked behind R42 (severely cognitively impaired resident) and forcefully pushed him causing him to fall to the ground. The interventions for this incident were not created until 08/15/22. On 08/15/22 R14's care plan was updated to include interventions for her aggressive behaviors. The interventions included giving her medications as ordered, staff observations with residents, assess and anticipate resident's needs, assess and address contributing factors, analyze the time of day and triggers, modify the environment as needed, and report any signs that the resident poses a danger to self or other. A review of an Incident Notes on 05/03/22 at 02:45 PM noted that while walking down the dementia care hallway R14 struck an unidentified resident's backside. This caused the resident to become agitated and attempted to hit R14 multiple times. This incident was not reported to the state agency. A review of R14's Incident Notes revealed that on 07/15/22 at 07:05 AM R14 forcefully pushed R42 from behind causing him to tumble and fall to the ground. R42 was sent out an acute medical facility for evaluation but return the same day with no major injuries. This incident was not reported to the state agency. A review of R 14's Skin Note for 08/02/22 indicated that R14 had a circular 5.6 centimeter (cm) by 6.0 cm bruise on her left hip. R14 was unable to identify the cause of the bruise. The facility did not provide an investigation for this injury of unknown origin. This event was not reported to the investigating agency. On 08/17/22 at 07:11 AM R14 sat at the dining room table waiting for breakfast. R14 attempted to take another residents food but Licensed Nurse (LN) I redirected her and provided her with her own plate On 08/16/22 at 05:05 PM Administrative Nurse D stated that all suspected abuse or injuries of unknown origins must be investigated by the facility and reported to the investigative agency. On 08/22/22 at 11:05 AM Administrator A was not sure why the incidents were not reported to the state agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review the facility's Recognizing Signs and Symptoms of Abuse policy revised 01/2011 indicated that all suspected signs of physical abuse must be reported immediately. The policy noted that signs of abuse may include cuts, bruises, paranoia, inconsistent injury explanation, lacerations, leaving someone unattended that required supervision, and injuries of questionable origin. A review of the facility's Abuse Prevention Program policy revised 12/2016 indicated that residents have the right to be free from abuse. The policy noted that residents will be protected from abuse from staff, family, volunteers, and other residents. The policy noted that the facility will identify and assess all possible incidents of abuse. The policy noted that suspected abuse will be reported within timeframe as required by federal law. The facility failed to ensure incidents of alleged abuse and/or neglect were identified as such and reported, as required, to the State Agency. This placed the residents at risk for unidentified and ongoing abuse and /or neglect.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents; five residents were sampled for abuse. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 37 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility staff failed to identify and investigate a fracture of unknown origin as potential abuse or neglect. R37 was dependent on staff for activities of daily living (ADLs), non-ambulatory, and cognitively impaired. R37's clinical record lacked documentation of recent falls or trauma. On 07/27/22, staff documented R37 hollered in pain when staff attempted to provide cares and then transferred to the acute care hospital, where it was determined R37 had an acute impacted transverse fracture (broken bone at a right angle to the axis of the bone) of the distal (away from the farthest point of origin or attachment) femur (thigh bone). Upon learning of the fracture, the facility failed to identify the serious injury of unknown origin as a potential abuse or neglect situation and failed to initiate an investigation to attempt to determine the cause of the fracture. The facility failed to implement protective measures. This deficient practice placed R37 in immediate jeopardy. The facility further failed to investigate a resident to resident altercation and initiate protective measures when R14 struck an unidentified resident on the back side, precipitating a fight, and later shoved R42 to the ground. Findings included: - The Diagnoses tab of R37's Electronic Medical Record (EMR) documented diagnoses of fracture of lower end of right femur subsequent encounter for closed fracture with routine healing, generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal cares. The Diagnoses tab of R37's EMR lacked record of a diagnosis of osteoporosis or pathological fractures. The Annual Minimum Data Set (MDS) dated [DATE], documented R37 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. R37 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; total physical dependence with one staff for locomotion; total physical dependence with two staff for bathing; and independent with setup help only for eating. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/14/22, lacked an analysis of findings. The ADL Functional/Rehabilitation Potential CAA dated 07/22/22, documented R37 had limitation to lower extremities and was non-ambulatory. She had a wheelchair for mobility and required total assistance with transfers via Hoyer (total body mechanical lift used to transfer residents). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Care Plan dated 03/04/15 (revised on 08/16/22) documented R37 had an ADL self-care performance deficit related to impaired physical mobility. The Care Plan documented an intervention initiated on 03/04/15 (revised 08/11/22) which directed R37 required extensive assistance with one to two staff to turn and reposition R37 in bed; an intervention revised on 02/02/19 which directed R37 required extensive assistance with one staff to complete upper and lower dressing. The care plan recorded an intervention, last revised 02/02/19, for physical assistance with incontinence cares, check and change in bed; and an intervention, last revised 02/02/19, which directed staff to provide total assistance with at least two staff via Hoyer lift (full body mechanical lift) for all transfers. The Orders tab documented an order with a start date of 07/07/22 to observe for pain every shift. The Orders tab documented an order with a start date of 07/11/22 to obtain an x-ray of the right hip. The Radiology Report on 07/11/22 documented R37 had chronic dislocation of the right hip with no acute fracture. The MAR for July 2022, documented R37 complained of pain rated a six out of 10 on 07/12/22 day shift, pain rated a six out of 10 on 07/15/22 day shift, pain rated a 10 out of 10 on 07/21/22 on day shift, and pain rated a two out of 10 on 07/25/22 day shift. The MAR revealed R37 received PRN acetaminophen on 07/08/22, 07/09/22, 07/10/22, 07/12/22 twice, 07/13/22, 07/14/22, 07/15/22, 07/18/22, 07/20/22, 07/21/22, 07/22/22, and 07/24/22. A Physical Therapy Treatment Encounter Note on 07/18/22 documented passive range of motion (PROM) was performed to both quadriceps (group of muscles on the front of the thigh) and gastrocnemius (muscle in the back of the leg that runs from just above the knee to the heel) muscles worked on increasing range of motion (ROM) in bilateral lower extremity (BLE). R37 performed rolling to both sides four times with moderate assistance to support right lower extremity (RLE) due to pain while R37 performed rolling. R37 rolled slower than previous sessions due to pain. An Occupational Therapy Treatment Encounter Note on 07/19/22 documented R37 reported RLE pain and refused to get into the wheelchair. A Physical Therapy Treatment Encounter Note on 07/19/22 documented R37 performed PROM with RLE knee flexion trying to increase ROM and decrease some pain in RLE. R37 performed rolling from side to side twice with moderate assistance due to pain. R37 was being assisted with RLE and no assistance was given except for holding where R37 moved RLE. An Occupational Therapy Treatment Encounter Note on 07/21/22 documented R37 screamed in pain with mechanical lift transfer and unable to complete transfer due to R37 screaming, pain was reported in RLE. A Physical Therapy Treatment Encounter Note on 07/21/22 documented R37 laid in bed and agreed to do therapy and agreed to transfer from bed to wheelchair. She was rolled with maximum assistance to the left and was set up with the sling. R37 was set up with the Hoyer lift and was being lift when she started screaming that she was in a lot of pain and did not want to transfer into the wheelchair. R37 was lowered back to the bed and sling was removed. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Occupational Therapy Treatment Encounter Note on 07/22/22 documented R37 screamed in pain with RLE knee, unable to be redirected, and refused to get out of bed. A Physical Therapy Treatment Encounter Note on 07/25/22 documented R37 screamed a couple times about her RLE and she could not tolerate any touching or movement. An Occupational Therapy Treatment Encounter Note on 07/26/22 documented R37 was unsafe to sit on the edge of the bed on air mattress and reported too much pain in RLE. R37 screamed with movement. A Physical Therapy Treatment Encounter Note, on 07/26/22, documented PROM was attempted to RLE with quadricep and hamstring (group of muscles located on the back of the thigh) stretching but R37 started yelling in pain when she had not been touched yet. R37 was educated that some of her pain was in her head and that she was creating this pain in her head. She was educated that she could have had pain in her leg but if she kept exaggerating her pain then nursing would not know what really hurt and could not find out the root cause of her pain. R37 stated that is was her whole RLE that hurt. Revision to note on 07/28/22 documented PROM was attempted to RLE with quadricep and hamstring stretching but R37 started yelling in pain when she had not even been touched yet. Education was provided about her pain and that moving it would decrease pain due to some of the pain due to osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R37 stated that is was her whole RLE that hurt. An Occupational Therapy Treatment Encounter Note on 07/27/22 documented R37 screamed from RLE pain and tolerated sitting in the wheelchair for 20 minutes then screamed to get back in bed due to RLE pain. The Notes tab of R37's EMR revealed the following: A Behavior Note on 07/25/22 at 06:34 AM documented R37 had hip surgery and Tylenol (pain medication) was given. R37 stated Tylenol did not help with pain. A Transfer to Hospital Summary on 07/27/22 at 11:09 AM documented the ambulance was called due to R37 hollering in pain. R37 screamed upon staff trying to provide care. An Advanced Registered Nurse Practitioner (ARNP) Progress Note on 07/27/22 at 09:11 PM documented R37 complained of right knee pain. R37's knee was noted to be warm to touch and swollen. R37 refused for provider to move leg. R37 was known to have chronic right hip dislocation. A History and Physical Note from the acute care hospital on 07/27/22 documented R37 was brought to the emergency room (ER) for evaluation of right-sided knee pain. R37 reported severe right knee pain with an intensity of 10 out of 10 and minimal movement relieved with rest and pain medication. R37 could not further clarify the duration of the pain or any recent fall or trauma. Computed Tomography (CT) scan showed an acute impacted transfer fracture of the distal femur. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Consults Note from the acute care hospital on 07/28/22 documented R37 presented to theER on [DATE] with a history of right knee pain which began approximately a week ago. R37's family reported that she suddenly started reporting right leg pain when they visited her in the facility. R37 could not recall an injury and facility staff reported no trauma. R37 had been non-weightbearing or ambulatory for several years. CT scan in the ER demonstrated a chronic dislocated hip that was asymptomatic for R37 and a right distal femur fracture with slight impaction. A Physician Progress Note on 08/14/22 at 11:42 AM documented R37 was evaluated due to the transfer of care from Consultant II to Consultant JJ. The note recorded Consultant JJ obtained a history from the nurse and reviewed the medical record. The note documented R37 had chronic comorbidities including pathological fractures (break in the bone that is caused by an underlying disease). Verbal orders were given to the facility nurse to continue all diet/fluid orders, mobility, weight-bearing status orders, medication orders, and follow-up appointment orders as prescribed by the hospital. On 08/18/22, upon request, the facility was unable to provide an investigation related to R37's fracture of unknown origin. On 08/22/22 at 12:40 PM, the facility provided a typed, unsigned, undated narrative titled External which documented on 07/27/22 R37 began complaining of increased pain in her right knee. The NP was notified, saw the resident in the facility, and ordered an x-ray. R37's family came to the facility prior to the x-ray technicians and requested R37 be sent to the emergency room . The NP was notified and agreed. R37 was sent to her preferred hospital where x-rays showed a fracture to the right knee. A knee immobilizer was placed as surgery was not warranted per hospital documentation. R37 did not have a reported fall or change in plane. There were no signs of acute trauma. R37 stated she did not know what happened and did not recall any trauma to the leg. The narrative noted review of the hospital documentation revealed R37 moderate to severe degenerative joint disease (DJD) and osteoarthritis (DJD-the most common form of arthritis). The note recorded the diagnoses were discussed with the NP after the change in provider [on 08/14/22] and it was possible the fracture was pathological as there were no signs of acute trauma. On 08/17/22 at 08:31 AM R37 laid in bed and finished eating breakfast. R37 had a knee immobilizer in place on her right knee. On 08/22/22 at 08:13 AM R37 stated she did not know what happened to her right leg, just that it was sore. She stated did not remember what happened to her leg. On 08/18/22 at 09:21 AM, Certified Nurse Aide (CNA) stated if she witnessed abuse, she reported to the facility's abuse coordinator. On 08/18/22 at 09:40 AM, Licensed Nurse (LN) G stated if he witnessed any abuse, he reported it to the physician, Assistant Director of Nursing (ADON) and Administrative Staff A immediately. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/18/22 at 05:17 PM, Administrative Nurse D stated R37 did not have a fall or any known accident. She stated that R37 had complained of hip pain, so an x-ray was completed which did not show anything, but she continued to complain of pain. Administrative Nurse D stated R37 was sent to the hospital; the hospital then called and reported the fracture to the facility. She stated that Administrative Nurse E asked the CNAs and the CNAs stated R37 did not have any falls. Administrative Nurse D stated that because the hospital physician stated the fracture was due to the resident's diagnosis of osteoporosis. Administrative Nurse D stated the fracture was not reported or looked at from an abuse perspective as there was no indication or any abuse or neglect because the resident had osteoporosis. Administrative Nurse D stated the origin of R37's fracture was known to be osteoporosis. Administrative Nurse D refused to answer any further questions regarding R37. On 08/22/22 at 09:30 AM R37's representative stated R37 had a broken leg and he/she wanted to know how it happened when R37 did not walk. He/she stated the facility reported there was no facility injury, R37 did not fall off the bed, and she did not get hit. He/she stated they asked facility staff if R37 had been abused and facility reported she had not been abused. He/she just wanted to know how the leg became broken. On 08/22/22 at 10:07 AM, Certified Medication Aide (CMA) R stated R37 was a total assistance with transfers and bed mobility. R37 had complained of pain for two to three weeks after the hip x-ray was obtained. CMA R stated she had requested an increase in pain medication for R37, but the facility was concerned it would make R37 sleepy. She stated R37 was yelling out in pain, so the facility sent her to the hospital. On 08/22/22 at 10:13 AM, Social Services X stated he would have found out about R37's fracture in a group text after diagnosis in the hospital. He stated he did not know anything about her fracture. Social Services X stated if a resident alleged abuse or neglect, he obtained further details, then he reported it to Administrative Staff A. He stated if an injury of an unknown cause occurred, he reported it to the charge nurse, and then the ADON. On 08/22/22 at 10:26 AM, LN L stated if a resident had an injury of unknown origin, she reported it immediately to the Director of Nursing (DON), ADON, and primary care physician (PCP). She stated she conducted a head-to-toe assessment to ensure no other injuries were present then reported the event to Administrative Staff A within two hours of the assessment. On 08/22/22 at 10:35 AM, CNA P stated any injuries were reported to the nurse and if there was abuse then he reported it to Administrative Staff A, who is the abuse coordinator. He stated he reported injuries or abuse immediately when he became aware of the situation. On 08/22/22 at 10:45 AM, LN G stated Administrative Staff A was the abuse coordinator and any abuse was reported to her within two hours of the occurrence. He stated for any injury that was grossly evident, the resident was sent to the hospital for treatment. LN G stated he did work with R37 when she was having pain and she was reportedly tolerating the Tylenol. He stated when R37 no longer responded to Tylenol, she was sent out to the hospital. On 08/22/22 at 11:08 AM, Administrative Nurse E was unavailable for interview. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/22/22 at 11:08 AM, Administrative Staff A stated that the day R37 was sent to the hospital, therapy staff reported to her that R37 seemed like she was in a lot of pain. She stated Administrative Nurse E knew about R37's pain and nursing sent R37 to the hospital. Administrative Staff A stated when the clinical management team discussed R37, they could not identify there was a fall and could not tell at that time that anything had happened. She stated she was not sure anyone ever reported to her that R37 had a fracture and she expected fractures or injuries, including injuries of unknown origin, to be reported to her as the abuse coordinator. Administrative Staff A stated that any allegations of abuse and injuries of unknown cause were reported then investigated to determine if abuse or neglect occurred. On 08/22/22 at 12:12 PM, Consultant HH stated R37 was on therapy prior to her hospital discharge on 07/27/22. She was participating in therapy for transfers, bed mobility, and self-care. Consultant HH stated R37 slowly began participating less and less with physical therapy then refused to get out of bed. She stated nursing gave R37 pain medication prior to therapy but she yelled out with any movement and occupational therapy reported the pain to nursing. She was not sure which nurse it was reported to or if an assessment had been completed by nursing. The facility's Abuse Prevention Program policy, last revised December 2016, directed residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The Policy directed administration protected residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. The facility's Recognizing Signs and Symptoms of Abuse/Neglect policy, last revised January 2011, directed to aid in abuse prevention, all personnel were to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. The following were some examples of actual abuse/neglect and signs and symptoms of abuse/neglect that were promptly reported: fractures, dislocations, or sprains of questionable origin. The facility's Abuse Investigation and Reporting policy, last revised July 2017, directed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source were promptly reported to local, state and federal agency and thoroughly investigated by facility management. Findings of abuse investigations were also reported. All alleged violations including injuries of unknown source were reported immediately but no later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure R37 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility failed to identify and investigate a fracture of unknown origin as potential abuse or neglect. R37 was dependent on staff for ADLs, non-ambulatory, and cognitively impaired. On 07/27/22, staff documented R37 hollered in pain when staff attempted to provide cares and she was sent to the acute care hospital where it was determined she had a femur fracture. Upon learning of the fracture, the facility failed to identify the serious injury of unknown origin as a potential abuse or neglect situation and failed to initiate an investigation to attempt to determine the cause of the fracture. The facility failed to implement protective measures. This deficient practice placed R37 in immediate jeopardy. On 08/22/22 the facility completed the following to review the immediacy: R37's fractured knee was reported to the State Agency as an injury of unknown origin. All incident and accident reports were reviewed immediately by the Interdisciplinary Team (IDT). All staff, to include the administrative staff, were educated immediately on abuse, neglect and exploitation (ANE), incidents, accidents, and investigating significant events. All residents were interviewed by Social Services or Designee to ensure that there have been no instances of ANE or injuries of unknown origin. The deficient practice remained at scope and severity of G. 45668 - The Medical Diagnosis section within R14's Electronic Medical Records (EMR) included diagnoses of altered mental status, chronic kidney disease, dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement). A review of R14's Quarterly Minimum Data Set (MDS) noted a Brief Interviews for Mental Status (BIMS) score of one indicating severe cognitive impairment. MDS indicated diagnoses of diabetes mellitus, Alzheimer's disease, dementia, anxiety disorder, and depression. The MDS noted that she had continuous inattention and disorganized thinking, short tempered, and easily annoyed. The MDS noted no behaviors directed towards others. A review of R14's Behavior Care Area Assessment (CAA) dated 09/13/21 noted that she frequently wandered around the unit but did not have eloping behaviors. A review of R14's Care Plan for aggressive behavior intervention revealed that on 10/20/21 an intervention was entered requiring staff to be in the dining room at all times when residents are present due to an altercation R14 had with another resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R14's care plan noted that on 07/15/22 R14 walked behind R42 (severely cognitively impaired resident) and forcefully pushed him causing him to fall to the ground. The interventions for this incident were not created until 08/15/22. A review of an Incident Notes on 05/03/22 at 02:45PM noted that while walking down the dementia care hallway R14's struck an unidentified resident's backside. This caused the resident to become agitated and attempted to hit R14 multiple times. The facility failed to provide investigate, and identify and implement interventions to address this situation. A review of R14's Incident Notes revealed that on 07/15/22 at 07:05 AM R14 forcefully pushed R42 from behind causing him to tumble and fall to the ground. R42 was sent out an acute medical facility for evaluation but return the same day with no major injuries. The facility did not investigate or implement interventions in response to this incident. A review of R14's Skin Note for 08/02/22 indicated that R14 had a circular 5.6 centimeter (cm) by 6.0 cm bruise on her left hip. R14 was unable to identify the cause of the bruise. The facility did not provide an investigation for this injury of unknown origin. The injury of unknown origin was not investigated by the facility to determine if abuse occurred. On 08/15/22 R14's care plan was updated to include interventions for her aggressive behaviors. The interventions included giving her medications as ordered, staff observations with residents, assess and anticipate resident's needs, assess and address contributing factors, analyze the time of day and triggers, modify the environment as needed, and report any signs that the resident poses a danger to self or others. On 08/17/22 at 07:11 AM R14 sat at the dining room table waiting for breakfast. R14 attempted to take another residents food but Licensed Nurse (LN) I redirected her and provided her with her own plate ON 08/16/22 at 05:05 PM Administrative Nurse D stated that all suspected abuse or injuries of unknown origins must be investigated by the facility and reported to the state agency. On 08/22/22 at 11:05 AM Administrator A was not sure why the incidents were not reported to the state agency. A review the facility's Recognizing Signs and Symptoms of Abuse policy revised 01/2011 indicated that all suspected signs of physical abuse must be reported immediately. The policy noted that signs of abuse may include cuts, bruises, paranoia, inconsistent injury explanation, lacerations, leaving someone unattended that required supervision, and injuries of questionable origin. A review of the facility's Abuse Prevention Program policy revised 12/2016 indicated that residents have the right to be free from abuse. The policy noted that residents will be protected from abuse from staff, family, volunteers, and other residents. The policy noted that the facility will identify and assess all possible incidents of abuse. The policy noted that suspected abuse will be reported within timeframe as required by federal law. The facility failed to ensure incidents of alleged abuse were identified and investigated by the facility. This placed the residents at risk for ongoing abuse.

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	175176	A. Building B. Wing	08/22/2022

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents; one resident reviewed for hospitalization . Based on observations, record reviews, and interviews, the facility failed to provide a written notification of transfer to Resident (R) 37 or to her family/durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare services. Findings included: - R37 admitted to facility 02/19/15, discharged to hospital 07/27/22, and readmitted to facility 08/01/22. The Diagnoses tab of R37's Electronic Medical Record (EMR) documented diagnoses of fracture of lower end of right femur (leg bone) subsequent encounter for closed fracture with routine healing, pain in right hip, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. R37 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; total physical assistance with one staff for locomotion. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/14/22, lacked an analysis of findings. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA dated 07/22/22, documented R37 was at risk for impaired physical mobility and ADL function as evidenced by limitation to lower extremities and being non-ambulatory. R37 had a wheelchair for mobility and required total assistance with transfers and Hoyer lift (total body mechanical lift used to transfer residents). The Care Plan dated 03/04/15, documented R37 had an ADL self-care performance deficit related to impaired physical mobility. The Care Plan documented an intervention, revised 08/11/22, directed R37 required extensive physical assistance with one to two staff to turn and reposition. The Care Plan documented an intervention, revised 02/02/19, directed R37 required total physical assistance with at least two staff via Hoyer lift. The clinical record lacked evidence of a written notification of discharge/transfer. On 08/16/22 at 03:24 PM, R37 laid in bed with eyes opened. She smiled and stated she had a good day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

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Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/18/22 at 04:11 PM, Social Services X stated he emailed the family/DPOA the bed hold policy and the nurses called the family members at time of transfers. He stated he did not send a written notification of transfer. On 08/18/22 at 04:49 PM, Licensed Nurse (LN) G stated if a resident was transferred to the hospital, the emergency contact was notified. He stated he did not send a written notification of transfer to family/DPOA. On 08/18/22 at 05:17 PM, Administrative Nurse D stated when a resident transferred to the hospital, a bed hold policy was sent to family and a Situation, Background, Assessment, and Recommendation (SBAR) was completed with who was notified of the transfer. She stated she was not sure of a written notification of transfer. The facility's Transfer or Discharge Notice policy, last revised December 2016, directed a notice was given as soon as it was practicable but before the transfer or discharge for an immediate transfer or discharge required by the resident's urgent medical needs. The resident and/or representative was notified in writing of the following information: the reason for the transfer/discharge; the effective date of the transfer/discharge; the location to which the resident was being transferred or discharged ; the statement of the resident's rights to appeal the transfer or discharge; the facility bed hold policy; the name, address, and telephone number for the Office of the State Long-term Care Ombudsman; the name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental disabilities; the name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental health disorder or related disabilities; and the name, address, and telephone number of the state health department agency that had been designated to handle the appeals of transfer and discharge notices. The facility failed to provide a written notification of transfer to R37 or to her family/DPOA in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare services.

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45668 The facility had a census of 54 residents. The sample included 22 residents. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS- tool for implementing standardized assessment and for facilitating care management in nursing homes) was accurately coded with Resident (R)14's weight as required by the Resident Assessment Instrument (RAI) Manual. This placed the resident at risk for an inaccurate care plan and unidentified care needs. Findings included: - The Medical Diagnosis section within R14's Electronic Medical Records (EMR) included diagnoses of altered mental status, chronic kidney disease, dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement). Review of R14's Quarterly MDS had an assessment reference date (ARD-last day of the MDS assessment period) of 06/21/22. The MDS recorded section K0200B (R14's weight) as 149 pounds (lbs.). R14's clinical record included the following weights recorded prior to the ARD: On 05/05/22, the resident weighed 149.6 lbs. On 05/06/22, the resident weighed 144 lbs. On 06/09/22, the resident weighed 135.2 lbs. On 06/13/22, the resident weighed 136.8 lbs. On 08/17/22 at 04:20 PM, Administrative Nurse F stated Administrative Nurse E and Administrative Nurse D completed all assessments related to the MDS. Administrative Nurse F stated if the necessary information was not collected by those nurses, she would complete the MDS with whatever information was available. The RAI Manual directed section K0200B should be coded with the most recent [weight] measure in last 30 days. The facility failed to ensure section K0200B on the Quarterly MDS with an ARD of 06/21/22, was accurately coded with R14s weight as directed by the RAI. This placed the resident at risk for an inaccurate care plan and unidentified care needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 54 residents. The sample included 22 residents with six residents reviewed for activities of daily living (ADL's). Based on observation, record review, and interviews, the facility failed to provide assistance with meals for Resident (R)4. This deficient practice placed R4 at increased risk for progressive loss of independence with eating and related complications such as malnutrition. Findings Included: - The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of right sided hemiplegia (paralysis of one side of the body), right sided hemiparesis (muscular weakness of one half of the body), need for assistance with personal cares, muscle weakness, dysphagia (difficulty in swallowing food or liquid), and aphasia (condition with disordered or absent language function). R4's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted that he required supervision and set-up only for eating. The MDS noted that had no weight loss within the last six months. The MDS noted that he required a mechanically altered diet. A review of R4's Communication Care Area Assessment (CAA) dated 03/09/22 indicated that he had aphasia but at times could make his needs known. A review of R4's Feeding Tube CAA dated 03/09/22 indicated that he was receiving fluid and nutrition via his PEG tube (feeding tube inserted through the abdominal wall into the stomach). The CAA indicated monthly weight checks, periodic dietary evaluations, and regular changing and replacements to avoid complications related to his diagnoses. R4's had not been triggered for Nutrition or Activities of Daily Living (ADL's) in the CAA. R4's Care Plan created 02/07/22 indicated that he was at risk for impaired nutrition or malnutrition related to his medical diagnoses. The care plan noted that he required assistance from one staff for eating. The plan noted that staff were to provide one to one assistance and supervision for the duration of his meals. A review of R4's Physicians Orders revealed a dietary order started 06/09/22 for R4 to receive a regular diet with his food cut up into small bite sizes before being served. On 08/16/22 at 07:34AM R4 ate his breakfast. Breakfast was mechanically soft but resident struggled to get the food on to his spoon. R4 consumed the majority of his meal. R4's did not have staff assistance during the entirety of meal. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/16/22 at 12:46PM R4 ate a pork sandwich in the dining room for lunch. Sandwich was whole and not cut up for him. R4 struggled to hold the sandwich but managed to eat entire meal without assistance. R4 did not have staff assistance provided during his meal. A review of R4's dietary ticket for lunch on 08/16/22 revealed that his food was to be cut into small bite sized portions. The ticket did not show that R4 required one to one assistance or supervision during his meals. On 08/22/22 at 07:33AM R4 ate his breakfast. R4 was served a whole bagel. R4 consumed part of his meal and returned to his room. Resident did not have staff assistance throughout the meal. On 08/18/22 at 01:05PM Certified Nurse's Aide (CNA) O stated that the care staff had access to the resident care plan and review what type of assistance each resident needed. She stated that the care staff will assist the residents to the dining area for meals. She stated that staff can also review the meal service tickets to see if a resident needs assistance during meal service and help the residents when needed. On 08/18/22 at 01:25PM Licensed Nurse (LN) H stated that the resident's dietary needs should be documented on the meal tickets during meal service. She stated that the care staff review the tickets while serving the meals and verify which residents are to be assisted and supervised based on their care plan. She was unsure if R4 needed one to one supervision during mealtime. The facility's Registered Dietician was called on 08/23/22 but did not return the call. A review of the facility's Person Centered Care Plan policy revised 12/2016 indicated that the facility's interdisciplinary team in conjunction with the resident to develop and implement a comprehensive person-centered care plan that will identify problem areas and implement interventions. The policy noted that care plan will aid in preventing or reducing a decline in the resident's functional status and levels and address identified concerns with reasonable goal-oriented interventions for identified concerns or risk. The facility failed to provide R4's care planned supervision and assistance during mealtime services. This deficient practice placed R4 at risk for decreased ability and independence at meals and complication related to choking and malnutrition.

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents; six residents were sampled for bathing. Based on observations, record review, and interviews, the facility failed to provide consistent bathing for Resident (R) 37, R40, R47 and R11. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for affected residents. Findings included: - The Diagnoses tab of R37's Electronic Medical Record (EMR) documented diagnoses of fracture of lower end of right femur subsequent encounter for closed fracture with routing healing, generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal cares. The Annual Minimum Data Set (MDS) dated [DATE], documented R37 had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. R37 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; total physical dependence with one staff for locomotion; total physical dependence with two staff for bathing; and independent with setup help only for eating. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/14/22, lacked an analysis of findings. The Activities of Daily Living (ADLs) Functional/Rehabilitation Potential CAA dated 07/22/22, documented R37 had limitation to lower extremities and was non-ambulatory. She had a wheelchair for mobility and required total assistance with transfers via Hoyer (total body mechanical lift used to transfer residents). The Care Plan dated 03/4/15, revised 08/16/22, documented R37 had an ADL self-care performance deficit related to impaired physical mobility. The Care Plan documented an intervention, last revised 08/11/22, for bed mobility with extensive assistance with one to two staff to turn and reposition R37 in bed; an intervention, last revised 02/02/19, for dressing with extensive assistance with one staff to complete upper and lower dressing; an intervention, last revised 02/02/19, for physical assistance with incontinence cares, check and change in bed; and an intervention, last revised 02/02/19, for transfers of total assistance with at least two staff via Hoyer lift; and an intervention, last revised 10/23/21, for bathing/shower with extensive assistance and two staff Monday, Wednesday, and Friday. The Task tab of R37's EMR revealed a task for ADL Bathing Monday, Wednesday, and Friday Mornings. Review of the documentation for the task revealed no bathing history in the last 30 days. The Documentation Survey Report for May 2022 revealed a task for As needed (PRN) Bathing. R37 received the following bathing: partial bath on 05/02/22 and 05/30/22; bed bath on 05/04/22, 05/06/22, 05/16/22, 05/19/22, 05/21/22, and 05/24/22; and shower on 05/07/22. R37 refused bathing on 05/18/22. The Documentation Survey Report lacked scheduled bathing documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Documentation Survey Report for June 2022 revealed a task for PRN Bathing. R37 received the following bathing: bed bath on 06/01/22, 06/03/22, 06/20/22, 06/22/22, 06/24/22, and 06/30/22. The Documentation Survey Report lacked scheduled bathing documentation. The Documentation Survey Report for July 2022 revealed a task for PRN Bathing. R37 received the following bathing: bed bath on 07/04/22, 07/06/22, 07/20/22, 07/22/22, and 07/27/22; partial bath 07/18/22. The Documentation Survey Report lacked scheduled bathing documentation. The Documentation Survey Report for August 2022 revealed a task for PRN Bathing. R37 received a bed bath on 08/11/22. The Documentation Survey Report revealed a task for ADL- Bathing (prn) and R37 received a bed bath on 08/08/22, 08/10/22, 08/11/22, and 08/12/22. The Documentation Survey Report lacked scheduled bathing documentation. The facility's Daily Showers sheets documented R37 was scheduled for showers on Monday day shift, Wednesday day shift, and Friday day shift. On 08/16/22 at 09:32 AM R37 laid in bed with eyes opened. She appeared comfortable and without signs of distress or discomfort. R37 wore a hospital gown. On 08/22/22 at 08:13 AM R37 stated she mostly received bed baths, but she would like a shower. She stated she received a bath maybe once a week. On 08/18/22 at 01:20PM Certified Nurses Aid (CNA) O stated that all staff should have access to the care plan to see when a resident's bath is and what type of assistance they would need. On 08/18/22 at 01:25PM Licensed Nurse (LN) H stated that the bathing days and interventions should be listed in the care plan. On 08/18/22 at 04:20 PM Certified Nurse Aide (CNA) M stated bathing was completed by the CNAs and charted in the EMR. She stated there was a shower schedule that the CNAs followed for bathing. On 08/18/22 at 04:49 PM LN G stated R37 liked a certain CNA and when he worked, she took a bath from him. He stated if R37 did not have a good rapport with the CNA then she often refused bathing. On 08/18/22 at 05:18 PM Administrative Nurse D stated the CNAs were responsible for bathing. She said the bathing should be documented in the residents' EMR. Administrative Nurse D stated the CNA were assigned residents to bath daily on assignment sheets. She said the facility had several residents that refused bathing and the team discussed this at the morning clinical meeting. The facility's Bathing policy, last revised February 2018, directed bathing opportunities were provided to the residents to promote cleanliness, comfort, and provide observations of the resident's skin. The policy directed that all bathing was documented in the resident's EMR and the nurse was notified if a resident refused a bath. The facility failed to provide consistent bathing for R37. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for R37. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Diagnoses tab of R40's Electronic Medical Record (EMR) documented diagnoses of diffuse traumatic brain injury (TBI) without loss of consciousness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal care. The Admission Minimum Data Set (MDS), dated [DATE], documented R40 had a Brief Interview for Mental Status (BIMS) score of six which indicated severe cognitive impairment. R40 required extensive physical assistance with two staff for bed mobility and transfers; extensive physical assistance with one staff with dressing, toileting, personal hygiene, and bathing; supervision with setup help only with eating and locomotion. The Quarterly MDS, dated [DATE], documented R40 had a BIMS score of nine which indicated moderate cognitive impairment. He required supervision with one staff for bed mobility, transfers, walking, locomotion; extensive physical assistance with one staff with dressing and bathing; limited physical assistance with one staff for toileting and personal hygiene; independent with setup help only for eating. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/07/22, documented R40 triggered for impaired cognition, had a BIMS score of six, and was able to respond to simple questions. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA, documented R40 was supervision to extensive assistance with ADLs and could make most of his needs known. The ADL Care Plan, dated 05/22/21, documented R40 had an ADL self-care performance deficit r/t cognition issues and frequently refused cares. The Care Plan documented an intervention, last revised 08/26/21, that R40 required supervision with showers on Mondays, Wednesday, and Fridays, he often refused showers, and he needed encouragement; an intervention, last revised 08/26/21, that R40 required extensive assistance with two staff for transfers; and an intervention, last revised 08/26/21, that R40 required extensive assistance with two staff to dress and he often refused to allow staff to assist and/or to change clothes. The Tasks tab of R40's EMR documented a task for ADL Bathing Tuesday and Thursday. Review of the task documentation revealed no bathing history in the last 30 days. The Documentation Survey Report for May 2022 revealed a task for As needed (PRN) Bathing. R40 received a partial bath on 05/02/22. R40 refused bathing on 05/17/22, 05/25/22, and 05/31/22. The Documentation Survey Report lacked scheduled bathing documentation. The Documentation Survey Report for June 2022 revealed a task for PRN Bathing. R40 received a partial bath on 06/03/22, 06/04/22, 06/05/22, 06/07/22, and 06/10/22. R40 refused bathing on 06/08/22. The Documentation Survey Report lacked scheduled bathing documentation. The Documentation Survey Report for July 2022 revealed a task for PRN Bathing. R40 received a partial bath on 07/16/22, 07/18/22, 07/19/22, 07/20/22, 07/26/22, 07/27/22, and 07/29/22. The Documentation Survey Report lacked scheduled bathing documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Documentation Survey Report for August 2022 revealed a task for PRN Bathing. R40 received the following bathing: a partial bath on 08/06/22 and 08/09/22; a shower on 08/11/22. R40 refused bathing on 08/03/22. The Documentation Survey Report lacked scheduled bathing documentation. The facility's Daily Showers sheets documented R40 was scheduled for showers on Tuesday evening shift and Thursday evening shift. On 08/16/22 at 03:26 PM R40 sat at a table in the dining room and smiled to everyone who passed by. R40's hair appeared unkempt and unwashed while his facial hair did not appear well groomed. On 08/17/22 at 11:49 AM R40 sat on the side of his bed, he appeared comfortable and without signs of distress. R40's hair appeared unkempt and unwashed while his facial hair did not appear well groomed. On 08/18/22 at 01:20PM Certified Nurses Aid (CNA) O stated that all staff should have access to the care plan to see when a resident's bath is and what type of assistance they would need. On 08/18/22 at 01:25PM Licensed Nurse (LN) H stated that the bathing days and interventions should be listed in the care plan. On 08/18/22 at 04:20 PM Certified Nurse Aide (CNA) M stated bathing was completed by the CNAs and charted in the EMR. She stated there was a shower schedule that the CNAs followed for bathing. On 08/18/22 at 04:49 PM LN G stated R40's bathing was not frequent as he often came up with excuses and refused bathing. On 08/18/22 at 05:18 PM Administrative Nurse D stated the CNAs were responsible for bathing. She said the bathing should be documented in the residents' EMR. Administrative Nurse D stated the CNA were assigned residents to bath daily on assignment sheets. She said the facility had several residents that refused bathing and the team discussed this at the morning clinical meeting. The facility's Bathing policy, last revised February 2018, directed bathing opportunities were provided to the residents to promote cleanliness, comfort, and provide observations of the resident's skin. The policy directed that all bathing was documented in the resident's EMR and the nurse was notified if a resident refused a bath. The facility failed to provide consistent bathing for R40. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for R40. 45668 - The Medical Diagnosis section within R47's Electronic Medical Records (EMR) included diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dysphagia (difficulty in swallowing food or liquid), and adult failure to thrive. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS noted that he required extensive assistance from two staff for bed mobility, dressing, and toileting. He required was totally dependent on one staff for personal hygiene, and totally dependent on two staff for transfers, and bathing. A review of R47's Activities of Daily Living (ADL's) Care Area Assessment (CAA) dated 06/24/22 indicated that he was paraplegic and required total assistance with his ADL's. R47's Care Plan revised 03/22/22 indicated that he was totally dependent on two staff members to provide bathing opportunities every Wednesday and Sunday. The care plan noted that he was totally dependent on two staff for toileting, personal hygiene, dressing, and bed mobility The care plan indicated that he required a Hoyer lift (total body mechanical lift used to transfer residents) for all transfers. A review of R47's Bathing Look Back report between 05/01/22 through 08/17/22 (109days reviewed) revealed he went ten days in May (5/12 through 5/22), 17 days in June (6/6 through 6/21), 12 days in July (7/1 through 7/13), and six days in August (8/1 through 8/7) without receiving bathing opportunities. The review indicated no refusals were documented. On 08/16/22 at 08:00AM R47 sat in his room. He was wearing clean clothing and well-groomed. His hair was combed as he returned from breakfast positioned in front of his television. On 08/18/22 at 01:20PM Certified Nurses Aid (CNA) O stated stated that the resident should be received minimum of two showers per week based upon his preferences. She stated that R47 has been getting his baths and should have been entered into the EMR. She stated that all staff should have access to the care plan to see when a resident's bath is and what type of assistance they would need. On 08/18/22 at 05:18 PM Administrative Nurse D stated the CNAs were responsible for bathing. She said the bathing should be documented in the residents' EMR. Administrative Nurse D stated the CNA were assigned residents to bath daily on assignment sheets. She said the facility had several residents that refused bathing and the team discussed this at the morning clinical meeting. A review of the facility's Bathing policy revised 02/2018 stated that bathing opportunities provided to the residents promote cleanliness, comfort, and provide observations of the resident's skin. The policy noted that all bathing should be documented in the resident's EMR. The policy noted that if a resident refuse to bath the staff will notify the nurse. The facility failed to provide consistent bathing opportunities for R47. This deficient practice placed the resident at risk for decreased psycho-social wellbeing and skin complications. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Medical Diagnosis section within R11's Electronic Medical Records (EMR) included diagnoses of moderate protein-calorie malnutrition (lack of sufficient nutrients in the body), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), gastrointestinal hemorrhage (loss of a large amount of blood in a short period of time), dementia (progressive mental disorder characterized by failing memory, confusion), seizures (violent involuntary series of contractions of a group of muscles), dysphagia (difficulty in swallowing food or liquid), muscle weakness, difficulty walking, and need for assistance with personal cares. R11's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted that she required extensive assistance from two members for dressing, toileting, and personal hygiene. The MDS noted that she was totally dependent on two staff for assistance for bathing. A review of R11's Dementia Care Area Assessment (CAA) dated 04/04/22 noted that she had disorganized thinking and had a difficult time communicating her needs due to diagnoses of dementia and schizophrenia. A review of R11's Pressure Ulcer CAA dated 04/04/22 noted that she was at risk for developing pressure injuries related to incontinence. R11's Care Plan created 03/29/22 indicated that she had an activities of daily living (ADL) self-care deficit but lacked documentation identifying the level of extent and number of staff assistance needed for bathing, dressing, transfers, mobility, personal hygiene, and toileting. A review of R11's Bathing Look-Back report from 06/01/22 through 08/17/22 (78 Days) revealed R11 received ten bathing opportunities (6/6, 6/15, 6/17, 6/20, 6/29, 7/1, 7/26, 8/2, 8/8, 8/11). The report revealed no documented refusals. On 08/15/22 at 11:30 AM R11 reported staff are slow to assist her with bathing and toileting needs. She stated that while staff were doing their best, she felt that she has had incontinence waiting for them to assist her. She stated that she has not been getting her showers and not sure what days she is actually supposed to be getting bathed. On 08/18/22 at 01:05PM Certified Nurse's Aide (CNA) O stated that staff should be checking on incontinent resident every two hours and assisting with peri-cares for residents that required cleaning and changing. She stated that if a resident refused to bath or shower it would be documented in the EMR. She stated that R11 did at times refuse cares when staff would offer help, but staff should continue to offer assistance to the resident. She stated that the amount of assistance a resident would need and how often should be noted in the care plan. On 08/18/22 at 01:25PM Licensed Nurse (LN) H stated that staff should be checking up on the resident at least every two hours for routine cares. She stated that incontinent residents should be offered restroom breaks during each check. She stated that the bathing days and interventions should be listed in the care plan. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/22 at 05:18 PM Administrative Nurse D stated the CNAs were responsible for bathing. She said the bathing should be documented in the residents' EMR. Administrative Nurse D stated the CNA were assigned residents to bath daily on assignment sheets. She said the facility had several residents that refused bathing and the team discussed this at the morning clinical meeting. A review of the facility's Bathing policy revised 02/2018 stated that bathing opportunities provided to the residents promote cleanliness, comfort, and provide observations of the resident's skin. The policy noted that all bathing should be documented in the resident's EMR. The policy noted that if a resident refuse to bath the staff will notify the nurse. The facility failed to provide consistent bathing opportunities for R11. This deficient practice placed her at increased risk for skin issues and decreased psychosocial wellbeing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 54 residents. The sample included 22 residents with one resident reviewed for 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 assess or treat an identified pressure area on R101's sacrum (large triangular bone between the two hip bones) and failed to ensure pressure relieving measures were in place on bilateral (both) lower extremities. This placed R101 at an increased risk for pressure ulcer development and delayed healing to current pressure injuries. Findings included: - R101's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), pneumonia (inflammation of the lungs), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The staff interview was not completed. The MDS documented R101 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R101 was at risk of development of pressure ulcers. R101's Pressure Ulcer Care Area Assessment (CAA) dated 11/05/21 documented R101 was at risk for skin break down, related to the resident required extensive assistance with his ADL's and having impaired cognition. The Quarterly MDS dated [DATE], documented a BIMS score of zero, which indicated severely impaired cognition. The staff interview was not completed. The resident required extensive assistance of two staff members for ADL's. The resident received oxygen therapy and was at risk of development of pressure ulcers during the look back period. The Care Plan, dated 11/12/19, documented a weekly skin assessment would be completed by a Licensed Nurse (LN) and any changes in skin would be documented. The Care Plan dated 08/07/22 documented staff would document weekly the stage, length, width, depth, odor, progression or the lack of progression and notify the physician. Staff would provide assistance with positioning and care needs and offloading the heels when in bed as needed. Review of the EMR under Orders tab revealed physician orders, revealed to clean the resident's right heel with wound cleanser, pat dry, and apply skin prep. Float heels while in bed, every day and night shift for suspected deep tissue injury, dated 08/07/22. Review of the EMR under Progress Notes document included: On 7/12/22 at 08:30 PM, the skin observation progress notes for R101 documented skin clear and had no impairment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/22 at 10:30 AM, the skin observation progress notes for R101 documented he had an existing skin impairment . On 7/26/22 at 10:30 AM, the skin observation progress notes for R101 documented he had an existing skin impairment. Review of the EMR under the Assessment tab of the Head to Toe Weekly Skin Check assessment, documented on 07/19/22, the resident had a pressure area on the sacrum, however, the assessment lacked measurements, staging, and a description of the pressure area. The Head to Toe Weekly Skin Check assessment dated [DATE] recorded the resident had a pressure area on the sacrum. The assessments lacked measurements, staging and a description of the pressure area. The clinical record lacked physician notification and treatment of the pressure area on R101's sacrum. A Admission/Readmission Nursing Evaluation dated 08/07/22 documented the resident had a suspected deep tissue injury on the right heel. On 08/17/22 at 04:13 PM, R101 laid in bed with his eyes closed and no behaviors or distress noted. R101's bilateral lower extremities/heels rested on the bed. R101 lacked offloading measures in place for his right lower extremity that had a suspected deep tissue injury. On 08/18/22 at 02:38 PM, R101 laid in bed on his left side, and his feet rested directly on the mattress. On 08/17/22 at 09:06 AM, Administrative Nurse D stated R101's clinical record had a pressure area noted on 07/19/22 and Administrative Nurse E had assessed R101's sacrum, and skin protectant applied. Administrative Nurse D stated she would follow up with Administrative Nurse E to locate any documentation related to R101's sacrum wound documented in the EMR. On 08/18/22 at 03:20 PM Certified Nurse's Aide (CNA) O stated she would notify the nurse if she noted any skin issues on a resident during bathing or ADL's. CNA O stated R101 had an area on his sacrum about two to four weeks ago that was dark pink. CNA O stated R101 had pressure relieving boots, but he never wore them. On 08/18/22 at 04:06 PM Licensed Nurse (LN) H stated the resident had a suspected deep tissue injury on R101 right heel but was not aware of the offloading pressure reducing boots. On 08/18/22 at 05:17 PM, Administrative Nurse D stated she spoke with Administrative Nurse E related to R101's sacrum pressure area. Administrative Nurse D verified Administrative Nurse E had not felt there was an issue and had not tracked R101's sacrum pressure area. The facility Prevention of Pressure Injuries policy, last revised April 2020, documented staff to inspect pressure points (sacrum, heels, buttocks, coccyx, elbows) for darkly pigmented skin, inspect for changes in skin tone, temperature and consistency. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Pressure Ulcers/Skin Breakdown-Clinical Protocol policy, last revised April 2020 documented the physician would help identify and define any complications related to pressure ulcers. The facility failed to ensure pressure relieving measures were in place on R101's bilateral lower extremities, though R101 had a suspected deep tissue injury to his right heel. The facility further failed to assess and treat a sacral wound for R101. These deficient practices placed R101 at increased risk of development or worsening of pressure related injuries.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility reported a census of 54 residents. The sample included 22 residents with four residents reviewed for positioning and/or limited range of motions (ROM). Based on observation, interview and record review, the facility failed to provide adequate services and positioning devices to prevent decreased range of motion and mobility for Resident (R)101. This deficient practice placed R101 at increased risk for ROM decline, contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and discomfort. Findings included: - R101's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), pneumonia (inflammation of the lungs), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The staff interview was not completed. The MDS documented that R101 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R101 was at risk of development of pressure ulcers. The Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. The staff interview was not completed. The MDS documented that R101 required extensive assistance of two staff members for ADL's. The MDS documented R101 received oxygen therapy and was at risk of development of pressure ulcers during the look back period. R101's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/05/21 documented a low BIMS related to Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R101's Care Plan dated 02/15/22 documented Physical Therapy (PT) Occupational Therapy (OT) was to evaluate as needed for wheelchair positioning. The Care Plan lacked directions for safe, comfortable and appropriate positioning after evaluation. On 08/15/22 at 08:31 AM R101 sat in wheelchair next to bed, his right lower extremity rested on the floor between the leg rests. An unidentified staff entered R101's room, lifted R101's right leg and placed it back onto the leg rest and then pushed his wheelchair into the hallway without announcing the cares to be provided and continued to propel him without any verbal interaction to inform R101 where staff were taking him. On 08/16/22 at 11:37 AM R101 sat in wheelchair in room, eyes closed as he was leaning to his left side. R101 had slid down in the wheelchair, and his right lower extremity rested on the floor between the leg rests. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/16/22 at 12:33 PM R101 sat in a wheelchair in the dining room. R101 slid down in the wheelchair, while his bilateral lower extremities rested on leg rests. Certified Nurses Aide (CNA) N and CNA Q repositioned R101 to an upright position in the wheelchair. On 08/17/22 at 07:54 AM Consultant Therapy Director HH stated OT completed an evaluation 08/08/22 and reviewed positioning during evaluation. Consultant Therapy Director HH stated R101 had a saddle cushion in the wheelchair to assist with positioning and prevent him from sliding down in the wheelchair. Consultant Therapy Director HH stated he has a decline in the past several months and therapy felt R101 was not in need of a broda chair (specialized wheelchair with the ability to tilt and recline) at the time of the evaluation. On 08/18/22 at 03:20 PM Certified Nurses Aide (CNA) O stated R101 needed to be repositioned at times and required two staff to reposition him in the bed and wheelchair, because he was unable to assist much with that activity. CNA O stated she would transfer R101 into bed when he fell asleep and slid down in the wheelchair. CNA O stated she was not aware of any specific positioning for R101. On 08/18/22 at 04:06 PM agency Licensed Nurse (LN) H stated she had only worked with R101 for a short amount of time and had not seen any issues or concerns with R101's positioning problems while he sat in the wheelchair. LN H stated she had seen staff reposition him at times. On 08/18/22 at 05:17 PM Administrative Nurse D stated she would have to refer to R101's care plan to know anything about positioning or any specific directions. The facility Repositioning policy last revised May 2020 documented repositioning was a common, effective intervention for prevention of skin breakdown, promoting circulation, and provide pressure relieve. Staff would review the care plan to determine any specific positioning needs, including special equipment, resident level of participation and the number of staff required to complete the process. The facility failed to provide adequate services and positioning devices to prevent decreased range of motion for R101. This deficient practice placed R101 at increased risk for ROM decline, contractures and discomfort.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents with nine residents sampled for accidents. Based on observations, record review, and interviews, the facility failed to provide adequate supervision to prevent accidents and elopement (when a cognitively impaired resident leaves the facility without staff knowledge), for Resident (R) 46. The facility failed to provide adequate supervision during smoking for R2, R5, R7, and R33 who were documented as needing supervision with smoking. The facility failed to implement fall prevention interventions following a fall for R42. This deficient practice placed the affected residents at increased risk for accidents and/or injuries. Findings included: - R46 admitted to facility 04/18/22 and was moved to the locked unit on 07/14/22. The Diagnoses tab of R46's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) in other diseases classified elsewhere with behavioral disturbance, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). The Quarterly Minimum Data Set (MDS) dated [DATE], documented R46 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. R46 had verbal behavioral symptoms directed towards others one to three days; wandering was not exhibited in the lookback period. R46 required extensive physical assistance with one staff for bed mobility and personal hygiene, total physical dependence with two staff for transfers, dressing, and toileting; locomotion only occurred once or twice. The Care Plan dated 04/19/22, documented R46 had a potential for impaired or inappropriate behaviors related to dementia and directed caregivers provided opportunity for positive interaction, attention. An Admission Nursing Evaluation on 04/18/22 documented R46 had an elopement risk score of one which indicated he was not an elopement risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Investigation dated 07/17/22, documented on 07/14/22 at 03:25 PM, Maintenance U used the code to allow R34 and R46 access to the facility lobby, R46 proceeded to propel himself through the main doors to the exterior of the building. R46 was sitting next to the bench on the north side of the front sitting area watching the sprinklers then began to roll himself away from the sitting area towards the parking lot. At approximately 03:30 PM, Administrative Nurse F alerted staff members that R46 was outside headed towards the parking lot. Licensed Nurse (LN) G and Maintenance U assisted in bringing R46 back into the facility. Upon re-entry to the facility, a head-to-toe assessment was completed and revealed no remarkable findings. R46 had not been an elopement risk prior to that day but did have a diagnosis of dementia. R46 had been working with therapy and was now able to propel himself, he was moved to the memory care unit. Administrative Nurse F stated that R46 was outside going to the right and that she had sent out an alert at 03:33 PM to notify department heads for assistance. She stated Maintenance U called her phone at 03:40 PM and stated he saw R46 and was headed to help. Maintenance U stated he did use the keypad to the lobby at 03:25 PM to allow R34 and R46 through then proceeded back to the clinical area. The Notes tab of R46's EMR revealed the following: A Nurse's Note on 07/14/22 at 05:26 PM documented the nurse notified the on-call physician and R46's durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) of a non-injury elopement. R46 currently resided on the locked unit with no complaints and staff continued to monitor. A Skin Observation Progress Note on 07/14/22 at 05:28 PM documented R46's skin was clear with no impairments. On 08/16/22 at 12:18 PM R46 sat in his wheelchair at the dining room table and waited for lunch to be served. He appeared comfortable, no signs of discomfort, and no behaviors noted. On 08/18/22 at 01:39 PM Maintenance U stated on 07/14/22, R34 was going out into the lobby so he had let him out. He stated he had seen R46 outside before, so he let him out into the lobby as well. Maintenance U stated he no longer lets any residents out but if he needed to, there was an elopement book at the nurse's station to verify residents who were at risk. On 08/18/22 at 03:20 PM Administrative Staff B stated she had been on lunch when R46 left the building on 07/14/22. She stated there was an elopement book behind her desk with who needed supervision outside. Administrative Staff B stated R46 had been outside before with other residents and he had such a rapid recovery, they did not know he was an elopement risk until he left. On 08/18/22 at 04:20 PM Certified Nurse Aide (CNA) M stated any resident was able to go outside without supervision unless they were on the memory care unit or a newly admitted resident. She stated there was an elopement book kept at the nurse's station that listed who was at risk. On 08/18/22 at 04:49 PM LN G stated there was an elopement book kept at the nurse's station that staff checked before letting residents out into the lobby. On 07/14/22, he was notified that R46 had slipped out the front door and he went looking for him. LN G stated R46 had been bed bound leading up to days prior to the incident and within three days, he was self-propelling in the wheelchair around the facility but had never exhibit any exit seeking behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/22 at 05:17 PM Administrative Nurse D stated there was an elopement book on the locked unit, at the nurse's station, and at the front desk. She stated Maintenance U was letting another resident out into the lobby and R46 was right by his side, so he did was not in his line of vision when putting in the code. Administrative Nurse D stated R46 had not been identified as an elopement risk at that time because he had been bed bound and had just got to the point where he was in a wheelchair. She stated R46 did not have any wandering or exit seeking behaviors. The facility's Wandering and Elopements policy, last revised March 2019, directed the facility identified residents who were at risk of unsafe wandering and strove to prevent harm while maintaining the least restrictive environment for residents. The facility failed to provide adequate supervision to prevent accidents and elopement for Resident (R) 46 when he exited the facility on 07/14/22 through the front door after staff let him out of the secured doors between the clinical area and the front lobby area. This deficient practice placed R46 at risk for accidents and/or hazards. - The Diagnoses tab of R2's Electronic Medical Record (EMR) documented diagnoses of essential hypertension (high blood pressure) and chronic pain. The Annual Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R2 was independent with activities of daily living (ADLs). The Quarterly MDS, dated [DATE], documented R2 had a BIMS score of 15, which indicated intact cognition. R2 was independent with ADLs. The ADL Functional/Rehabilitation Potential Care Area (CAA), dated 04/19/22, documented R2 was mainly independent with ADLs and was able to alert staff to his needs. The Care Plan, dated 10/13/20, documented R2 smoked cigarettes and vapes. The Care Plan directed staff provided supervision while R2 was smoking, redirected R2 during nonsmoking times as indicated, and completed smoking assessments quarterly and as indicated. The Assessments tab of R2's EMR revealed a Smoking- Safety Screen dated 02/15/22, which documented a smoking safety score of two, safe to smoke with supervision. On 08/16/22 at 03:39 PM, R2 pushed against the emergency door on 100 hall and set the alarm off. After 15 seconds, the emergency door opened and R2 exited the building with R7 and R33. R2 stated they used to stick to the smoking times, but staff never came down at that time to take them out, so they went out by themselves now and set the alarm off. R33 stated staff came down to shut the alarm off but did not check on them. R2 stated there was a doorbell outside for them to use but staff never answered it. On 08/16/22 at 03:46 PM, Licensed Nurse (LN) J came down to shut the emergency door alarm off on the 100-hall. She did not open the door or go outside to check on the residents. On 08/16/22 at 03:47 PM, LN J brought a female resident to the 100-hall emergency door, used the code on the keypad, and exited the building with resident. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/16/22 at 03:53 PM, LN J brought the female resident back inside. R2, R7, and R33 remained outside. On 08/16/22 at 03:56 PM, surveyor exited building via 100-hall emergency door, using code. R2, R7, and R33 were still outside with no staff supervision. The three residents were ready to go back inside, the doorbell was pushed for staff to let resident inside. On 08/16/22 at 03:56 PM, staff answered the doorbell and let R2, R7, and R33 back inside the building. On 08/17/22 at 02:02 PM, R2 self-propelled down the 100-hallway towards the emergency door with R7. Administrative Staff C used the code to open the emergency door and let R2 and R7 outside to smoke then shut the door, left residents unsupervised. On 08/16/22 at 03:59 PM, LN J stated there was a code required to open the 100-hall emergency door and it could not be opened without a code by a staff member. She stated she was not aware the door opened if someone pushed on it for 15 seconds. On 08/18/22 at 04:20 PM, Certified Nurse Aide (CNA) M stated there were assigned times that residents could smoke if they needed supervision. She stated a few residents signed out and went out of the front doors to smoke and if residents started to congregate near the 100-hall exit door, she let them out to smoke. CNA M stated no resident off the memory care unit was restricted from smoking and were able to go on their own without supervision unless they were new to the building. On 08/18/22 at 04:49 PM, LN G stated there were supervised and unsupervised residents, the supervised residents went out with staff during scheduled times while unsupervised resident went out the front lobby or out the 100-hall exit door to smoke. He stated residents who went out the front doors were supposed sign out if they were not compliant with smoking times, but staff did a good job of being aware of who wanted to go out. LN G stated compliant residents asked for staff to open the door while noncompliant residents pushed on the door which opened after 15 seconds. He stated the door alarmed when pushed on and staff were expected to go outside to see who went out. He stated a smoking screen was completed and there was a list at the nurse's station of which residents were able to go out unsupervised. On 08/18/22 at 05:17 PM, Administrative Nurse D stated a smoking assessment was completed on smoking residents and those that were safe to smoke without supervision were able to go out on their own. She stated there were some residents who needed supervision during the smoking times and the care plan documented their smoking assistance. She stated residents signed out and went out the front doors or some went out of the 100-hall emergency door to smoke. Administrative Nurse D stated if someone pushed on the 100-hall emergency door, it alarmed, then opened after 15 seconds. She stated staff were expected to check to see who exited the building and were educated on who could smoke unsupervised and what to do when the emergency door alarms. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/22 at 01:11 PM, Administrative Staff A stated the smoking policy was just updated and the facility had independent and supervised smokers. She stated the designation was dependent upon the smoking assessment upon admission, with any change, and quarterly. Administrative Staff A stated those residents who needed assistance with smoking should have remained with staff and residents who were independent sometimes signed out and went to the smoking area. She stated the dependent residents were taken outside the emergency door on 100-hall, all the outside doors have a keypad and will alarm then open after 15 seconds. She expected when the door alarmed for staff to identify the individual that came in or went out the door and to see if they were able to be in that area. The facility's Smoking Policy- Residents, last revised July 2017, directed a resident's ability to smoke safely was re-evaluated quarterly, upon a significant change, and as determined by staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) were noted on the care plan and all personnel caring for the resident were alerted to those issues. The policy directed any resident with restricted smoking privileges requiring monitoring had direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking. The facility failed to ensure adequate supervision was provided during smoking for R2 who was documented as needing supervision during smoking. - The Diagnoses tab of R5's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness, and essential hypertension (high blood pressure). The Annual Minimum Data Set (MDS), dated [DATE], documented R5 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R5 required supervision with one staff for activities of daily living (ADLs). The Quarterly MDS, dated [DATE], documented R5 had a BIMS score of 11 which indicated moderate cognitive impairment. R5 required extensive physical assistance with one staff for bed mobility, transfers, dressing, and personal hygiene; supervision with one staff for locomotion; and limited physical assistance with one staff for toileting. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 08/13/21, documented R5 required supervision to independent with ADLs. The Care Plan, dated 01/18/22, documented R5 smoked cigarettes and had left sided weakness. The Care Plan directed staff redirected R5 during nonsmoking times as indicated, R5 attended supervised smoke breaks outside with staff, and staff performed smoking assessment quarterly and as indicated. The Assessments tab of R5's EMR revealed a Smoking- Safety Screen dated 07/27/22 which documented a smoking safety score of two, safe to smoke with supervision. On 08/17/22 at 08:46 AM R5 and R30 sat in wheelchairs outside of the 100-hall emergency door and smoked. There were no staff members observed outside with R5. On 08/17/22 at 08:51 AM R7 pushed on the 100-hall emergency door, alarm sounded, door opened after 15 seconds, and R7 exited the building to smoke. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/17/22 at 08:52 AM Administrative Staff CC entered code for 100-hall emergency door and exited the building, she walked to the smoking area, then entered the building. On 08/17/22 at 08:53 AM Maintenance U entered code for 100-hall emergency door and exited the building with a shop vacuum. On 08/17/22 at 08:56 AM Maintenance U entered code to enter the 100-hall emergency door and let R5, R7, and R30 back into the building. On 08/16/22 at 03:59 PM, LN J stated there was a code required to open the 100-hall emergency door and it could not be opened without a code by a staff member. She stated she was not aware the door opened if someone pushed on it for 15 seconds. On 08/18/22 at 04:20 PM, Certified Nurse Aide (CNA) M stated there were assigned times that residents could smoke if they needed supervision. She stated a few residents signed out and went out of the front doors to smoke and if residents started to congregate near the 100-hall exit door, she let them out to smoke. CNA M stated no resident off the memory care unit was restricted from smoking and were able to go on their own without supervision unless they were new to the building. On 08/18/22 at 04:49 PM, LN G stated there were supervised and unsupervised residents, the supervised residents went out with staff during scheduled times while unsupervised resident went out the front lobby or out the 100-hall exit door to smoke. He stated residents who went out the front doors were supposed sign out if they were not compliant with smoking times, but staff did a good job of being aware of who wanted to go out. LN G stated compliant residents asked for staff to open the door while noncompliant residents pushed on the door which opened after 15 seconds. He stated the door alarmed when pushed on and staff were expected to go outside to see who went out. He stated a smoking screen was completed and there was a list at the nurse's station of which residents were able to go out unsupervised. On 08/18/22 at 05:17 PM, Administrative Nurse D stated a smoking assessment was completed on smoking residents and those that were safe to smoke without supervision were able to go out on their own. She stated there were some residents who needed supervision during the smoking times and the care plan documented their smoking assistance. She stated residents signed out and went out the front doors or some went out of the 100-hall emergency door to smoke. Administrative Nurse D stated if someone pushed on the 100-hall emergency door, it alarmed, then opened after 15 seconds. She stated staff were expected to check to see who exited the building and were educated on who could smoke unsupervised and what to do when the emergency door alarms. On 08/22/22 at 01:11 PM, Administrative Staff A stated the smoking policy was just updated and the facility had independent and supervised smokers. She stated the designation was dependent upon the smoking assessment upon admission, with any change, and quarterly. Administrative Staff A stated those residents who needed assistance with smoking should have remained with staff and residents who were independent sometimes signed out and went to the smoking area. She stated the dependent residents were taken outside the emergency door on 100-hall, all of the outside doors have a keypad and will alarm then open after 15 seconds. She expected when the door alarmed for staff to identify the individual that came in or went out the door and to see if they were able to be in that area. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Smoking Policy- Residents, last revised July 2017, directed a resident's ability to smoke safely was re-evaluated quarterly, upon a significant change, and as determined by staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) were noted on the care plan and all personnel caring for the resident were alerted to those issues. The policy directed any resident with restricted smoking privileges requiring monitoring had direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking. The facility failed to ensure adequate supervision was provided during smoking for R5 who was documented as needing supervision during smoking. - The Diagnoses tab of R7's Electronic Medical Record (EMR) documented a diagnosis of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (cerebrovascular accident- 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) affecting left non-dominant side. The Admission Minimum Data Set (MDS), dated [DATE], documented R7 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R7 required extensive physical assistance with two staff for bed mobility; extensive physical assistance with one staff for transfers, dressing, and toileting; limited physical assistance with one staff for personal hygiene; and was independent with setup help only for locomotion and eating. The Quarterly MDS, dated [DATE], documented R7 had a BIMS score of 14 which indicated intact cognition. R7 required extensive physical assistance with one staff for bed mobility, transfers, dressing, toileting, and personal hygiene; supervision with setup help only with eating; and was independent with no setup help for locomotion. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 11/03/21, documented R7 needed assistance with ADLs. The Care Plan, dated 10/13/20, documented R7 smoked cigarettes. The Care Plan directed staff provided supervision when R7 was smoking, redirected R7 during nonsmoking times as indicated, and performed smoking assessment quarterly and as indicated. The Assessments tab of R7's EMR revealed a Smoking- Safety Screen dated 03/21/22 which documented a smoking safety score of two, safe to smoke with supervision. On 08/16/22 at 03:39 PM, R2 pushed against the emergency door on 100 hall and set the alarm off. After 15 seconds, the emergency door opened and R2 exited the building with R7 and R33. R2 stated they used to stick to the smoking times, but staff never came down at that time to take them out, so they went out by themselves now and set the alarm off. R33 stated staff came down to shut the alarm off but did not check on them. R2 stated there was a doorbell outside for them to use but staff never answered it. On 08/16/22 at 03:46 PM, Licensed Nurse (LN) J came down to shut the emergency door alarm off on 100 hall. She did not open the door or go outside to check on the residents. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/16/22 at 03:47 PM, LN J brought a female resident to the 100-hall emergency door, used the code on the keypad, and exited the building with resident. On 08/16/22 at 03:53 PM, LN J brought the female resident back inside. R2, R7, and R33 remained outside. On 08/16/22 at 03:56 PM, surveyor exited building via 100 hall emergency door, using code. R2, R7, and R33 were still outside with no staff supervision. The three residents were ready to go back inside, the doorbell was pushed for staff let residents inside. On 08/16/22 at 03:56 PM, staff answered the doorbell and let R2, R7, and R33 back inside the building. On 08/17/22 at 08:46 AM R5 and R30 sat in wheelchairs outside of the 100-hall emergency door and smoked. There were no staff members observed outside with R5. On 08/17/22 at 08:51 AM R7 pushed on the 100-hall emergency door, alarm sounded, door opened after 15 seconds, and R7 exited the building to smoke. On 08/17/22 at 08:52 AM Administrative Staff CC entered code for 100-hall emergency door and exited the building, she walked to the smoking area, then entered the building. On 08/17/22 at 08:53 AM Maintenance U entered code for 100-hall emergency door and exited the building with a shop vacuum. On 08/17/22 at 08:56 AM Maintenance U entered code to enter the 100-hall emergency door and let R5, R7, and R30 back into the building. On 08/17/22 at 02:02 PM, R7 self-propelled down 100-hallway towards emergency door with R2. Administrative Staff C used the code to open the emergency door and let R2 and R7 outside to smoke then shut the door, left residents unsupervised. On 08/16/22 at 03:59 PM, LN J stated there was a code required to open the 100-hall emergency door and it could not be opened without a code by a staff member. She stated she was not aware the door opened if someone pushed on it for 15 seconds. On 08/18/22 at 04:20 PM, Certified Nurse Aide (CNA) M stated there were assigned times that residents could smoke if they needed supervision. She stated a few residents signed out and went out of the front doors to smoke and if residents started to congregate near the 100-hall exit door, she let them out to smoke. CNA M stated no resident off the memory care unit was restricted from smoking and were able to go on their own without supervision unless they were new to the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/22 at 04:49 PM, LN G stated there were supervised and unsupervised residents, the supervised residents went out with staff during scheduled times while unsupervised resident went out the front lobby or out the 100-hall exit door to smoke. He stated residents who went out the front doors were supposed sign out if they were not compliant with smoking times, but staff did a good job of being aware of who wanted to go out. LN G stated compliant residents asked for staff to open the door while noncompliant residents pushed on the door which opened after 15 seconds. He stated the door alarmed when pushed on and staff were expected to go outside to see who went out. He stated a smoking screen was completed and there was a list at the nurse's station of which residents were able to go out unsupervised. On 08/18/22 at 05:17 PM, Administrative Nurse D stated a smoking assessment was completed on smoking residents and those that were safe to smoke without supervision were able to go out on their own. She stated there were some residents who needed supervision during the smoking times and the care plan documented their smoking assistance. She stated residents signed out and went out the front doors or some went out of the 100-hall emergency door to smoke. Administrative Nurse D stated if someone pushed on the 100-hall emergency door, it alarmed, then opened after 15 seconds. She stated staff were expected to check to see who exited the building and were educated on who could smoke unsupervised and what to do when the emergency door alarms. On 08/22/22 at 01:11 PM, Administrative Staff A stated the smoking policy was just updated and the facility had independent and supervised smokers. She stated the designation was dependent upon the smoking assessment upon admission, with any change, and quarterly. Administrative Staff A stated those residents who needed assistance with smoking should have remained with staff and residents who were independent sometimes signed out and went to the smoking area. She stated the dependent residents were taken outside the emergency door on 100 hall, all of the outside doors have a keypad and will alarm then open after 15 seconds. She expected when the door alarmed for staff to identify the individual that came in or went out the door and to see if they were able to be in that area. The facility's Smoking Policy- Residents, last revised July 2017, directed a resident's ability to smoke safely was re-evaluated quarterly, upon a significant change, and as determined by staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) were noted on the care plan and all personnel caring for the resident were alerted to those issues. The policy directed any resident with restricted smoking privileges requiring monitoring had direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking. The facility failed to ensure adequate supervision was provided during smoking for R7 who was documented as needing supervision during smoking. - The Diagnoses tab of R33's Electronic Medical Record (EMR) documented diagnoses of essential hypertension (high blood pressure) and tobacco use. The Annual Minimum Data Set (MDS), dated [DATE], documented R33 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R33 was independent with activities of daily living (ADLs). The Quarterly MDS, dated [DATE], documented R33 had a BIMS score of 15 which indicated intact cognition. R33 was independent with bed mobility, transfers, walking, dressing, toileting, and personal hygiene; supervision with one staff for eating. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Pain Care Area Assessment (CAA), dated 02/21/22, documented R33 had chronic pain, had a BIMS of 15, and made his needs known. The Care Plan, dated 01/29/21, documented R33 smoked cigarettes. The Care Plan directed staff redirected R33 during nonsmoking times as indicated and completed a smoking assessment quarterly and as indicated. The Assessments tab of R33's EMR revealed a Smoking- Safety Screen dated 03/21/22 which documented a smoking safety score of two, safe to smoke with supervision. On 08/16/22 at 03:39 PM, R2 pushed against the emergency door on 100 hall and set the alarm off. After 15 seconds, the emergency door opened and R2 exited the building with R7 and R33. R2 stated they used to stick to the smoking times, but staff never came down at that time to take them out, so they went out by themselves now and set the alarm off. R33 stated staff came down to shut the alarm off but did not check on them. R2 stated there was a doorbell outside for them to use but staff never answered it. On 08/16/22 at 03:46 PM, Licensed Nurse (LN) J came down to shut the emergency door alarm off on 100-hall. She did not open the door or go outside to check on the residents. On 08/16/22 at 03:47 PM, LN J brought a female resident to the 100-hall emergency door, used the code on the keypad, and exited the building with resident. On 08/16/22 at 03:53 PM, LN J brought the female resident back inside. R2, R7, and R33 remained outside. On 08/16/22 at 03:56 PM, surveyor exited building via 100-hall emergency door, using code. R2, R7, and R33 were still outside with no staff supervision. The three residents were ready to go back inside, the doorbell was pushed for staff to let residents inside. On 08/16/22 at 03:56 PM, staff answered the doorbell and let R2, R7, and R33 back inside the building. On 08/16/22 at 03:59 PM, LN J stated there was a code required to open the 100-hall emergency door and it could not be opened without a code by a staff member. She stated she was not aware the door opened if someone pushed on it for 15 seconds. On 08/18/22 at 04:20 PM, Certified Nurse Aide (CNA) M stated there were assigned times that residents could smoke if they needed supervision. She stated a few residents signed out and went out of the front doors to smoke and if residents started to congregate near the 100-hall exit door, she let them out to smoke. CNA M stated no resident off the memory care unit was restricted from smoking and were able to go on their own without supervision unless they were new to the building. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/22 at 04:49 PM, LN G stated there were supervised and unsupervised residents, the supervised residents went out with staff during scheduled times while unsupervised resident went out the front lobby or out the 100-hall exit door to smoke. He stated residents who went out the front doors were supposed sign out if they were not compliant with smoking times, but staff did a good job of being aware of who wanted to go out. LN G stated compliant residents asked for staff to open the door while noncompliant residents pushed on the door which opened after 15 seconds. He stated the door alarmed when pushed on and staff were expected to go outside to see who went out. He stated a smoking screen was completed and there was a list at the nurse's station of which residents were able to go out unsupervised. On 08/18/22 at 05:17 PM, Administrative Nurse D stated a smoking assessment was completed on smoking residents and those that were safe to smoke without supervision were able to go out on their own. She stated there were some residents who needed supervision during the smoking times and the care plan documented their smoking assistance. She stated residents signed out and went out the front doors or some went out of the 100-hall emergency door to smoke. Administrative Nurse D stated if someone pushed on the 100-hall emergency door, it alarmed, then opened after 15 seconds. She stated staff were expected to check to see who exited the building and were educated on who could smoke unsupervised and what to do when the emergency door alarms. On 08/22/22 at 01:11 PM, Administrative Staff A stated the smoking policy was just updated and the facility had independent an[TRUNCATED]

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	175176	A. Building B. Wing	08/22/2022

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 54 residents. The sample included 22 residents with three reviewed for bowel and bladder management. Based on observation, record review, and interviews, the facility failed to provide Resident (R)11 with a person-centered toileting program, to ensure maintenance of as much normal bladder function as possible. Furthermore, the facility failed to ensure appropriate cares and services for R12's suprapubic catheter (tube inserted through the abdomen into the bladder to drain urine) when the facility failed to properly anchor the catheter tubing and keep the catheter tubing from coming into direct contact with the floor. These deficient practices placed R11 at increased risk for impaired health related to incontinence and placed R12 at increased risk of catheter related complications. Findings Included: - The Medical Diagnosis section within R11's Electronic Medical Records (EMR) included diagnoses of moderate protein-calorie malnutrition (lack of sufficient nutrients in the body), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), gastrointestinal hemorrhage (loss of a large amount of blood in a short period of time), dementia (progressive mental disorder characterized by failing memory, confusion), seizures (violent involuntary series of contractions of a group of muscles), dysphagia (difficulty in swallowing food or liquid), muscle weakness, difficulty walking, and need for assistance with personal cares. R11's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required extensive assistance from two members for dressing, toileting, and personal hygiene. The MDS indicated that she was not on a toileting program for bowel and bladder but was occasionally incontinent of both. Review of R11's Dementia Care Area Assessment (CAA) dated 04/04/22, noted that she had disorganized thinking and had a difficult time communicating her needs due to her diagnoses of dementia and schizophrenia. Review of R11's Urinary Incontinence CAA dated 04/04/22, revealed she required extensive assistance for toileting and was frequently incontinent but could alert staff at times when needed. The Care Plan created 03/23/22, revealed she had both bowel and bladder incontinence. Staff were to check her every two hours and as required for incontinence. The care plan instructed that peri-care be performed as needed. The care plan lacked documentation identifying the level of extent and number of staff assistance needed for toileting. R11's incontinence care plan lacked resident specific toileting schedule or interventions to decrease incontinent episodes. A review of R11's Quarterly Nursing Evaluation completed 06/22/22, indicated her evaluation for bowel and bladder rehabilitation were within normal limits but the resident did not wish to participate in the plan. The evaluation noted the resident had occasional bowel and bladder incontinence. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/22 at 11:20 AM, R11 reported staff were slow to respond to her room for assistance and she often attempted to take herself to the bathroom without them. She stated that staff rarely came into the room at nighttime, and she often had incontinent episodes at night. On 08/22/22 at 12:08 PM, R11 entered the common area by the nurse's station from the hallway and requested staff assistance. R11 then began yelling out for someone to help her. After approximately five minutes, R11 sat down and waited for staff next to the nurses' station. At 12:40 PM, R11 got up to walk back to her room. R11's pink pants were saturated. She ambulated to her room and received assistance from staff after the incontinent episode occurred. On 08/18/22 at 01:05PM, Certified Nurse's Aide (CNA) O stated staff should check on incontinent residents every two hours and assist them with peri-cares (dealing with private areas) for residents that required cleaning and changing. She stated that R11 did at times refuse cares when staff would offer help, but staff should continue to aid the resident. She stated the amount of assistance a resident would need and how often should be noted in the care plan. She stated that R11 did have a lot of incontinent episodes and would often yell out for help when she needed bathroom assistance. On 08/18/22 at 01:25PM, Licensed Nurse (LN) H stated staff should check up on the resident at least every two hours for routine cares. She stated that incontinent residents should be offered restroom breaks during each check. She stated R11 required a lot of assistance with incontinence cares and needed staff assistance each time due to her mobility issues and dementia. On 08/18/22 at 05:18 PM, Administrative Nurse D stated staff should complete bowel and bladder assessments on admission, quarterly, annually, and when a resident had a significant change occur for bowel and bladder management. Staff were to offer assistance and check residents every two hours with incontinence care needs. The facility's Urinary Continence and Incontinence policy revised 09/2010, indicated the facility will provide appropriate services and treatments to help residents restore or improve bladder functions and prevent urinary tract infections to the extent possible. The facility failed to provide this resident with a person-centered toileting program, to ensure maintenance of as much normal bladder function as possible. 41037 - R12's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of retention of urine (lack of ability to urinate and empty the bladder), and dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R12 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R12 had an indwelling catheter during the look back period. R12's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 06/22/22 documented he had a suprapubic catheter (urinary bladder catheter inserted through the skin) and required assistance with care and monitoring of the catheter. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Care Plan dated 08/16/21 documented he had a 12 French (FR) Foley (tube inserted into the bladder to drain urine into a collection bag) suprapubic catheter; if the catheter becomes dislodged notify the physician. Review of the EMR under Orders tab revealed physician orders: Irrigate suprapubic catheter every eight hours with 60 milliliters of normal saline as needed dated 07/20/21. Clean suprapubic catheter site every night shift with soap and water or normal saline/wound cleaner. May leave open to air if no drainage or cover with a dressing. Secure to body to prevent dislodgement, position below bladder for catheter maintenance dated 07/21/21. Resident has a suprapubic 12 FR Foley catheter. Catheter is replaced monthly at the hospital. Monitor catheter for signs or symptoms of infection. If signs or symptoms of infection at site are present, or if catheter is without output, notify physician for further orders for suprapubic catheter maintenance dated 10/06/21. Review of the EMR under the Progress Notes tab revealed: On 06/28/22 at 06:43 PM documented R12 was found without his suprapubic catheter and was sent to the hospital for reinsertion and returned with an antibiotic order. On 08/07/22 at 02:50 PM R12 was sent out of the facility to the hospital to have his suprapubic catheter reinserted. On 08/15/22 at 08:55 AM observation revealed R12's catheter drainage bag contained dark amber urine with sediment noted in the tubing. The catheter drainage bag was attached to the wheelchair under the seat and lacked a dignity bag. The catheter bag drug along the floor as R12 propelled himself. On 08/22/22 at 08:21 AM R12's catheter drainage bag, which contained dark amber urine, was attached to the wheelchair next to the dignity bag under the seat. the catheter tubing drug along the floor as R12 propelled himself in the dining room. R12 refused to allow observation of catheter care. On 08/18/22 at 03:40 PM Certified Nurses Aide (CNA) N stated catheter care would be provided every two hours and when soiled. CNA N stated a catheter drainage bag would be placed in a dignity bag below the bladder. CNA N stated she had not seen a system in place to secure R12's catheter tubing to prevent dislodgement. On 08/18/22 at 04:15 PM Licensed Nurse (LN) I stated R12's catheter drainage bag should always be placed in a dignity bag and never be placed on the floor. LN, I stated R12 did not have an anchor in place to prevent catheter dislodgement. She stated she was not familiar with anchoring a suprapubic catheter on the abdomen to prevent the catheter from being pulled or tugged out. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/18/22 at 05:17 PM Administrative Nurse D stated catheter care should be preformed every shift. Administrative Nurse D stated R12 was not always cooperative with ADL's and needed a lot of encouragement to participate. Administrative Nurse D stated catheter drainage bag should be placed in a dignity bag. Administrative Nurse D stated she would have to review R12's care plan to know what was used to anchor the tubing to prevent dislodgement. The facility Catheter Care, Urinary policy lasted revised September 2014 documented to be sure the catheter tubing and drainage bag are kept off the floor for infection control. The facility failed to ensure a method was in place to anchor catheter tubing to prevent dislodgment off suprapubic catheter and catheter tubing and drainage was not on the floor to prevent possible urinary tract infections for R12. This deficient practice placed him at risk from unnecessary trauma and urinary related infections.

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	175176	A. Building B. Wing	08/22/2022

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 54 residents. The sample included 22 residents with six residents reviewed for nutrition. Based on observation, record review, and interviews,the facility failed to implement relevant nutritional interventions to prevent continued weight loss for Resident (R)14, who had a significant weight loss. The facility further failed to weigh weekly as ordered by the physician. The facility failed to identify residents preferred snacks and add to the plan of care to ensure availability, and failed to identify opportunities to fortify non-cereal foods the resident consistently consumed, in order to prevent further loss. This deficient practice placed the residents at risk for complications with unplanned weight loss and malnutrition. Findings Included: - The Medical Diagnosis section within R14's Electronic Medical Records (EMR) included diagnoses of altered mental status, chronic kidney disease, dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement). R14's Admission Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS noted R14 required supervision with assistance of one person for eating. The MDS recorded no difficulties chewing or swallowing. The MDS noted R14 weighed 157 pounds (lbs.). A review of R14's Quarterly MDS dated [DATE] noted a BIMS score of one, indicating severe cognitive impairment. R14 had no difficulties chewing or swallowing. The MDS noted her weight to be 149 lbs. (refer to F641) and indicated unplanned weight loss. A review of R14's Nutrition Care Area Assessment (CAA) dated 09/14/21 documented R14 had potential nutritional risks related to her cognitive loss, dementia, wandering, and communication difficulties. A review of R14's Care Plan revealed initial interventions created on 09/02/21 to honor her food requests and preferences, complete her labs as ordered, serve her diet as ordered, and obtain/record her weight as ordered. On 02/15/22 R14's care plan documented an intervention for staff to offer snacks throughout the day. The care plan lacked direction to staff on what kind of snacks R14 preferred. On 03/04/22 R14's Care Plan informed staff to redirect her when she wandered or took food from other residents and to provide fortified cereals daily at breakfast. Staff were to offer and encourage supplements per order. Nursing to monitor percentage consumed. The care plan lacked direction to offer R14 finger foods as she tended to wander instead of sitting for a full meal. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's Care Plan recorded an intervention dated 08/15/22 which documented R14 weighed 136.7 lbs on 08/11/22. She triggered for a 10.0% loss over 180 day(s). The intervention noted R14 resided on the memory unit. She walked throughout the day and put finger foods down and did not eat when offered. She received a regular diet. R14 was able to feed herself with set up assistance but liked to get up throughout meals. Staff redirected R14 at times and offered finger foods as able. R14 had confusion and took other residents' food off their plate as she walked by, but she did not always eat it. R14 continued with mighty shakes three times daily, her acceptance varied. R14 continued with fortified cereal daily at breakfast. Staff continued to offer her favorite snacks throughout the day. Remeron was administered as ordered for appetite stimulant. A review of R14's Physician's Orders indicated an active order for mirtazapine started 09/01/21. The order indicated staff to give 15 milligrams (mg) to improve appetite. A Nutrition Data Collection dated 03/04/22 under the Assessment tab in R14's EMR revealed R14's current body weight reflected a 3.5 % loss since 02/08/22 and 10.8 % loss in three months. The tool recorded R14 had gained weight right after admission though had gradually declined in weight in the last two months. R14 liked to wander throughout the day and tried to take food from other residents' plates. Staff were supposed to redirect R14 back to her own meal. R14 had a regular diet. She was able to feed herself after set up. She had confusion but was able to make food choices at meals/snacks. The note recorded no new labs since 11/09/21. Staff were to offer choices at meals, offer snacks, and monitor weights. The registered dietician (RD) recommended adding weekly weights, four ounce (oz) mighty shake with lunch/dinner and fortified cereal daily at breakfast to promote weight maintenance. R14's EMR recorded a physician's order dated 03/14/22 (10 days later) for a four oz health shake twice daily for weight loss. The EMR recorded an order dated 03/14/22 for a weekly weight. Review of the Treatment Administration Record (TAR) for March 2022 revealed an order to obtain weekly weight in the morning on Thursday, starting 03/17/22. The March 2022 TAR revealed a weight was signed off as completed but lacked a weight measurement on 03/17/22, 03/24/22, and 03/31/22. R14's weights under the Vitals tab revealed a weight of 147.5 lbs. and 148.5 lbs., both on 03/03/22. The record lacked further weights from March. Review of the April 2022 TAR revealed R14 refused a weight on 04/07/22. The weight was checked as completed but lacked an actual measurement of weight on 04/14/22, 04/21/22, and 04/28/22. R14's weights under the Vitals tab revealed a weight of 149.0 lbs. on 04/04/22 and 149.0 lbs. on 04/21/22. The record lacked further weights for April. Review of the May 2022 TAR revealed the weights for R14 were checked as completed but lacked an actual measurement of weight on 05/05/22, 05/12/22, and 05/19/22. The weight was not completed on 05/26/22. R14's weights under the Vitals tab revealed a weight of 149.6 lbs. on 05/05/22 and 144 lbs. on 05/06/22. The record lacked further weights for May. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's EMR recorded R14 tested positive for Covid (highly contagious respiratory infection) on 05/31/22. The Nutrition Risk Evaluation dated 05/31/22 recorded R14 had a 3.5 % loss in one month, a 6.4% loss in three months, and a 11% percent loss in six months. The evaluation recorded R14 liked to wander throughout the day and tried to take food from other residents' plates. Staff were supposed to redirect R14 back to her own meal. R14 had a regular diet. She was able to feed herself after set up. She had confusion but was able to make food choices at meals/snacks. The note recorded no new labs since 11/09/21. Staff were to offer choices at meals; offer snacks and monitor weights. The evaluation recorded r14 was on weekly weights. She received health shakes at lunch and dinner and fortified cereal at breakfast. The RD recommended to increase health shakes to three times daily and monitor weights. R14's Physician's Orders also indicated that she was to receive four ounces of supplemental health shakes three times daily starting on 06/01/22. R14's weights under the Vitals tab revealed a weight of 135.2 lbs. on 06/09/22, 136.8 lbs. on 06/13/22, 140.2 lbs. on 06/23/22, and 139.9 lbs. and 140.6 lbs. both on 06/30/22. A Vitals Note recorded a weight warning on 06/13/22 and recorded the resident recently had Covid. Staff would continue to monitor now that she was no longer in isolation. A Nutrition Note dated 06/13/22 recorded a 6.1% loss in one month; a 9.3% loss in three months, and a 18. 8% loss in six months. The note recorded R14 was recently diagnosed with Covid. No new labs since 11/09/21 labs. Staff to offer choices at meals; encourage snacks and monitor weights as ordered. The nurse practitioner (NP) had approved increasing four oz mighty shakes to three times daily. The note directed to continue with fortified cereal daily at breakfast to minimize continued weight loss. A Vitals Note recorded a weight warning on 06/27/22 which recorded weight loss was discussed in risk and staff would continue to monitor. The weight value was 140.2 lbs. A Vitals Note recorded a weight warning on 06/30/22 which recorded the resident continued to lose weight. It was discussed at risk to offer her finger foods as she constantly walked and was unable to sit long enough to consume a meal. R14's clinical record lacked evidence the facility implemented the identified intervention of finger foods and added to the residents plan of care in effort to avoid continued weight loss. An Interdisciplinary Team (IDT) Progress Note dated 07/08/22 documented staff to continue to monitor due to weight loss. A Nutrition Note on 07/11/22 recorded the resident wandered throughout the day. The note recorded R14 needed redirection and staff to offer finger foods as able. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nutrition Note on 07/25/22 recorded the resident wandered throughout the day, put finger foods down, and did not eat when offered. The note recorded R14 needed redirection and staff to offer finger foods as able. The note directed staff to offer R14 her favorite snacks throughout the day but lacked identification of R14's favored snacks. R14's weights under the Vitals tab revealed a weight of 138.2 lbs. on 08/04/22. This reflected a 7.62% weight loss in three months and a 10.49% weight loss in six months. On 08/17/22 at 07:11 AM R14 sat at the dining room table waiting for breakfast. R14 attempted to take another residents food but Licensed Nurse (LN) I redirected her and provided her with her own plate. R14 consumed her eggs, toast, sausage, and fortified malt cereal. R14 consumed her supplemental protein shake and exited the dining room. The meal served was of regular diet and not finger food. On 08/18/22 at 07:20 AM R14 ate her breakfast of cheese omelet, sausage links, toast, and fortified cereal. She consumed her entire meal without issues or concerns. She consumed her supplemental protein shake. A review of R14's service ticket revealed no mention of finger foods and the meal served was regular. In an interview on 08/17/22 at 08:00 AM with LN I, she stated that all residents on the dementia unit should receive a dietary meal ticket indicating the specific dietary needs of the residents. She stated that all dementia residents receive supervision during mealtime and their intake is documented in the EMR. She stated R14 needed prompts and redirection while eating and R14 had a noted weight loss. She stated that staff offer her snacks of peanut butter and jelly sandwiches, chips, and peanut butter crackers. She stated R14 loved to eat peanut butter-based snacks. She stated residents at risk for weight loss should be weighed frequently, per their orders. In an interview with Dietary Staff BB on 08/17/22 at 11:30AM, she stated staff prepared the food based on each resident's dietary profile. She stated the resident's tickets were printed and contained the type of diet the resident received, and any special requirements would be noted. She stated the facility used pre-fortified cereals and would add in additional nutrients to the cereal based on the dietary needs of the residents. She stated the facility also supplements protein shakes for residents at risk. In an interview with Dietary Staff DD on 08/17/22 at 11:50 AM, she stated she often served meals on the dementia unit. She stated R14 needed redirections every now and then but usually would consume her meals without issue. She stated she would often be offered snacks that she preferred such as crackers, chips, and sandwiches. The facility's Registered Dietician was called but did not return the call. A review of the facility's Weight Assessment and Intervention policy revised 09/2008 indicated that the facility strived to prevent, monitor, and intervene for undesirable weight loss. The policy noted that the threshold for severe weight loss was over 10 percent in six months. The policy noted that the care plans will initiate interventions that identify the cause of the weight loss, set goals for improvement, and have set timeframes with parameters to monitor and allow reassessment. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to implement nutritional interventions identified as relevant by the IDT team to prevent continued weight loss for R14, who had a significant weight loss. The facility further failed to weigh weekly as ordered by the physician. The facility failed to identify residents preferred snacks and add to the plan of care to ensure availability, and failed to identify opportunities to fortify non-cereal foods the resident consistently consumed, in order to prevent further loss. This deficient practice placed the residents at risk for complications with unplanned weight loss and malnutrition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 F693-D The facility identified a census of 54 residents. The sample included 22 residents with two residents reviewed for tube feeding. Based on observation, record review, and interviews, the facility failed to provide consistent tube feedings and water boluses as ordered by the physician for Resident (R)4. This deficient practice placed R4 at risk for malnutrition and complications related to his feeding tube (tube inserted through the abdominal wall into the stomach). Findings Included: - The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of right sided hemiplegia (paralysis of one side of the body), right sided hemiparesis (muscular weakness of one half of the body), need for assistance with personal cares, muscle weakness, dysphagia (difficulty in swallowing food or liquid), and aphasia (condition with disordered or absent language function). R4's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated that he required extensive assistance from one staff member for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS indicated that he was totally dependent on assistance from one staff for bathing. The MDS noted that he required supervision and set-up only for eating. The MDS noted that had no weight loss within the last six months. The MDS noted that he required a mechanically altered diet. A review of R4's Communication Care Area Assessment (CAA) dated 03/09/22 indicated he had aphasia but at times could make his needs known. A review of R4's Feeding Tube CAA dated 03/09/22 indicated he was receiving fluid and nutrition via his feeding tube. The CAA indicated monthly weight checks, periodic dietary evaluations, and regular changing and replacements to avoid complications related to his diagnoses. R4's Care Plan created 02/07/22 indicated that he was at risk for impaired nutrition or malnutrition related to his medical diagnoses. Resident had a feeding tube and received nutritional intake by mouth as well. The care plan noted that staff were to provide one to one assistance and supervision for the duration of the meal. The care plan noted that if he did not eat at least 50 percent of his meal, he would receive tube feeding. The care plan indicated that on 08/13/22 R4 pulled out his feeding tube and refused it to be replaced when sent out. A review of R4's Physician's Orders noted an order enteral feed (providing nutrition directly to the stomach using the peg tube) order started 03/28/22. The order indicated that staff were to administer 237 milliliters (ml) of Jevity (protein rich supplemental drink) if R4 consumed less than 50 percent of his meals for nutritional support. This order was discontinued on 08/16/22. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R4's Medication Administration Record (MAR) from 05/01/22 through 08/17/22 revealed he had missed ten opportunities for his tube feeding after consuming less than 50 percent of his meals. The review revealed no documented refusals. R4's Physician Orders noted an order started 03/24/22 for staff to give 90 ml of water bolus twice a day through his feeding tube to ensure patency (make sure the feeding tube was unobstructed) and for hydration. This order was discontinued on 08/16/22. A review of R4's MAR from 03/24/22 through 08/13/22 revealed that his ordered water bolus was not given on ten occasions. The review revealed no documented refusals. On 08/18/22 at 01:25PM Licensed Nurse (LN) H stated all staff access to review the residents care plans and see for tube feedings. She noted that she had not recently worked with any residents that required feedings but was aware R4 had recently removed his. She stated that tube feedings are shown in the resident's orders and can be tracked in the MAR. On 08/18/22 at 05:18 PM Administrative Nurse D reported that staff were expected to follow all physician's orders and parameters. She noted that if a resident refused treatment or medication the nurse should notify the physician. A review of the Facility's Enteral Tube Feeding policy revised 11/2018 indicated that the facility should have a physician's order and care planned documentation for all tube feeding. The facility failed to provide the physician ordered tube feedings and water boluses to R4. This deficient practice placed R4 at risk for malnutrition and complications related to his feeding tube.

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	175176	A. Building B. Wing	08/22/2022

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 54 residents. The sample included 22 residents with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to store oxygen (O2) tubing (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) properly for Resident (R) 101. Furthermore, the facility failed to change the oxygen tubing weekly as ordered for R21. This deficient practice placed R101 and R21 at increased risk for development of respiratory complications. Findings included: - R101's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), pneumonia (inflammation of the lungs), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The resident required extensive assistance of two staff members for activities of daily living (ADL's). The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/05/21, documented a low BIMS related to Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The Quarterly MDS dated [DATE], documented a BIMS score of zero, which indicated severely impaired cognition. The resident required extensive assistance of two staff members for ADL's. The resident received oxygen therapy. The Care Plan dated 10/13/21, documented oxygen therapy via nasal cannula (NC- a device used to deliver supplemental oxygen or increase air flow to person in need of respiratory help). Review of the EMR under Orders tab revealed physician orders: 1. Check and clean the oxygen concentrator filter every month on the 15th, and as needed, on day shift, for shortness of breath, dated 07/15/20. 2. Oxygen, at two liters via NC, as needed, for dyspnea (difficulty breathing) or decreased oxygen saturation, dated 08/07/22. 3. Change the oxygen tubing and concentrator bubbler every Sunday evening. Ensure the tubing and bubbler are dated for infection control, dated 08/14/22. On 08/15/22 at 01:44 PM, observation revealed R101's oxygen tubing, along with the nasal cannula, was unbagged and draped over the oxygen concentrator. The cannula and tubing rested directly on the floor. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/22 08:37 AM, R101's undated, unbagged oxygen tubing was coiled inside the handle of the oxygen concentrator at the foot of the bed. On 08/18/22 at 03:20 PM, Certified Nurse's Aide (CNA) O stated staff change the oxygen tubing on a regular basis. CNA O stated she would clean the tubing and nasal cannula if it had touched the floor. CNA O stated the oxygen tubing and nasal cannula would be stored wrapped around the oxygen concentrator or attached to the back of the concentrator. On 08/18/22 at 04:06 PM, Licensed Nurse (LN) H stated staff changed the oxygen tubing weekly on Sunday night. LN H stated the tubing should be dated and stored in a bag on the concentrator when not in use. On 08/18/22 at 05:17 PM, Administrative Nurse D stated staff change the oxygen tubing weekly on night shift. Administrative Nurse D stated the oxygen tubing should be dated and stored in a bag on the oxygen concentrator when not in use. The facility Departmental (Respiratory Therapy)- Prevention of Infection policy, last revised November 2011, documented change the oxygen cannula every seven days and as needed. The facility failed to provide necessary respiratory care and services in accordance with professional standards of practice placing this at risk for developing a respiratory infection and/or illness when staff failed to store the oxygen tubing and nasal cannula effectively. - R21's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented that R21 required extensive assistance of one staff member for activities of daily living (ADL's). The resident received oxygen therapy during the look back period. The ADL's Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 04/18/22, documented R21 required limited assistance to extensive assistance with ADL's. The Quarterly MDS dated [DATE], documented a BIMS score of nine, which indicated moderately impaired cognition. The MDS documented that R21 required extensive assistance of one staff member for ADL's. The resident's Care Plan dated 03/24/22, documented R21 received oxygen at two liter per minute (LPM). Check the resident's oxygen saturation (measure of how much oxygen the blood carried as a percentage of the maximum it could carry) every shift and as needed. Review of the EMR under Orders tab revealed physician orders: 1. Oxygen at two LPM, via nasal cannula, continuously at night for shortness of breath. Please note resident goes to bed at 02:00 PM in the afternoon, dated 04/8/20. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Change oxygen tubing on Saturday, and when visibly soiled, on night shift, for COPD, dated 06/27/20. 3. Check and clean the concentrator filter every month on the 15th and as needed on night shift, for CPOD, dated 07/15/20. On 08/15/22 at 12:04 PM, R21 sat on the side of the bed with a nasal cannula in her nostrils. The oxygen concentrator was set at two LPM. The tubing was dated 08/03/22, a total of 12 days earlier. On 08/18/22 at 03:20 PM, Certified Nurse's Aide (CNA) O stated staff should change the oxygen tubing on a regular basis. On 08/18/22 at 04:06 PM, Licensed Nurse (LN) H stated staff should change the oxygen tubing weekly on Sunday night shift. The facility Departmental (Respiratory Therapy)- Prevention of Infection policy, last revised November 2011, documented change the oxygen cannula every seven days and as needed. The facility Departmental (Respiratory Therapy)- Prevention of Infection policy, last revised November 2011, documented change the oxygen cannula every seven days and as needed. The facility failed to provide necessary respiratory care and services in accordance with professional standards of practice placing this at risk for developing a respiratory infection and/or illness when staff failed to change the oxygen tubing every seven days.

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	175176	A. Building B. Wing	08/22/2022

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents; one resident was sampled for pain. Based on observations, record reviews, and interviews, the facility failed to ensure Resident (R) 37 received the necessary nursing services to prevent and manage pain. This deficient practice placed R37 at increased risk for untreated pain and related complications. Findings included: - The Diagnoses tab of R37's Electronic Medical Record (EMR) documented diagnoses of fracture of lower end of right femur subsequent encounter for closed fracture with routing healing, generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal cares. The Annual Minimum Data Set (MDS) dated [DATE], documented R37 had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. R37 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; total physical dependence with one staff for locomotion; total physical dependence with two staff for bathing; and independent with setup help only for eating. R37 received as needed (PRN) pain medication during the lookback period and denied pain at time of assessment. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/14/22, lacked an analysis of findings. The ADL Functional/Rehabilitation Potential CAA dated 07/22/22, documented R37 had limitation to lower extremities and was non-ambulatory. She had a wheelchair for mobility and required total assistance with transfers via Hoyer (total body mechanical lift used to transfer residents). The Care Plan dated 03/4/15, revised 08/16/22, documented R37 had an ADL self-care performance deficit related to impaired physical mobility. The Care Plan documented an intervention, last revised 08/11/22, for bed mobility with extensive assistance with one to two staff to turn and reposition R37 in bed; an intervention, last revised 02/02/19, for dressing with extensive assistance with one staff to complete upper and lower dressing; an intervention, last revised 02/02/19, for physical assistance with incontinence cares, check and change in bed; and an intervention, last revised 02/02/19, for transfers of total assistance with at least two staff via Hoyer lift. The Care Plan dated 03/04/15, revised 04/22/21, documented R37 was at risk for pain due to arthritis, impaired mobility, depression, staying in bed per her request. The Care Plan documented an intervention, last revised 11/25/19, for staff to administer pain medication per medical doctor (MD) orders and notify the MD of onset of pain; an intervention, dated 03/04/15, to anticipate R37's need for pain relief and respond immediately to any complaint of pain; an intervention, dated 03/04/15, to notify physician if interventions were unsuccessful or if current complaint was a significant change from R37's past experience of pain; and an intervention, dated 03/04/15, to observe, record, and report to nurse R37's complaints of pain or requests for pain treatment. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Orders tab of R37's EMR documented an order with a start date of 02/01/21 for acetaminophen 650 mg every six hours PRN for pain. The Orders tab documented an order with a start date of 07/07/22 to observe for pain every shift. The Orders tab documented an order with a start date of 07/11/22 to obtain x-ray of right hip. The Medication Administration Record (MAR) for June 2022 revealed R37 received PRN acetaminophen on 06/17/22 and 06/18/22. The MAR for July 2022, documented R37 complained of pain rated a six out of 10 on 07/12/22 day shift, pain rated a six out of 10 on 07/15/22 day shift, pain rated a 10 out of 10 on 07/21/22 on day shift, and pain rated a two out of 10 on 07/25/22 day shift. The MAR revealed R37 received PRN acetaminophen on 07/08/22, 07/09/22, 07/10/22, 07/12/22 twice, 07/13/22, 07/14/22, 07/15/22, 07/18/22, 07/20/22, 07/21/22, 07/22/22, and 07/24/22. The Radiology Report on 07/11/22 documented R37 had chronic dislocation of the right hip with no acute fracture. A Physical Therapy Treatment Encounter Note on 07/18/22 documented passive range of motion (PROM) was performed to both quadriceps (group of muscles on the front of the thigh) and gastrocnemius (muscle in the back of the leg that runs from just above the knee to the heel) muscles worked on increasing range of motion (ROM) in bilateral lower extremity (BLE). R37 performed rolling to both sides four times with moderate assistance to support right lower extremity (RLE) due to pain while R37 performed rolling. R37 rolled slower than previous sessions due to pain. A Occupational Therapy Treatment Encounter Note on 07/19/22 documented R37 reported RLE pain and refused to get into the wheelchair. A Physical Therapy Treatment Encounter Note on 07/19/22 documented R37 performed PROM with RLE knee flexion trying to increase ROM and decrease some pain in RLE. R37 performed rolling from side to side twice with moderate assistance due to pain. R37 was being assisted with RLE and no assistance was given except for holding where R37 moved RLE. A Occupational Therapy Treatment Encounter Note on 07/21/22 documented R37 screamed in pain with mechanical lift transfer and unable to complete transfer due to R37 screaming, pain was reported in RLE. A Physical Therapy Treatment Encounter Note on 07/21/22 documented R37 laid in bed and agreed to do therapy and agreed to transfer from bed to wheelchair. She was rolled with maximum assistance to the left and was set up with the sling. R37 was set up with the Hoyer lift and was being lift when she started screaming that she was in a lot of pain and did not want to transfer into the wheelchair. R37 was lowered back to the bed and sling was removed. A Occupational Therapy Treatment Encounter Note on 07/22/22 documented R37 screamed in pain with RLE knee, R37 unable to be redirected and refused to get out of bed. A Physical Therapy Treatment Encounter Note on 07/25/22 documented R37 screamed a couple times about her RLE and she could not tolerate any touching or movement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Occupational Therapy Treatment Encounter Note on 07/26/22 documented R37 was unsafe to sit on the edge of the bed on air mattress and reported too much pain in RLE. R37 screamed with movement. A Physical Therapy Treatment Encounter Note, on 07/26/22, documented PROM was attempted to RLE with quadricep and hamstring (group of muscles located on the back of the thigh) stretching but R37 started yelling in pain when she had not been touched yet. R37 was educated that some of her pain was in her head and that she was creating this pain in her head. She was educated that she could have had pain in her leg but if she kept exaggerating her pain then nursing would not know what really hurt and could not find out the root cause of her pain. R37 stated that is was her whole RLE that hurt. Revision to note on 07/28/22 documented PROM was attempted to RLE with quadricep and hamstring stretching but R37 started yelling in pain when she had not even been touched yet. Education was provided about her pain and that moving it would decrease pain due to some of the pain due to osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R37 stated that is was her whole RLE that hurt. A Occupational Therapy Treatment Encounter Note on 07/27/22 documented R37 screamed from RLE pain and tolerated sitting in the wheelchair for 20 minutes then screamed to get back in bed due to RLE pain. R37's clinical record lacked documentation the provider was notified of R37's RLE pain from 07/18/22 to 07/26/22. The Notes tab of R37's EMR revealed the following: A Behavior Note on 07/25/22 at 06:34 AM documented R37 had hip surgery and Tylenol (pain medication) was given. R37 stated Tylenol did not help with pain. A Transfer to Hospital Summary on 07/27/22 at 11:09 AM documented the ambulance was called due to R37 hollering in pain. R37 screamed upon staff trying to provide care. A Advanced Registered Nurse Practitioner (ARNP) Progress Note on 07/27/22 at 09:11 PM documented R37 complained of right knee pain. R37's knee was noted to be warm to touch and swollen. R37 refused for provider to move leg. R37 was known to have chronic right hip dislocation. A History and Physical Note from the acute care hospital on 07/27/22 documented R37 was brought to the emergency room (ER) for evaluation of right-sided knee pain. R37 reported severe right knee pain with an intensity of 10 out of 10 and minimal movement relieved with rest and pain medication. R37 could not further clarify the duration of the pain or any recent fall or trauma. Computed Tomography (CT) scan showed an acute impacted transfer fracture of the distal femur. A Consults Note from the acute care hospital on 07/28/22 documented R37 presented to theER on [DATE] with a history of right knee pain which began approximately a week ago. R37's family reported that she suddenly started reporting right leg pain when they visited her in the facility. R37 could not recall an injury and facility staff reported no trauma. R37 had been non-weightbearing or ambulatory for several years. CT scan in the ER demonstrated a chronic dislocated hip that was asymptomatic for R37 and a right distal femur fracture with slight impaction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/17/22 at 08:31 AM R37 laid in bed and finished eating breakfast. She smiled at and conversed with surveyor. R37 appeared comfortable and without signs of distress or discomfort. R37 had a knee immobilizer in place on her right knee. On 08/22/22 at 08:13 AM R37 stated she did not know what happened to her right leg, just that it was sore. On 08/18/22 at 05:17 PM, Administrative Nurse D stated R37 did not have a fall or anything She stated that R37 had complained of hip pain so an x-ray was completed which did not show anything, but she continued to complain of pain. Administrative Nurse D stated R37 was sent to the hospital, the hospital then called and reported R37 had a fracture to the facility. On 08/22/22 at 10:07 AM, Certified Medication Aide (CMA) R stated R37 was a total assistance with transfers and bed mobility. CMA R said R37 complained of pain for two to three weeks after the hip x-ray was obtained. CMA R stated she requested an increase in pain medication for R37 but the facility was concerned it would make R37 sleepy. She stated R37 was yelling out in pain, so the facility sent her to the hospital. On 08/22/22 at 10:26 AM, LN L stated she treated the resident's pain according to their orders and if a medication was not working, she called the doctor to ask for a stronger medication. She stated she also attempted non-pharmacological interventions such as positioning, snacks, ice/heat, and other ways to help control pain. On 08/22/22 at 10:35 AM, CNA P stated if a resident was in pain, staff tried to reposition them, offer them ice, or offer an activity to help take their focus off the pain. He stated if those did not work then he asked the nurse if the resident had their medications. On 08/22/22 at 10:45 AM, LN G stated he did work with R37 when she was having pain and she was reportedly tolerating the Tylenol. He stated when R37 no longer responded to Tylenol, she was sent out to the hospital. LN G stated the physician was always notified for significant injuries or concerns. He stated sometimes they faxed concerns to the nurse practitioner (NP) but for significant situations, staff notified physicians and NP by phone call. On 08/22/22 at 11:08 AM, Administrative Staff A stated that the day R37 was sent to the hospital, therapy staff reported to her that R37 seemed like she was in a lot of pain. She stated Administrative Nurse E knew about R37's pain and nursing had sent R37 to the hospital. On 08/22/22 at 12:12 PM, Consultant HH stated R37 was on therapy prior to her hospital discharge on 07/27/22. She was participating in therapy for transfers, bed mobility, and self-care. Consultant HH stated R37 slowly began participating less and less with physical therapy then refused to get out of bed. She stated nursing gave R37 pain medication prior to therapy but she yelled out with any movement and occupational therapy reported the pain to nursing. She was not sure which nurse it was reported to or if an assessment had been completed by nursing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Change in a Resident's Condition or Status policy, last revised May 2017, directed the nurse notified the resident's attending physician or physician on call when there had been a significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, or with specific instruction to notify the physician of changes in the resident's condition The facility failed to ensure R37 received the necessary nursing services to prevent and manage pain. This deficient practice had the risk for untreated pain and related complications for R37.

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents; one resident was reviewed for side rails. Based on observations, record reviews, and interviews, the facility failed to educate Resident (R) 37's Durable Power of Attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) on the risks versus benefits of using side rails and failed to obtain consent from the DPOA to utilize side rails on R37's bed. This deficient practice had the risk for accidents and/or hazards and miscommunication between the DPOA and facility. Findings included: - The Diagnoses tab of R37's Electronic Medical Record (EMR) documented diagnoses of fracture of lower end of right femur subsequent encounter for closed fracture with routing healing, generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal cares. The Annual Minimum Data Set (MDS) dated [DATE], documented R37 had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. R37 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; total physical dependence with one staff for locomotion; total physical dependence with two staff for bathing; and independent with setup help only for eating. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/14/22, lacked an analysis of findings. The Activities of Daily Living (ADLs) Functional/Rehabilitation Potential CAA dated 07/22/22, documented R37 had limitation to lower extremities and was non-ambulatory. She had a wheelchair for mobility and required total assistance with transfers via Hoyer (total body mechanical lift used to transfer residents). R37 had quarter side rails. The Care Plan dated 03/4/15, revised 08/16/22, documented R37 had an ADL self-care performance deficit related to impaired physical mobility. The Care Plan documented an intervention, last revised on 08/11/22, that R37 required extensive assistance with one to staff assistance to turn and reposition; R37 had quarter side rails to facilitate participation in bed mobility, risks and benefits reviewed, and consent was obtained. The Care Plan documented an intervention, last revised 11/22/20, that R37 had quarter side rails to promote independence on assist in bed mobility per her request and she was educated on the risks. The Assessments tab of R37's EMR revealed a Nursing- Admission/Readmission Nursing Evaluation on 08/01/22 that documented side rail recommendations were completed with education provided to and consent obtained from R37 for side rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

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Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R37's clinical record lacked a signed consent from R37's DPOA for side rail use and lacked evidence of education on risks of side rails to R37's DPOA. The facility was unable to provide the education and consent upon request. On 08/22/22 at 08:29 AM R37 laid in bed and waited for breakfast to be delivered. R37 had quarter rails on both sides of the bed with a low air-loss mattress. She stated she used side rails to move in bed and when staff help pull her up in bed. On 08/22/22 at 09:30 AM R37's DPOA stated he/she did not recall discussing side rail use or giving permission for side rail use. On 08/22/22 at 10:07 AM Certified Medication Aide (CMA) R stated side rails were care planned for use and showed on the Kardex (care record) if a resident was able to use siderails. She stated R37 had always had the siderails and used them to assist with turning. On 08/22/22 at 10:16 AM Licensed Nurse (LN) H stated a side rail assessment was completed and were on the care plan and Kardex for use. She stated R37 used the side rails for turning and repositioning and therapy reviewed for safety. On 08/22/22 at 03:43 PM Administrative Nurse D stated side rail assessments were completed by the nurses on admission/readmission and quarterly. She stated nurses printed off consent form and obtained consent from the family while going over risks of side rails. Administrative Nurse D stated side rail consents were scanned in the Misc tab of the EMR. The facility's Bed Safety policy, last revised December 2007, directed staff obtained consent for the use of side rails from the resident or their legal representative prior to their use and informed the resident and family about the benefits and potential hazards associated with side rails. The facility failed to educate R37's DPOA on the risks versus benefits of using side rails and failed to obtain consent from DPOA to utilize side rails on R37's bed. This deficient practice had the risk for accidents and/or hazards and miscommunication between the DPOA and facility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 54 residents with 22 reviewed for competent nursing staff. Based on observations, record review, and interviews, the facility failed to ensure staff possessed the skills and knowledge necessary when nursing staff allowed Resident (R)42 to have four staples remain inserted in his scalp for 70 days past the recommended removal date. The facility additionally failed to identify, assess, and document the staples in his head during the 70 days. This deficient practice placed R42 at risk for infections and pain. Findings Included: - The Medical Diagnosis section within R42's Electronic Medical Records (EMR) included diagnoses of dysphagia (swallowing difficulty), aphasia (condition with disordered or absent language function), impulse disorder, dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion), cerebral infarction (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 insomnia (inability to sleep). A review of R42's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interviews for Mental Status (BIMS) score of one, indicating severe cognitive impairment. The MDS indicated that he required limited assistance from two staff for bed mobility, transfers, but required extensive assistance from staff for dressing, personal hygiene, and bathing. The MDS noted he had one non-injury fall. A review of R42's Dementia Care Area Assessment (CAA) dated 04/29/22 indicated that due to his dementia and aphasia R42 would not speak very often. The CAA noted that he had a decreased ability to make self-understood or to understand others due to his cognitive status and medical conditions. R42's Falls CAA dated 04/29/22 noted the he was at risk for falls related to his difficulty maintaining balance, impaired balance during transitions, medical diagnoses, and medications. A review of R42's Care Plan revised 08/15/22 indicated that R42 was at risk for falls related to his medical diagnoses, medications, unsteady balance, and diminished memory. The care plan lacked documentation and interventions related to R42's 05/21/22 fall that required him to receive four staples to his right scalp. A Progress Note dated 05/21/22 at 05:20 AM that stated he had an unwitnessed fall resulting in a laceration to his right-side scalp. The note indicated that he was sent out to an acute care facility for treatment. A Progress Note dated 05/21/22 at 03:26 PM indicated that R42 returned to the facility with four staples to his right scalp. The note indicated that he was to have the staples removed on or around 05/28/22. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R42's clinical record between 05/22/22 through 08/03/22 revealed no documentation related to the staples in R42's scalp. The reviewed timeframe revealed no documentation indicating that R42 refused to have the staples removed. On 08/03/22 at 04:32 PM a nursing note indicated that R42 was assessed to have four staples intact in his right scalp area. On 08/04/22 at 08:53AM Administrative Nurse E was notified of the staples remaining in his right scalp area. On 08/05/22 at 10:55 AM a note indicated that the staples were removed. On 08/18/22 at 09:20 AM R42 slept in a chair while in the dining room area on the dementia unit. He appeared clean and well groomed. R42 had a visible bruise on right inner arm running from his forearm up to his to his upper arm. R42 had a small closed scar on his upper right scalp. On 08/18/22 at 09:53 AM Licensed Nurse (LN) I reported that R42 was a high fall risk due to his unsteady balance and dementia. She reported that he required assistance for his ADL's and would often attempt to complete them without calling for staff to help. She noted that if a resident fell , the nurse completed a post fall assessment and ensured the resident was okay. LN I noted that she did notice the four staples when she first started working at the facility about three weeks ago but they were removed when she came back the next week. She was unaware of why the staples were still intact and did not think to look further into it at the time. She reported that R42's EMR indicated that the staples were placed on 05/21/22. She stated that usually staples are only in for about two weeks or less. She was unsure why the staples were not removed on the scheduled date of 05/28/22. On 08/18/22 at 03:05PM Administrative Nurse E noted that R42's staples had not been removed due to him refusing. She noted that the facility should have had them removed around 05/28/22 but he would not allow them to remove them. On 08/18/22 at 05:00PM Administrative Nurse D stated that the staples should have been removed within two weeks but R42 had been refusing to allow staff to have them removed. The facility did not provide a policy related to skin assessments. The facility failed to ensure staff possessed the skills and knowledge necessary when nursing staff allowed R42 to have four staples remain inserted in his scalp for 70 days past the recommended removal date. The facility additionally failed to identify, assess, and document the staples in his head during the 70 days. This deficient practice placed R42 at risk for infections and pain.

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	175176	A. Building B. Wing	08/22/2022

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Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42966 The facility identified a census of 54 residents. Based on record and interview, the facility failed to provide a Registered Nurse (RN) services for at least eight consecutive hours, seven days a week. This placed all residents in the facility at risk for decreased quality of care. Findings included: - Review of the Daily Staffing Assignment sheets and the posted staffing sheets provided by the facility on 08/16/22, the facility failed to provide RN coverage for 05/24/22, 07/02/22, 07/7/22, and 07/18/22. Upon request, the facility failed to provide clock-in times or timesheets for RN coverage for the above dates. On 08/22/22 at 12:34 PM Administrative Nurse D stated that Administrative Nurse E completed the schedule and notified her when she needed to cover RN coverage. She stated since she was salaried, she did not clock in or have a way to track her hours in the facility. On 08/22/22 at 01:11 PM Administrative Staff A stated the staffing coordinator or unit manager made sure there was RN coverage and the facility typically made a good faith effort to have RN coverage. She stated that when Administrative Nurse D provided RN coverage, she did not clock in or out because she was not on the facility's payroll. The facility failed to provide a policy on RN coverage. The facility failed to provide a RN for at least eight consecutive hours, seven days a week. This placed all residents in the facility at risk for decreased quality of care.

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	175176	A. Building B. Wing	08/22/2022

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 54 residents. The sample included 22 residents with two residents reviewed for behavioral health. Based on observation, record review, and interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for, Resident (R) 31, who has a history of striking himself in the head. This placed the resident at risk for further decline of his emotional and mental wellbeing. Findings included: - R31's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of schizophrenia (-psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), and major depression (major mood disorder). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented that R31 required supervision of one staff member assistance for activities of daily living (ADL's). The MDS documented no behaviors for R31 for the look back period. The MDS documented R31 received antipsychotic medication (class of medications used to treat psychosis {any major mental disorder characterized by a gross impairment testing} and other mental emotional conditions) for seven days during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of one, which indicated severely impaired cognition. The MDS documented that R31 required supervision of one staff members assistance of for ADL's. The MDS documented no behaviors during the look back period. The MDS documented R31 received antipsychotic medication and antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression {abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness}) for seven days during the look back period. R31's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/09/22 documented R31 had received antidepressant medication and antipsychotic medication for long term and was stable. R31's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/09/22 documented R31 had a low BIMS and was unsure why R31 had significant problems with cognition. R31's Care Plan dated 03/09/21 documented to continue weekly psych services and monitor for behaviors every shift. Document any observed behaviors every shift and attempted interventions. Notify the physician with each event. The Care Plan dated 01/27/22 documented social services to follow up with behavior presentation Review of the EMR under Progress Notes tab revealed: (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/8/22 at 11:54 AM R31 was seen by psych services for mental health. Reported R31 had been yelling, screaming, and hitting his head with his fist. R31 admitted to having auditory and visual hallucinations at that time. Nurse Practitioner (NP) was going to increase R31's antipsychotic medication. On 03/15/22 at 11:53 AM R31 was seen by psych services for mental health. NP reviewed current dose and duration of antipsychotic medication. R31 continued to have having auditory and visual hallucinations. R31 reported he heard voices told him to hurt himself and others. R31was observed hitting and yelling at himself. NP scheduled follow up appointment in one week. On 03/22/22 at 03:00 PM R31 was seen by psych services for mental health. R31 was seen by NP for aggressive behavior for hitting himself in the head and continued to hallucinate. NP recommended antipsychotic medication be increased. Physician notified, and medication was increased. Review of the EMR revealed a progress note for psych services dated 04/12/22. On 05/24/22 at 12:57 PM R31 was seen in room hitting himself in the head and was yelling at things that were not in the room. No aggressive behavior noted toward staff when assisted with ADL's was provided. R31 was easily distracted from the from the aggressive behavior toward himself. The record lacked physician notification of behavior and social services follow up with R31. On 08/13/22 at 10:37 PM R31 demonstrated self-induced physical harm as noted via slapping and hitting himself. Minimal infraction noted with redness to face and head. R31 was cooperative with staff. The clinical record lacked physician notification and social worker follow up for R31. The record lacked evidence the resident was followed by mental health services after 04/12/22. On 08/22/22 08:52 AM, observation revealed R31 ambulated independently from the dining room back down the hallway to his room no behaviors noted. On 08/22/22 at 02:33 PM agency Certified Nurse's Aide (CNA) QQ stated she had not worked very much with R31. CNA QQ stated she had seen R31 hit himself in the head a lot and yell out at times and the staff attempt to redirect him by engaging conversation. CNA QQ stated she was not aware of any special interventions in place for R31 when having behaviors. On 08/22/22 at 03:42 PM agency Licensed Nurse (LN) L stated she had not seen R31 be aggressive toward other residents only to himself by yelling out and striking himself in the head. LN L stated she had never notified the physician when she had seen that type of behavior, the staff would redirect him if possible, but R31 would only stop hitting himself for 30 to 60 minutes and then start hitting himself again. LN K stated she was not sure if was provided with any type of mental health services. On 08/22/22 at 04:49 PM Social Service X stated the facility had changed mental health services provider possibly around May 2022, then the lady providing the mental health services had a medical emergency and had not returned. Social Service X stated the facility had no [NAME] mental health services available at this time to address R31's behavior. Social Services X stated he was sure R31 had not been seen for mental health services since his last visits with NP on 04/12/22. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Behavioral Assessment, Intervention and Monitoring policy last revised March 2019 documented the facility would provide and residents would receive behavioral services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for R31, who has a history of striking himself in the head. This placed the resident at risk for further decline of his emotional and mental wellbeing.

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 54 residents. The sample included 22 residents with two residents reviewed for behavioral health. Based on observation, record review, and interviews, the facility failed to identify and provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R) 31, who had a history of striking himself in the head and hallucinations. This placed the resident at risk for further decline of his emotional and mental wellbeing. Findings included: - R31's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), and major depression (major mood disorder). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented that R31 required supervision of one staff member for activities of daily living (ADL's). The MDS documented no behaviors for R31 for the look back period. The MDS documented R31 received antipsychotic medication (class of medications used to treat psychosis {any major mental disorder characterized by a gross impairment testing} and other mental emotional conditions) for seven days during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of one which indicated severely impaired cognition. The MDS documented that R31 required supervision of one staff members assistance of for ADL's. The MDS documented no behaviors during the look back period. The MDS documented R31 received antipsychotic medication and antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression {abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness}) for seven days during the look back period. R31's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/09/22 documented R31 had received antidepressant medication and antipsychotic medication for long term and was stable. R31's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/09/22 documented R31 had a low BIMS and was unsure why R31 had significant problems with cognition. R31's Care Plan dated 03/09/21 documented to continue weekly psych services and monitor for behaviors every shift. Document any observed behaviors every shift and attempted interventions. Notify the physician with each event. The Care Plan dated 01/27/22 documented social services to follow up with behavior presentation Review of the EMR under Progress Notes tab revealed: (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Behavioral Assessment, Intervention and Monitoring policy last revised March 2019 documented the facility would provide and residents would receive behavioral services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The facility failed to identify and provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for R31, who has a history of striking himself in the head and hallucinations. This placed the resident at risk for further decline of his emotional and mental wellbeing.

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	175176	A. Building B. Wing	08/22/2022

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents. Based on observations, record review, and interviews, the facility's contracted pharmacy failed to ensure the necessary clarification were received for a pain medication order for Resident (R) 2. The facility's contracted pharmacy continued to fill conflicting and inconsistent morphine (controlled opioid pain medication) orders. The orders were unclear regarding whether the 15 milligrams (mg) of morphine should be immediate release or extended release. This deficient practice placed the resident at risk for overmedication and poor pain control. Findings included: - The Diagnoses tab of R2's Electronic Medical Record (EMR) documented diagnoses of type two diabetes mellitus (DMII- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The Annual Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R2 was independent with activities of daily living (ADLs). R2 received opioid (pain reliever) medications seven days in the seven-day lookback period. The Quarterly MDS, dated [DATE], documented R2 had a BIMS score of 15 which indicated intact cognition. R2 was independent with ADLs. R2 received opioid medications seven days in the seven-day lookback period. The ADL Functional/Rehabilitation Potential Care Area (CAA), dated 04/19/22, documented R2 was mainly independent with ADLs and was able to alert staff to his needs. The Pain CAA, dated 04/19/22, documented R2 had pain but stated it was mainly under control with current medication. The Care Plan, initiated 03/30/18, documented R2 had chronic pain related to osteoarthritis and impaired mobility and R2 received scheduled morphine. The Care Plan directed staff administered pain medication per medical doctor (MD) orders, anticipated R2's need for pain relief and responded immediately to any complaint of pain. The Orders tab of R2's EMR documented an order with a start date of 12/11/21 for morphine sulfate 15 milligrams (mg) two times a day for chronic pain. The Notes tab of R2's EMR revealed the following notes: A Physician Progress Note on 04/20/22 at 12:44 PM documented R2 was seen for opioid counseling and he was on morphine 15 mg twice a day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Alert Note on 04/24/22 at 05:48 AM documented staff reached out to pharmacy for refill of R2's morphine extended release (ER) tablets; the tablets were to be sent out on first run. A Physician's Note on 04/25/22 at 01:31 PM documented R2 received morphine 15 mg twice a day. R2's Medication Regimen Review for June 2022 documented a recommendation to clarify R2's morphine 15 mg twice a day order as it was entered into the EMR as immediate release tabs which were typically dosed more frequently throughout the day for breakthrough pain; pharmacy records indicated they were sending the extended release formation, please clarify and update the order. The record lacked documentation the facility acted upon recommendation or provide provider response upon request. Upon request, the facility provided Controlled Medication Utilization Records for the past three months. The Controlled Medication Utilization Records revealed the following: from 05/23/22 to 06/06/22, R2 received morphine sulfate 15 mg ER tablets; from 07/17/22 to 07/25/22, R2 received morphine sulfate 15 mg immediate release (IR) tablets; from 08/06/22 to 08/11/22, R2 received morphine sulfate 15 mg IR tablets; on 08/15/22, R2 received morphine sulfate 15 mg IR; on 08/17/22 morphine sulfate 15 mg ER tablet card was received by facility with 27 tablets. On 08/17/22 at 11:50 AM R2 laid in bed on his left side facing the wall. He appeared to be resting comfortably and without signs of distress. On 08/18/22 at 09:40 AM Licensed Nurse (LN) G opened the narcotic box on the 400-hall medication cart and pulled out R2's card of morphine 15 mg. The card had 27 tablets of morphine 15 mg ER and had not been used yet. On 08/18/22 at 09:40 AM LN G stated R2 had been receiving morphine 15 mg ER for some time but apparently received one tablet of morphine 15 mg IR over the weekend. On 08/22/22 at 12:34 PM Administrative Nurse D stated R2 had always been on morphine ER but the order had been put in the EMR incorrectly. She stated he received one tablet of morphine IR, it was not treated as a medication error, but the order was fixed in the EMR. The facility's Pharmacy Services Overview policy, last revised April 2019, directed the facility accurately and safely provided or obtained pharmaceutical services. The policy directed pharmaceutical services consisted of the process of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, and using and/or disposing of all medications, biologicals, and chemicals; the process of identifying, evaluating, and addressing medication-related issues including the prevention and reporting of medication errors. The facility's contracted pharmacy failed to ensure the necessary clarification were received for a pain medication order for R2. The facility's contracted pharmacy continued to fill conflicting and inconsistent morphine orders. The orders were unclear regarding whether the 15 mg of morphine should be immediate release or extended release. R2 received both IR and ER tablets. This deficient practice placed the resident at risk for overmedication and poor pain control.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents with seven residents sampled for unnecessary medication review. Based on observations, record review, and interviews, the facility failed to act upon medication regimen review (MRR) recommendations for Resident (R) 2 and R40; failed to ensure the Consultant Pharmacist (CP) identified and reported to facility the lack of consistent behavior monitoring for R2 and R40 who received psychotropic (any drug that affects brain activities associated with mental processes and behavior) medications; failed to ensure the CP identified and reported lack of physician notification as ordered when blood glucose (BG) was outside of parameters for R2 and R40; failed to ensure the CP identified and reported to facility the lack of bowel monitoring for R37; failed to ensure the CP identified and reported to facility lack of consistent bowel monitoring and failure to administer an as needed (PRN) laxative (medication used to loosen stool or stimulate a bowel movement) for R1; and failed to act upon MRR recommendations for R1. This deficient practice had the risk for unnecessary medication use and physical complications for all residents affected. Findings included: - The Diagnoses tab of R2's Electronic Medical Record (EMR) documented diagnoses of type two diabetes mellitus (DMII- when the body cannot use glucose, not enough insulin [hormone that lowers the level of glucose in the blood] made or the body cannot respond to the insulin), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought], major depressive disorder (major mood disorder), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and insomnia (inability to fall asleep). The Annual Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R2 was independent with activities of daily living (ADLs). R2 received insulin, antianxiety (class of medications that calm and relax people with excessive anxiety [mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear], nervousness, or tension), antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression), diuretic (medication to promote the formation and excretion of urine), and opioid (pain reliever) medications seven days in the seven-day lookback period. The Quarterly MDS, dated [DATE], documented R2 had a BIMS score of 15, which indicated intact cognition. R2 was independent with ADLs. R2 received insulin, antianxiety, antidepressant, diuretic, and opioid medications seven days in the seven-day lookback period. The ADL Functional/Rehabilitation Potential Care Area (CAA), dated 04/19/22, documented R2 was mainly independent with ADLs and was able to alert staff to his needs. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Psychotropic Drug Use CAA, dated 04/19/22, documented R2 was on antianxiety and antidepressant medications and was stable with current dose. The Pain CAA, dated 04/19/22, documented R2 had pain, but stated it was mainly under control with current medication. The Care Plan, initiated 03/30/18, documented R2 had a mood problem related to history of mental issues of depression and chronic pain and had scheduled sertraline (medication used to treat depression), trazodone (medication used to treat depression and insomnia), and morphine (pain medication). The Care Plan directed staff administered medications as ordered, encouraged R2 to express his feelings in an appropriate manner, and offered support and reassurance as needed. The Care Plan, initiated 03/30/18, documented R2 had chronic pain related to osteoarthritis and impaired mobility and R2 received scheduled sertraline, trazodone, and morphine. The Care Plan directed staff administered pain medication per medical doctor (MD) orders, anticipated R2's need for pain relief and responded immediately to any complaint of pain. The Diabetic Care Plan, initiated 10/30/19, documented R2 was at risk for diabetic compliance and potential for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) related to diagnoses of DMII. The Diabetic Care Plan directed staff administered medications as ordered and notified MD of any changes in status as indicated. The Behavior Care Plan, initiated 04/22/20, documented R2 had manipulative behavior with other residents and intentionally excited and stirred up other residents to get them upset about things to make them complain about staff and the facility. The Behavior Care Plan directed staff monitored behavior episodes and attempted to determine underlying cause and documented behavior and potential causes. The Care Plan, initiated 10/20/22, documented R2 reported difficulty sleeping and received trazodone scheduled. The Care Plan directed staff educated R2 about the use of over the counter, herbal, and prescription sleep aides. The Orders tab of R2's EMR documented an order with a start date of 11/20/21 for aspirin enteric-coated (EC) 81 milligrams (mg) one time a day for prophylaxis for coronary artery disease (CAD- abnormal condition that may affect the flow of oxygen to the heart); an order with a start date of 11/05/21 for trazodone 50 mg at bedtime for insomnia; an order with a start date of 12/09/21 for sertraline 50 mg in the evening for major depressive disorder; an order with a start date of 12/11/21 for morphine sulfate 15 mg two times a day for chronic pain; an order with a start date of 03/04/22 for Novolog (insulin) 100 unit/milliliters (mL) inject as per sliding scale at bedtime for DMII with parameters to notify MD for BG of less than (<) 90 mg/deciliter (mg/dL) or more than (>) 400 mg/dL; an order with a start date of 03/05/22 for Insulin Glargine 40 units one times a day for diabetes with parameters to call MD for BG < 90 mg/dL or > 400 mg/dL; an order with a start date of 05/19/22 for lorazepam (antianxiety) 0.25 mg two times a day for anxiety; and an order with a start date of 07/08/22 for aspirin 325 mg one time a day for elevated D-dimer (protein made in the body when a clot dissolves) for 30 days. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Orders tab of R2's EMR documented the following behavior monitoring orders: behavior monitoring- antianxiety every shift for antianxiety medication use, start date 08/18/21, discontinued date 07/07/22; behavior monitoring- antidepressants every shift for medication use, start date 02/15/22, discontinued date 07/07/22; behavior monitoring- antianxiety every shift for anxiety medication use, start date 07/07/22; behavior monitoring- antidepressants every shift for antidepressant use, start date 07/07/22. R2's Medication Administration Record (MAR) for May 2022 revealed R2's BG on 05/26/22 was 464 mg/dL. R2's clinical record lacked documentation the MD was notified as ordered. R2's MAR for June 2022 revealed R2's BG on 06/30/22 was 411 mg/dL. R2's clinical record lacked documentation the MD was notified as ordered. R2's MAR for July 2022 revealed the following BG for R2: 07/22/22- 429 mg/dL, 07/23/22- 421 mg/dL, 07/24/22- 466 mg/dL, 07/29/22- 403 mg/dL, and 07/31/22- 479 mg/dL. R2's clinical record lacked documentation the MD was notified as ordered. R2's MAR for August 2022 revealed the following BG for R2: 08/01/22- 401 mg/dL, 08/09/22- 474 mg/dL, 08/10/22- 500 mg/dL, and 08/12/22- 434 mg/dL. R2's clinical record lacked documentation the MD was notified as ordered. Review of R2's MAR from May 2022 to 08/18/22 revealed the following missing behavior monitoring for antianxiety medication use: 05/03/22 night, 05/13/22 night, 05/22/22 night, 05/23/22 evening, 06/02/22 evening, 06/03/22 day, 06/10/22 day/evening/night, 06/16/22 night, 06/17/22 day, 06/19/22 day, and 07/07/22 day. The MAR revealed the following missing behavior monitoring for antidepressant medication use: 05/03/22 night, 06/03/22 day, 06/10/22 day/evening/night, 06/16/22 night, 06/18/22 day, and 07/07/22 day. R2's MRR for February 2022 documented a recommendation that any medication to induce sleep should be re-evaluated for gradual dose reduction quarterly. Please evaluate to determine if a trial dose reduction of R2's trazodone 50 mg to 25 mg at bedtime could be attempted at that time. Facility did not act upon recommendation or provide provider response upon request. R2's MRR for June 2022 documented a recommendation to clarify R2's morphine 15 mg twice a day order as it was entered into the EMR as immediate release tabs, which were typically dosed more frequently throughout the day for breakthrough pain; pharmacy records indicated they were sending the extended-release formation, please clarify and update the order. Facility did not act upon recommendation or provide provider response upon request. R2's MRR for July 2022 documented a recommendation that R2 had two active orders for aspirin, aspirin 81 mg every day and aspirin 325 mg every day for 30 days; asked facility if they wanted to place the 81 mg order on hold until completion of R2's 30-day order. Facility did not act upon recommendation or provide provider response upon request. Review of R2's MRR for May 2022 to July 2022 lacked evidence the CP identified and reported to the facility the lack of consistent behavior monitoring for antianxiety and antidepressant medication use or the lack of physician notification when BG was outside parameters as ordered. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/16/22 at 01:19 PM R2 laid in bed, watched television, and ate cake. He stated he did not eat lunch because he ate a late breakfast. He appeared comfortable and without signs of distress or discomfort. On 08/18/22 at 09:40 AM Licensed Nurse (LN) G stated behavior monitoring was completed every shift. On 08/18/22 at 04:49 PM LN G stated there were some orders that had parameters and if the blood pressure, pulse, or BG was outside ordered parameters then the physician and management was notified. He stated the notification was documented in the EMR. LN G stated he did not handle the pharmacy reviews. On 08/18/22 at 05:17 PM Administrative Nurse D stated she was responsible for most of monthly pharmacy reviews. She stated they were sent to her and two other people, she made a copy of what was sent to the physician and gave some to the nurse practitioner. Administrative Nurse D stated once she received back the recommendations the provider wrote on; she made the changes that were not made by the physician and gave the document to medical records to be uploaded into the resident's chart. She stated the physician should have been notified if vitals were outside ordered parameters, but staff had been a little lax on notifying the physician. Administrative Nurse D stated the facility had not been really good about completing behavior monitoring; behavior monitoring was charted on the MAR and expected to be completed every shift. She stated if there was a blank on the behavior monitoring documentation, that meant it was not completed. On 08/25/22 at 12:42 PM Consultant GG stated when she completed the monthly pharmacy reviews, she made sure if a resident received psychotropic medications, then they had behavior side effects monitoring in place. She stated she reviewed the behavior to make sure it was being completed and had noticed some blanks in documentation. Consultant GG stated she reviewed the MARs for blood sugars outside of parameters and if the physician was notified in the progress notes. She stated if the facility did not address a recommendation after the first month, it showed up in a report of active recommendations lacking final response and if it was not addressed after that second month then she re-recommended it or told the facility. The facility's Behavioral Assessment, Intervention, and Monitoring policy, last revised March 2019, directed behavioral symptoms were identified using facility-approved behavioral screening tools. The policy directed if a resident was being treated for altered behavior or mood, the Interdisciplinary Team (IDT) sought and documented any improvements or worsening in the individual's behavior, mood, and function. The facility's Pharmacy Services- Role of the Consultant Pharmacist, last revised April 2019, directed the CP provided consultation on all aspects of pharmacy services in the facility, collaborated with the facility and medical director to: develop, implement, evaluate, and revise the procedures for the provision of all aspects of pharmacy services and provided feedback about performance and practices related to medication administration. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Medication Regimen Reviews, last revised May 2019, directed the CP reviewed the medication regimen of each resident at least monthly. The MRR involved a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors, and other regularities, for example: inadequate monitoring for adverse consequences and other medication errors including those related to documentation. The policy directed within 24 hours of the MRR, the CP provided a written report to the attending physician for each resident and the attending physician documented in the medical record that the irregularity had been reviewed and what (if any) action was taken. Copies of the MRR reports, including physician responses, were maintained as part of the permanent medical record. The facility's Obtaining a Fingerstick Glucose Level policy, last revised October 2011, directed after obtaining a fingerstick glucose level, staff recorded the resident's medical record the blood sugar results and followed facility policies for appropriate nursing interventions regarding blood sugar results. The policy directed staff reported results promptly to the supervisor and attending physician. The facility failed to act upon recommendations made by the CP, failed to ensure the CP identified and reported the lack of consistent behavior monitoring for R2 who received psychotropic medications, and failed to ensure the CP identified and reported the lack of physician notification when blood glucose was outside parameters as ordered. This deficient practice placed R2 at risk for unnecessary medication use and unwarranted physical complications. - The Diagnoses tab of R40's Electronic Medical Record (EMR) documented diagnoses of diffuse traumatic brain injury (TBI) without loss of consciousness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, psychosis (any major mental disorder characterized by a gross impairment in reality testing) not due to a substance or known physiological condition, schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought] bipolar type (episodes of severe high and low moods), alcohol-induced persisting dementia, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), major depressive disorder (major mood disorder), and type two diabetes mellitus (DMII- when the body cannot use glucose, not enough insulin [hormone that lowers the level of glucose in the blood] made or the body cannot respond to the insulin), The Admission Minimum Data Set (MDS) dated [DATE], documented R40 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. R40 did not have any behaviors in the lookback period. R40 required extensive physical assistance with two staff for bed mobility and transfers; extensive physical assistance with one staff with dressing, toileting, personal hygiene, and bathing; supervision with setup help only with eating and locomotion. R40 received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medications five days and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications six days, and insulin seven days in the seven-day lookback period. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly MDS dated [DATE], documented R40 had a BIMS score of nine, which indicated moderate cognitive impairment. R40 had other behaviors not directed towards others one to three days in the lookback period. He required supervision with one staff for bed mobility, transfers, walking, locomotion; extensive physical assistance with one staff with dressing and bathing; limited physical assistance with one staff for toileting and personal hygiene; independent with setup help only for eating. R40 received antidepressant and insulin medications seven days in the seven-day lookback period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/07/22, documented R40 triggered for impaired cognition, had a BIMS score of six, and was able to respond to simple questions. The Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Drug Use CAA dated 02/07/22, documented R4 had been on long term antidepressant and antianxiety medications and was stable at that time with current dosages. The Behavior Care Plan dated 02/28/19, revised 03/14/22, documented R40 had potential for impaired or inappropriate behaviors and included: verbally aggressive/inappropriate, making threats to others, refusing cares/showers/assessments/medications. R40's occupation was former boxer. The Behavior Care Plan documented the following interventions: staff anticipated and met R40's needs, initiated 02/28/19; staff frequently and closely monitored R40 for unwanted behaviors and when R40 showed aggressive behaviors, staff redirected immediately and kept away from other residents, initiated 10/11/19. The Care Plan, dated 11/07/19, documented R40 had type two diabetes mellitus and directed staff administered diabetes medication as ordered and monitored/documented for side effects and effectiveness. The Antidepressant Care Plan, initiated 05/14/21, documented R40 was at risk for adverse side effects related to use of antidepressant medications for depression and directed staff administered antidepressant medications as ordered by physician and monitored/documented for side effectiveness and effectiveness every shift. The Orders tab of R40's EMR documented an order with a start date of 01/07/22 for sertraline (antidepressant) 75 milligrams (mg) one time a day for major depressive disorder and an order with a start date of 03/04/22 for accu-check (device used to check the levels of glucose in the blood) four times a day related to DM with parameters to call medical doctor (MD) for BG less than (<) 90 mg/deciliters (dL) or greater than (>) 400 mg/dL. The Orders tab of R40's EMR documented an order with a start date of 06/30/21 for behavior monitoring-antidepressants every shift for antidepressant medication use, order was discontinued on 07/07/22. The Orders tab of R40's EMR documented an order with a start date of 07/07/22 for behavior monitoring-antidepressants every shift for antidepressant medication use. R40's Medication Administration Record (MAR) for July 2022 to 08/18/22 revealed the following BG: 07/03/21 evening- 453 mg/dL, 07/04/22 morning- 509 mg/dL, 07/05/22 morning- 488 mg/dL, 07/08/22 bedtime- 432 mg/dL, 07/14/22 morning- 417 mg/dL, 07/31/22 bedtime- 451 mg/dL, 08/01/22 evening- 418 mg/dL, and 08/02/22 morning- 485 mg/dL. R40's clinical record lacked documentation the MD was notified as ordered. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R40's MAR for May 2022 to 08/18/22 revealed missing behavior monitoring for the following: 05/03/22 night, 05/13/22 evening/night, 05/17/22 evening, 05/22/22 night, 05/23/22 evening, 06/03/22 day, 06/06/22 evening, 06/10/22 day/evening/night, 06/16/22 night, 06/18/22 day, 06/19/22 day, 07/01/22 day, and 07/07/22 day. R40's MRR for July 2022 documented a recommendation that R40 was receiving sertraline 75 mg every day and that dose had been in place since last reduced in August 2021. It was time for an annual evaluation, physician needed to evaluate to determine if a trial dose reduction to sertraline 50 mg daily could have been attempted at that time. If a dose reduction was not appropriate, document rationale for why it was clinically contraindicated. Facility did not act upon recommendation or provide provider response upon request. Review of R40's MRR for May 2022 to July 2022 lacked evidence the CP identified and reported to the facility the lack of consistent behavior monitoring for antidepressant use or the lack of physician notification for BG outside parameters. On 08/18/22 at 08:46 AM R40 sat on the edge of his bed and ate breakfast independently. He appeared comfortable and without signs of distress or behaviors. On 08/18/22 at 09:40 AM Licensed Nurse (LN) G stated behavior monitoring was completed every shift. On 08/18/22 at 04:49 PM LN G stated there were some orders that had parameters and if the blood pressure, pulse, or BG were outside of ordered parameters then the physician and management would be notified. He stated the notification was documented in the EMR. LN G stated he did not handle the pharmacy reviews. On 08/18/22 at 05:17 PM Administrative Nurse D stated she was responsible for most of monthly pharmacy reviews. She stated they were sent to her and two other people, she made a copy of what was sent to the physician and gave some to the nurse practitioner. Administrative Nurse D stated once she received back the recommendations the provider wrote on; she made the changes that were not made by the physician and gave the document to medical records to be uploaded into the resident's chart. She stated the physician should have been notified if vitals were outside ordered parameters, but staff had been a little lax on notifying the physician. Administrative Nurse D stated the facility had not been really good about completing behavior monitoring; behavior monitoring was charted on the MAR and expected to be completed every shift. She stated if there was a blank on the behavior monitoring documentation, that meant it was not completed. On 08/25/22 at 12:42 PM Consultant GG stated when she completed the monthly pharmacy reviews, she made sure if a resident received psychotropic medications, then they had behavior side effects monitoring in place. She stated she reviewed the behavior to make sure it was being completed and had noticed some blanks in documentation. Consultant GG stated she reviewed the MARs for blood sugars outside parameters and if the physician was notified in the progress notes. She stated if the facility did not address a recommendation after the first month, it showed up in a report of active recommendations lacking final response and if it was not addressed after that second month then she re-recommended it or told the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Behavioral Assessment, Intervention, and Monitoring policy, last revised March 2019, directed behavioral symptoms were identified using facility-approved behavioral screening tools. The policy directed if a resident was being treated for altered behavior or mood, the Interdisciplinary Team (IDT) sought and documented any improvements or worsening in the individual's behavior, mood, and function. The facility's Pharmacy Services- Role of the Consultant Pharmacist, last revised April 2019, directed the CP provided consultation on all aspects of pharmacy services in the facility, collaborated with the facility and medical director to: develop, implement, evaluate, and revise the procedures for the provision of all aspects of pharmacy services and provided feedback about performance and practices related to medication administration. The facility's Medication Regimen Reviews, last revised May 2019, directed the CP reviewed the medication regimen of each resident at least monthly. The MRR involved a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors, and other regularities, for example: inadequate monitoring for adverse consequences and other medication errors including those related to documentation. The policy directed within 24 hours of the MRR, the CP provided a written report to the attending physician for each resident and the attending physician documented in the medical record that the irregularity had been reviewed and what (if any) action was taken. Copies of the MRR reports, including physician responses, were maintained as part of the permanent medical record. The facility's Obtaining a Fingerstick Glucose Level policy, last revised October 2011, directed after obtaining a fingerstick glucose level, staff recorded the resident's medical record the blood sugar results and followed facility policies for appropriate nursing interventions regarding blood sugar results. The policy directed staff reported results promptly to the supervisor and attending physician. The facility failed to act upon recommendations made by the CP, failed to ensure the CP identified and reported the lack of consistent behavior monitoring for R40 who received psychotropic medications, and failed to ensure the CP identified and reported the lack of physician notification when blood glucose was outside parameters as ordered. This deficient practice placed R2 at risk for unnecessary medication use and unwarranted physical complications. - The Diagnoses tab of R37's Electronic Medical Record (EMR) documented diagnoses of fracture of lower end of right femur subsequent encounter for closed fracture with routine healing, generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal cares. The Annual Minimum Data Set (MDS) dated [DATE], documented R37 had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. R37 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; total physical dependence with one staff for locomotion; total physical dependence with two staff for bathing; and independent with setup help only for eating. R37 was always incontinent of bowel and bladder. R37 received anticoagulant (medication that inhibited clotting in the blood) medications seven days in the seven-day lookback period. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/14/22, lacked an analysis of findings. The ADL Functional/Rehabilitation Potential CAA dated 07/22/22, documented R37 had limitation to lower extremities and was non-ambulatory. She had a wheelchair for mobility and required total assistance with transfers via Hoyer (total body mechanical lift used to transfer residents). The Care Plan dated 03/4/15, revised 08/16/22, documented R37 had an ADL self-care performance deficit related to impaired physical mobility. The Care Plan documented an intervention, last revised 08/11/22, for bed mobility with extensive assistance with one to two staff to turn and reposition R37 in bed; an intervention, last revised 02/02/19, for dressing with extensive assistance with one staff to complete upper and lower dressing; an intervention, last revised 02/02/19, for physical assistance with incontinence cares, check and change in bed; an intervention, last revised 02/02/19, for transfers of total assistance with at least two staff via Hoyer lift; and an intervention, last revised 02/02/19, that R37 was incontinent of bowel and bladder and required physical assistance with incontinence cares. The Care Plan, initiated 06/30/15, documented R37 was at risk for constipation related decreased mobility and directed staff observed/documented/reported as needed any signs/symptoms of complications related to constipation. The Orders tab of R37's EMR documented an order with a start date of 06/05/21, discontinued date of 06/17/22 for Miralax (laxative) 17 gram (GM) one time a day for bowel regulation; an order with a start date of 03/05/21, discontinued date of 07/29/22 for if no bowel movement for three days give 120 milliliters (mL) of prune juice as needed for constipation, if prune juice was not effective in 24 hours then progress to day four orders; an order with a start date of 03/05/21, discontinued date of 06/17/22 for milk of magnesia (laxative) 10 mL as needed for constipation for no bowel movement for four days. R37's Documentation Survey Report for May 2022 to July 2022 revealed there was not a task for bowel monitoring. R37's MRR for May 2022 to July 2022 lacked evidence the CP identified and reported to facility the lack of bowel monitoring for R37. On 08/16/22 at 03:24 PM R37 laid in bed with her eyes opened. She smiled and stated she had a good day. On 08/18/22 at 04:20 PM Certified Nurse Aide (CNA) M stated bowel movements were documented in the EMR by whoever performed incontinence cares on R37. She stated if a resident had not had a bowel movement after three days, it showed up as an alert in the EMR. On 08/18/22 at 04:49 PM Licensed Nurse (LN) G stated the facility had a bowel protocol that started if a resident had not had a bowel movement in greater than three days. He stated the CNAs documented bowel movements and the EMR alerted them if it had been greater than three days. LN G stated he did not handle for pharmacy reviews. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/22 at 05:17 PM Administrative Nurse D stated she was responsible for most of monthly pharmacy reviews. She stated they were sent to her and two other people, she made a copy of what was sent to the physician and gave some to the nurse practitioner. Administrative Nurse D stated once she received back the recommendations the provider wrote on; she made the changes that were not made by the physician and gave the document to medical records to be uploaded into the resident's chart. She stated the facility's bowel protocol started if a resident had not had a bowel movement in three days and the EMR alerted staff. She stated they discussed who was on the alerts in clinical meeting every morning and she was not aware that R37 did not have a bowel monitoring task for May 2022 to July 2022. On 08/25/22 at 12:42 PM Consultant GG stated when she completed monthly pharmacy reviews, she looked to make sure bowel monitoring was in place. She stated sometimes the facility started a medication to treat loose stools, so she recommended a decrease in constipation medications. The facility's Pharmacy Services- Role of the Consultant Pharmacist, last revised April 2019, directed the CP provided consultation on all aspects of pharmacy services in the facility, collaborated with the facility and medical director to: develop, implement, evaluate, and revise the procedures for the provision of all aspects of pharmacy services and provided feedback about performance and practices related to medication administration. The facility's Medication Regimen Reviews, last revised May 2019, directed the CP reviewed the medication regimen of each resident at least monthly. The MRR involved a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors, and other regularities, for example: inadequate monitoring for adverse consequences and other medication errors including those related to documentation. The policy directed within 24 hours of the MRR, the CP provided a written report to the attending physician for each resident and the attending physician documented in the medical record that the irregularity had been reviewed and what (if any) action was taken. Copies of the MRR reports, including physi[TRUNCATED]

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	175176	A. Building B. Wing	08/22/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents with seven residents sampled for unnecessary medication review. Based on observations, record review, and interviews, the facility failed to notify the physician as ordered when blood glucose (BG) was outside of parameters for Resident (R) 2 and R40; failed to provide bowel monitoring for R37; and failed to provide consistent bowel monitoring and failed to administer an as needed (PRN) laxative (medication used to loosen stool or stimulate a bowel movement) for R1; failed to ensure medications had indications of use for R1, and failed to obtain BG levels as ordered for R11. This deficient practice had the risk for unnecessary medication use and physical complications for all residents affected. Findings included: - The Diagnoses tab of R2's Electronic Medical Record (EMR) documented a diagnosis of type two diabetes mellitus (DMII- when the body cannot use glucose, not enough insulin [hormone that lowers the level of glucose in the blood] made or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R2 was independent with activities of daily living (ADLs). R2 received insulin medications seven days in the seven-day lookback period. The Quarterly MDS, dated [DATE], documented R2 had a BIMS score of 15 which, indicated intact cognition. R2 was independent with ADLs. R2 received insulin medications seven days in the seven-day lookback period. The ADL Functional/Rehabilitation Potential Care Area (CAA), dated 04/19/22, documented R2 was mainly independent with ADLs and could alert staff to his needs. The Diabetic Care Plan, initiated 10/30/19, documented R2 was at risk for diabetic compliance and potential for hyperglycemia (high blood sugar), and hypoglycemia (low blood sugar) related to diagnoses of DMII. The Diabetic Care Plan directed staff administered medications as ordered and notified MD of any changes in status as indicated. The Orders tab of R2's EMR documented an order with a start date of 03/04/22 for Novolog (insulin) 100 unit/milliliters (mL) inject as per sliding scale at bedtime for DMII with parameters to notify MD for BG of less than (<) 90 mg/deciliter (mg/dL) or more than (>) 400 mg/dL; an order with a start date of 03/05/22 for Insulin Glargine 40 units one times a day for diabetes with parameters to call MD for BG < 90 mg/dL or > 400 mg/dL. R2's Medication Administration Record (MAR) for May 2022 revealed R2's BG on 05/26/22 was 464 mg/dL. R2's clinical record lacked documentation the MD was notified as ordered. R2's MAR for June 2022 revealed R2's BG on 06/30/22 was 411 mg/dL. R2's clinical record lacked documentation the MD was notified as ordered. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's MAR for July 2022 revealed the following BG for R2: 07/22/22- 429 mg/dL, 07/23/22- 421 mg/dL, 07/24/22- 466 mg/dL, 07/29/22- 403 mg/dL, and 07/31/22- 479 mg/dL. R2's clinical record lacked documentation the MD was notified as ordered. R2's MAR for August 2022 revealed the following BG for R2: 08/01/22- 401 mg/dL, 08/09/22- 474 mg/dL, 08/10/22- 500 mg/dL, and 08/12/22- 434 mg/dL. R2's clinical record lacked documentation the MD was notified as ordered. On 08/16/22 at 01:19 PM R2 laid in bed, watched television, and ate cake. He stated he did not eat lunch, because he ate a late breakfast. He appeared comfortable and without signs of distress or discomfort. On 08/18/22 at 04:49 PM LN G stated there were some orders that had parameters and if the blood pressure, pulse, or BG was outside ordered parameters then the physician and management was notified. He stated the notification was documented in the EMR. On 08/18/22 at 05:17 PM Administrative Nurse D stated the physician should have been notified if vitals were outside ordered parameters, but staff had been a little lax on notifying the physician. Administrative Nurse D stated the facility had not been really good about completing behavior monitoring; behavior monitoring was charted on the MAR and expected to be completed every shift. She stated if there was a blank on the behavior monitoring documentation, that meant it was not completed. The facility's Obtaining a Fingerstick Glucose Level policy, last revised October 2011, directed after obtaining a fingerstick glucose level, staff recorded the resident's medical record the blood sugar results and followed facility policies for appropriate nursing interventions regarding blood sugar results. The policy directed staff reported results promptly to the supervisor and attending physician. The facility failed to notify the physician when blood glucose was outside parameters as ordered. This deficient practice placed R2 at risk for unnecessary medication use and unwarranted physical complications. - The Diagnoses tab of R40's Electronic Medical Record (EMR) documented a diagnosis of type two diabetes mellitus (DMII- when the body cannot use glucose, not enough insulin [hormone that lowers the level of glucose in the blood] made or the body cannot respond to the insulin). The Admission Minimum Data Set (MDS) dated [DATE], documented R40 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. R40 did not have any behaviors in the lookback period. R40 required extensive physical assistance with two staff for bed mobility and transfers; extensive physical assistance with one staff with dressing, toileting, personal hygiene, and bathing; supervision with setup help only with eating and locomotion. R40 received insulin seven days in the seven-day lookback period. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly MDS dated [DATE], documented R40 had a BIMS score of nine, which indicated moderate cognitive impairment. R40 had other behaviors not directed towards others one to three days in the lookback period. He required supervision with one staff for bed mobility, transfers, walking, locomotion; extensive physical assistance with one staff with dressing and bathing; limited physical assistance with one staff for toileting, and personal hygiene; independent with setup help only for eating. R40 received insulin medications seven days in the seven-day lookback period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/07/22, documented R40 triggered for impaired cognition, had a BIMS score of six, and was able to respond to simple questions. The Care Plan, dated 11/07/19, documented R40 had type two diabetes mellitus and directed staff administered diabetes medication as ordered and monitored/documented for side effects and effectiveness. The Orders tab of R40's EMR documented an order with a start date of 03/04/22 for accu-check (device used to check the levels of glucose in the blood) four times a day related to DM with parameters to call medical doctor (MD) for BG less than (<) 90 mg/deciliters (dL) or greater than (>) 400 mg/dL. R40's Medication Administration Record (MAR) for July 2022 to 08/18/22 revealed the following BG: 07/03/21 evening- 453 mg/dL, 07/04/22 morning- 509 mg/dL, 07/05/22 morning- 488 mg/dL, 07/08/22 bedtime- 432 mg/dL, 07/14/22 morning- 417 mg/dL, 07/31/22 bedtime- 451 mg/dL, 08/01/22 evening- 418 mg/dL, and 08/02/22 morning- 485 mg/dL. R40's clinical record lacked documentation the MD was notified as ordered. On 08/18/22 at 08:46 AM R40 sat on the edge of his bed and ate breakfast independently. He appeared comfortable and without signs of distress, discomfort, or behaviors. On 08/18/22 at 04:49 PM LN G stated there were some orders that had parameters and if the blood pressure, pulse, or BG was outside ordered parameters then the physician and management was notified. He stated the notification was documented in the EMR. On 08/18/22 at 05:17 PM Administrative Nurse D stated the physician should have been notified if vitals were outside ordered parameters, but staff had been a little lax on notifying the physician. The facility's Obtaining a Fingerstick Glucose Level policy, last revised October 2011, directed after obtaining a fingerstick glucose level, staff recorded the resident's medical record the blood sugar results and followed facility policies for appropriate nursing interventions regarding blood sugar results. The policy directed staff reported results promptly to the supervisor and attending physician. The facility failed to notify the physician when blood glucose was outside parameters as ordered. This deficient practice placed R2 at risk for unnecessary medication use and unwarranted physical complications. - The Diagnoses tab of R37's Electronic Medical Record (EMR) documented diagnoses of fracture of lower end of right femur subsequent encounter for closed fracture with routine healing, generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and need for assistance with personal cares. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Annual Minimum Data Set (MDS) dated [DATE], documented R37 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. R37 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; total physical dependence with one staff for locomotion; total physical dependence with two staff for bathing; and independent with setup help only for eating. R37 was always incontinent of bowel and bladder. R37 received anticoagulant (medication that inhibited clotting in the blood) medications seven days in the seven-day lookback period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/14/22, lacked an analysis of findings. The ADL Functional/Rehabilitation Potential CAA dated 07/22/22, documented R37 had limitation to lower extremities and was non-ambulatory. She had a wheelchair for mobility and required total assistance with transfers via Hoyer (total body mechanical lift used to transfer residents). The Care Plan dated 03/4/15, revised 08/16/22, documented R37 had an ADL self-care performance deficit related to impaired physical mobility. The Care Plan documented an intervention, last revised 08/11/22, for bed mobility with extensive assistance with one to two staff to turn and reposition R37 in bed; an intervention, last revised 02/02/19, for dressing with extensive assistance with one staff to complete upper and lower dressing; an intervention, last revised 02/02/19, for physical assistance with incontinence cares, check and change in bed; an intervention, last revised 02/02/19, for transfers of total assistance with at least two staff via Hoyer lift; and an intervention, last revised 02/02/19, that R37 was incontinent of bowel and bladder and required physical assistance with incontinence cares. The Care Plan, initiated 06/30/15, documented R37 was at risk for constipation related decreased mobility and directed staff observed/documented/reported as needed any signs/symptoms of complications related to constipation. The Orders tab of R37's EMR documented an order with a start date of 06/05/21, discontinued date of 06/17/22 for Miralax (laxative) 17 gram (GM) one time a day for bowel regulation; an order with a start date of 03/05/21, discontinued date of 07/29/22 for if no bowel movement for three days give 120 milliliters (mL) of prune juice as needed for constipation, if prune juice was not effective in 24 hours then progress to day four orders; an order with a start date of 03/05/21, discontinued date of 06/17/22 for milk of magnesia (laxative) 10 mL as needed for constipation for no bowel movement for four days. R37's Documentation Survey Report for May 2022 to July 2022 revealed there was not a task for bowel monitoring. On 08/16/22 at 03:24 PM R37 laid in bed with her eyes opened. She smiled and stated she had a good day. On 08/18/22 at 04:20 PM Certified Nurse Aide (CNA) M stated bowel movements were documented in the EMR by whoever performed incontinence cares on R37. She stated if a resident had not had a bowel movement after three days, it showed up as an alert in the EMR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

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Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/22 at 04:49 PM Licensed Nurse (LN) G stated the facility had a bowel protocol that started if a resident had not had a bowel movement in greater than three days. He stated the CNAs documented bowel movements and the EMR alerted them if it had been greater than three days. On 08/18/22 at 05:17 PM Administrative Nurse D stated the facility's bowel protocol started if a resident had not had a bowel movement in three days and the EMR alerted staff. She stated they discussed who was on the alerts in clinical meeting every morning and she was not aware that R37 did not have a bowel monitoring task for May 2022 to July 2022. The facility's Bowel (Lower Gastrointestinal Tract) Disorders- Clinical Protocol policy, last revised September 2017, directed the staff and physician monitored the individual's response to interventions and overall progress, for example, overall degree of comfort or distress, frequency and consistency of bowel movements, and the frequency, severity, and duration of abdominal pain. The facility failed to provide bowel monitoring for R37. This deficient practice had the risk for unnecessary medications and unwarranted physical complications. 41037 - R1's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) with psychotic symptoms (psychosis-any major mental disorder characterized by a gross impairment in reality). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R1 received antianxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions), diuretic medication (medication to promote the formation and excretion of urine), and opioid medication(a class of medication used to treat pain) for seven days during look back period. R1's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/23/22 documented staff would monitor for unwanted side effects of medication to decrease any severity of symptoms that may interfere with R1's quality of life. R1's Care Plan dated 05/20/20 documented medication would be given as ordered. It directed to attempt gradual dose reduction as indicated. Staff would monitor and report to the physician any signs or symptoms, increase or decrease of behaviors or adverse effects from the use of antipsychotic medication. Staff would monitor/document/report as needed adverse reactions to analgesic therapy: altered mental status, anxiety, depression, dizziness, lack of appetite and constipation. Review of the EMR under Orders tab revealed the following physician orders: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fluticasone propionate (allergy- a response by the body to a substance) suspension 50 microgram (mcg) one spray in both nostrils two times a day as directed. Shake bottle gently before use dated 05/23/22. The order lacked an indication for use. Pantoprazole sodium (antacid - medication used to treat indigestion and heartburn) tablet delayed release give 40 mg by mouth two times a day dated 05/24/22. The order lacked an indication for use. If no bowel movement for three days give 120 milliliters (ml) of prune juice as needed for constipation. If prune juice is not effective in 24 hours, progress to day four orders dated 03/05/21. Milk of Magnesia (laxative- medication used to stimulate or facility evacuation of the bowels) suspension 400mg/five ml give 10 ml by mouth as needed for constipation. Give for no bowel movement for four days. Monitor for effectiveness. If no noted BM in 24 hours, notify physician for further instructions dated 03/05/21. MiraLAX Powder (laxative) give 17 grams by mouth every 12 hours as needed for constipation give with eight ounces of water dated 06/02/21. Review of the EMR under Tasks tab reviewed from 06/01/22 through 08/15/22 (76 days) lacked documentation of bowel movement 06/09/22 to 06/17/22 (9 days), MiraLAX 17 GM was documented on 06/12/22 as given with no results documented under tasks charting. The Tasks tab revealed periods of no bowel movements on 06/19/22 to 06/22/22 (four days), 06/24/22 to 06/30/22 (seven days), and 07/02/22 to 07/15/22 (15 days). The EMR lacked any documentation of any as needed laxative medication was administered or physician was notified. On 08/16/22 at 11:36 AM R1 sat in wheelchair as she propelled herself around the room. On 08/18/22 at 03:20 PM Certified Nurse's Aide (CNA) O stated an alert comes up on the dashboard of PCC when a resident has not had a bowel movement charted in the past two or three days. CNA O would notify the nurse if the resident did not have a bowel movement on that shift. On 08/18/22 at 04:06 PM Licensed Nurse (LN) H stated bowel monitoring was done on every shift. LN H stated she would review the residents as needed (PRN) orders for laxatives. LN H stated she would notify the physician if no results from PRM laxative for further orders. LN H stated every medication should have reason to be given or diagnosis. On 08/18/22 at 05:17 PM Administrative Nurse D stated an alert on the EMR was triggered for all residents that have not had a bowel movement chart for three days. Administrative Nurse D stated the list was reviewed by Administrative Nurse E then taken out the charge nurses on the unit to review and administer PRN's or notify the physician fore orders. Administrative Nurse D stated no residents had triggered for no bowel movement this week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Medication Therapy policy last revised April 2007 documented that upon or shortly after admission and periodically thereafter, the staff, practitioner with the assistance of the Consultant Pharmacist will review current medication regimen, to identify whether there was a clear indication for treating the individual with the medication and potential or suspected side effects are present. The facility shall review medication issues as part of its Quality Assurance Committee and activities. The facility Bowel (Lower Gastrointestinal Tract) Disorder- Clinical Protocol policy last revised September 2017 documented the staff and physician would identify risk factors relayed to bowel dysfunction, for example, severe anxiety disorder or taking medication that are used to treat, or that may cause or contribute to constipation. The facility failed to identify multiple episodes in which R1 had no documented bowel movements and administer the as needed medications as ordered. The facility further failed to ensure all medication administered had an appropriate indication for use. This deficient practice had the potential for unnecessary medication use and unwarranted side effects. 45668 - The Medical Diagnosis section within R11's Electronic Medical Records (EMR) included diagnoses of moderate protein-calorie malnutrition (lack of sufficient nutrients in the body), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), gastrointestinal hemorrhage (loss of a large amount of blood in a short period of time), dementia (progressive mental disorder characterized by failing memory, confusion), seizures (violent involuntary series of contractions of a group of muscles), dysphagia (difficulty in swallowing food or liquid), muscle weakness, difficulty walking, and need for assistance with personal cares. R11's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted that she required extensive assistance from two members for dressing, toileting, and personal hygiene. The MDS noted that she was totally dependent on two staff for assistance for bathing. The MDS noted the that she had diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) but was not taking insulin (hormone which regulates blood sugar). A review of R11's Dementia Care Area Assessment CAA dated 04/04/22 noted that she had disorganized thinking and had a difficult time communicating her needs due to diagnoses of dementia and schizophrenia. A review of R11's Nutritional CAA dated 04/04/22 indicated that she was on a regular mechanically soft diet. The CAA noted that she prefers soft textures and able to feed herself. A review of R11's Physician's Orders noted an active order dated 06/13/22 that instructed staff to begin checking her blood glucose levels once daily related to diabetes mellitus. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R11's Medication Administration Record (MAR) and Tasks between 06/13/22 through 08/22/22 revealed that her blood glucose readings were not taken on 17 occasions (6/13, 6/14, 6/21, 6/22, 6/24, 6/26, 6/29, 7/4, 7/21, 7/30, 8/4, 8/5, 8/9, 8/10, 8/11, 8/14, and 8/15). The MAR revealed no refusals from R11. On 08/15/22 at 11:30 AM R11 reported that staff have not been completing her blood glucose checks in the morning for her diabetes mellitus. She stated that it is being monitored inconsistently and she is worried that it will make her sick. On 08/18/22 at 14:01 PM Licensed Nurse G stated that R11's blood sugar should be checked every morning, but R11 often refuses. He stated that it should be documented in the EMR each time if refused. On 08/18/22 at 01:30PM Licensed Nurse H stated that blood sugar checks should be charted in the EMR each time the check was completed. She stated that if a resident refused to have their blood sugar checked the nurse would make several attempts and then mark the refusal. She stated that R11 sometimes had moments where she did not want anyone to care for her, but the refusals should still be documented in the chart. On 08/18/22 at 05:18 PM Administrative Nurse D stated that staff were expected to follow the physician's order and report anything outside of parameters to the physician. She stated that staff should have documented any refusals in the EMR. A review of the facility's Obtaining Glucose Levels policy revised 10/2011 indicated that blood glucose will be completed per physician order and the result must be documented in the resident's EMR. The policy noted that if the resident refused or the test could not be completed, staff were to document the reason and intervention taken. The facility failed to provide consistent monitoring of R11's daily blood glucose checks. This deficient practice placed R11 at risk for complications related to her diabetes mellitus.

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	175176	A. Building B. Wing	08/22/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. The sample included 22 residents and seven residents were sampled for unnecessary medication review. Based on observations, record review, and interviews, the facility failed to provide consistent behavior monitoring for Resident (R) 2 and R40 who received psychotropic (any drug that affects brain activities associated with mental processes and behavior) medications and failed to ensure a stop date for an as needed (PRN) antianxiety (class of medications that calm and relax people with excessive anxiety[mental or emotional reaction characterized by apprehension, uncertainty and irrational fear], nervousness, or tension) for R1. This deficient practice had the risk for unnecessary medication use and physical complications for all residents affected. Findings included: - The Diagnoses tab of R2's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought], major depressive disorder (major mood disorder), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and insomnia (inability to fall asleep). The Annual Minimum Data Set (MDS) dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R2 was independent with activities of daily living (ADLs). R2 received insulin (hormone that lowers the level of glucose in the blood), antianxiety, antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression), diuretic (medication to promote the formation and excretion of urine), and opioid (pain reliever) medications seven days in the seven-day lookback period. The Quarterly MDS dated [DATE] documented R2 had a BIMS score of 15, which indicated intact cognition. R2 was independent with ADLs. R2 received insulin, antianxiety, antidepressant, diuretic, and opioid medications seven days in the seven-day lookback period. The ADL Functional/Rehabilitation Potential Care Area (CAA), dated 04/19/22, documented R2 was mainly independent with ADLs and could alert staff to his needs. The Psychotropic Drug Use CAA, dated 04/19/22, documented R2 was on antianxiety and antidepressant medications and was stable with current dose. The Care Plan, initiated 03/30/18, documented R2 had a mood problem related to history of mental issues of depression and chronic pain and had scheduled sertraline (medication used to treat depression) and trazodone (medication used to treat depression and insomnia). The Care Plan directed staff administered medications as ordered, encouraged R2 to express his feelings in an appropriate manner, and offered support and reassurance as needed. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Behavior Care Plan, initiated 04/22/20, documented R2 had manipulative behavior with other residents and intentionally excited and stirred up other residents to get them upset about things to make them complain about staff and the facility. The Behavior Care Plan directed staff to monitor behavior episodes, attempt to determine underlying causes, and document the behavior, and potential causes. The Care Plan, initiated 10/20/22, documented R2 reported difficulty sleeping and received trazodone as scheduled. The Care Plan directed staff to educate R2 about the use of over-the-counter, herbal, and prescription sleep aides. The Orders tab of R2's EMR documented an order with a start date of 11/05/21 for trazodone 50 mg at bedtime for insomnia; an order with a start date of 12/09/21 for sertraline 50 mg in the evening for major depressive disorder; and an order with a start date of 05/19/22 for lorazepam (antianxiety medication) 0.25 mg two times a day for anxiety. The Orders tab of R2's EMR documented the following behavior monitoring orders: behavior monitoring- antianxiety every shift for antianxiety medication use, start date 08/18/21, discontinued date 07/07/22; behavior monitoring- antidepressants every shift for medication use, start date 02/15/22, discontinued date 07/07/22; behavior monitoring- antianxiety every shift for anxiety medication use, start date 07/07/22; behavior monitoring- antidepressants every shift for antidepressant use, start date 07/07/22. Review of R2's MAR from May 2022 to 08/18/22 revealed the following missing behavior monitoring for antianxiety medication use: 05/03/22 night, 05/13/22 night, 05/22/22 night, 05/23/22 evening, 06/02/22 evening, 06/03/22 day, 06/10/22 day/evening/night, 06/16/22 night, 06/17/22 day, 06/19/22 day, and 07/07/22 day. The MAR revealed the following missing behavior monitoring for antidepressant medication use: 05/03/22 night, 06/03/22 day, 06/10/22 day/evening/night, 06/16/22 night, 06/18/22 day, and 07/07/22 day. On 08/16/22 at 01:19 PM R2 laid in bed, watched television, and ate cake. He stated he did not eat lunch, because he ate a late breakfast. He appeared comfortable and without signs of distress or discomfort. On 08/18/22 at 09:40 AM Licensed Nurse (LN) G stated behavior monitoring was completed every shift. On 08/18/22 at 05:17 PM Administrative Nurse D stated the facility had not been really good about completing behavior monitoring; behavior monitoring was charted on the MAR and expected to be completed every shift. She stated if there was a blank on the behavior monitoring documentation, that meant it was not completed. The facility's Behavioral Assessment, Intervention, and Monitoring policy, last revised March 2019, directed behavioral symptoms were identified using facility-approved behavioral screening tools. The policy directed if a resident was being treated for altered behavior or mood, the Interdisciplinary Team (IDT) sought and documented any improvements or worsening in the individual's behavior, mood, and function. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide consistent behavior monitoring for R2 who received antianxiety and antidepressant medications. This deficient practice placed R2 at risk for unnecessary medication use and unwarranted physical complications. - The Diagnoses tab of R40's Electronic Medical Record (EMR) documented diagnoses of diffuse traumatic brain injury (TBI) without loss of consciousness, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, psychosis (any major mental disorder characterized by a gross impairment in reality testing) not due to a substance or known physiological condition, schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought] bipolar type (episodes of severe high and low moods), alcohol-induced persisting dementia, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and major depressive disorder (major mood disorder). The Admission Minimum Data Set (MDS) dated [DATE], documented R40 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. R40 did not have any behaviors in the lookback period. R40 required extensive physical assistance with two staff for bed mobility and transfers; extensive physical assistance with one staff with dressing, toileting, personal hygiene, and bathing; supervision with setup help only with eating and locomotion. R40 received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medications five days and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications six days in the seven-day lookback period. The Quarterly MDS dated [DATE], documented R40 had a BIMS score of nine, which indicated moderate cognitive impairment. R40 had other behaviors not directed towards others one to three days in the lookback period. He required supervision with one staff for bed mobility, transfers, walking, locomotion; extensive physical assistance with one staff with dressing and bathing; limited physical assistance with one staff for toileting and personal hygiene; independent with setup help only for eating. R40 received antidepressant medications seven days in the seven-day lookback period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/07/22, documented R40 triggered for impaired cognition, had a BIMS score of six, and was able to respond to simple questions. The Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Drug Use CAA dated 02/07/22, documented R4 had been on long term antidepressant and antianxiety medications and was stable at that time with current dosages. The Behavior Care Plan dated 02/28/19, revised 03/14/22, documented R40 had potential for impaired or inappropriate behaviors and included: verbally aggressive/inappropriate, making threats to others, refusing cares/showers/assessments/medications. R40's occupation was former boxer. The Behavior Care Plan documented the following interventions: staff anticipated and met R40's needs, initiated 02/28/19; staff frequently and closely monitored R40 for unwanted behaviors and when R40 showed aggressive behaviors, staff redirected immediately and kept away from other residents, initiated 10/11/19. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Antidepressant Care Plan, initiated 05/14/21, documented R40 was at risk for adverse side effects related to use of antidepressant medications for depression and directed staff administered antidepressant medications as ordered by physician and monitored/documented for side effectiveness and effectiveness every shift. The Orders tab of R40's EMR documented an order with a start date of 01/07/22 for sertraline (antidepressant) 75 milligrams (mg) one time a day for major depressive disorder and an order with a start date of 03/04/22 for accu-check (device used to check the levels of glucose in the blood) four times a day related to DM with parameters to call medical doctor (MD) for BG less than (<) 90 mg/deciliters (dL) or greater than (>) 400 mg/dL. The Orders tab of R40's EMR documented an order with a start date of 06/30/21 for behavior monitoring-antidepressants every shift for antidepressant medication use, order was discontinued on 07/07/22. The Orders tab of R40's EMR documented an order with a start date of 07/07/22 for behavior monitoring-antidepressants every shift for antidepressant medication use. Review of R40's MAR for May 2022 to 08/18/22 revealed missing behavior monitoring for the following: 05/03/22 night, 05/13/22 evening/night, 05/17/22 evening, 05/22/22 night, 05/23/22 evening, 06/03/22 day, 06/06/22 evening, 06/10/22 day/evening/night, 06/16/22 night, 06/18/22 day, 06/19/22 day, 07/01/22 day, and 07/07/22 day. On 08/18/22 at 08:46 AM R40 sat on the edge of his bed and ate breakfast independently. He appeared comfortable and without signs of distress or behaviors. On 08/18/22 at 09:40 AM Licensed Nurse (LN) G stated behavior monitoring was completed every shift. On 08/18/22 at 05:17 PM Administrative Nurse D stated the facility had not been really good about completing behavior monitoring; behavior monitoring was charted on the MAR and expected to be completed every shift. She stated if there was a blank on the behavior monitoring documentation, that meant it was not completed. The facility's Behavioral Assessment, Intervention, and Monitoring policy, last revised March 2019, directed behavioral symptoms were identified using facility-approved behavioral screening tools. The policy directed if a resident was being treated for altered behavior or mood, the Interdisciplinary Team (IDT) sought and documented any improvements or worsening in the individual's behavior, mood, and function. The facility failed to provide consistent behavior monitoring for R40 who received antidepressant medications. This deficient practice placed R2 at risk for unnecessary medication use and unwarranted physical complications. 41037 (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R1's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) with psychotic symptoms (psychosis-any major mental disorder characterized by a gross impairment in reality). 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 R1 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R1 received antianxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions), diuretic medication (medication to promote the formation and excretion of urine), and opioid medication(a class of medication used to treat pain) for seven days during look back period. R1's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/23/22 documented staff would monitor for unwanted side effects of medication to decrease any severity of symptoms that may interfere with R1's quality of life. R1's Care Plan dated 05/20/20 documented medication would be given as ordered. It directed to attempt gradual dose reduction as indicated. Staff would monitor and report to the physician any signs or symptoms, increase or decrease of behaviors or adverse effects from the use of antipsychotic medication. Staff would monitor/document/report as needed adverse reactions to analgesic therapy: altered mental status, anxiety, depression, dizziness, lack of appetite and constipation. Review of the EMR under Orders tab revealed the following physician orders: Xanax (antianxiety) tablet 0.25 milligrams (mg) give one tablet by mouth daily every 24 hours as needed (PRN) for anxiety dated 05/12/22. The order lacked a stop date. Xanax tablet 0.25 mg give one tablet by mouth two times a day for anxiety until 09/21/22 dated 06/21/22. On 08/16/22 at 11:36 AM R1 sat in wheelchair as she propelled herself around the room. On 08/18/22 at 04:06 PM, Licensed Nurse (LN) H stated there should be a stop date for as needed psychotropic medication. LN H stated she would notify the physician for an order if needed. On 08/18/22 at 05:17 PM Administrative Nurse D Stated Administrative Nurse E reviewed the orders from the physician for the MRR and was not aware of the physician's order related to R1's psychotropic medication and would have to review the clinical record. The facility Behavioral Assessment, Intervention and Monitoring policy last revised March 2019 documented the facility would comply with regulatory requirements related to the use of medications to manage behavioral changes. When medications have been prescribed for behavioral symptoms, documentation will include the duration, dose, and specific targeted behaviors. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure the physician had specific a duration for R1's psychotropic PRN medication for R1. This had the potential for unnecessary medication administration or possible harmful side effects.

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	175176	A. Building B. Wing	08/22/2022

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42966 The facility identified a census of 54 residents; four medication carts and two medication storage rooms. Based on observations, record reviews, and interviews, the facility failed to discard expired insulin (medication used to treat a chronic condition that affected the way the body processed blood sugar) and failed to properly store and date insulin. This deficient practice had the risk for physical complications and ineffective treatment for affected residents. Findings included: - On 08/15/22 at 07:55 AM, 500 hall medication cart revealed the following: One Novolog (fast acting insulin) insulin vial, opened 07/12/22 One Insulin Lispro (fast acting insulin) vial, opened but not dated One Insulin Aspart (fast acting insulin) vial, opened and dated 06/03/22 One Insulin Aspart vial, opened and dated 05/21/22 One Insulin Aspart vial, opened and dated 06/20/22 On 08/15/22 at 08:12 AM, 300 hall medication cart revealed one Lantus (long acting insulin) insulin pen opened but not dated. A review of the manufacturer's instructions for Novolog insulin vials directed Novolog insulin vials opened and/or stored at room temperature were good for 28 days. A review of the manufacturer's instructions for Insulin Aspart vials directed Insulin Aspart vials opened and/or stored at room temperature were good for 28 days. A review of the manufacturer's instructions for Insulin Lispro vials directed Insulin Lispro vials opened and/or stored at room temperature were good for 28 days. A review of the manufacturer's instructions for Lantus pens directed opened Lantus pens opened and/or stored at room temperature were good for 28 days. On 08/18/22 at 04:49 PM, Licensed Nurse (LN) G stated the Certified Medication Aides (CMAs) and nurses were responsible for checking the cart for expired medications. He stated insulin was good for 28 days once opened and insulins were dated when opened. On 08/18/22 at 05:17 PM, Administrative Nurse D stated the unit manager checked medication carts for expired medications. She stated insulin was good for 28 days when opened and was dated when opened. (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Storage of Medications policy, last revised November 2020, directed the facility stored all drugs and biologicals in a safe, secure, and orderly manner and nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The facility's Insulin Administration policy, last revised September 2014, directed staff checked expiration date, followed manufacturer recommendations for expiration after opening, and recorded expiration date and time on the vial when opening a new vial. The facility failed to discard expired insulin and failed to properly store and date insulin. This deficient practice had the risk for physical complications and ineffective treatment for affected residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 54 residents. The sample included 22 residents with two reviewed for food preferences. Based on observation, record review, and interviews, the facility failed to ensure safe and palatable food temperatures for Resident (R)11 during meal services. This deficient practice placed the resident at risk for malnutrition and decrease psychosocial wellbeing. Findings Included: - The Medical Diagnosis section within R11's Electronic Medical Records (EMR) included diagnoses of moderate protein-calorie malnutrition (lack of sufficient nutrients in the body), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), gastrointestinal hemorrhage (loss of a large amount of blood in a short period of time), dementia (progressive mental disorder characterized by failing memory, confusion), seizures (violent involuntary series of contractions of a group of muscles), dysphagia (difficulty in swallowing food or liquid), muscle weakness, difficulty walking, and need for assistance with personal cares. R11's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted that R11 required assistance with meal setup and supervision. The MDS noted that she weighed 213 pounds (lbs.) and had no weight loss within the last six months. The MDS noted that she was on a mechanically altered diet. A review of R11's Dementia Care Area Assessment CAA dated 04/04/22 noted that she had disorganized thinking and had a difficult time communicating her needs due to her diagnoses of dementia and schizophrenia. R11's Care Plan created 03/23/22 noted that she was at risk for impaired nutrition. The plan encouraged staff to offer healthy snacks and low-calorie food between meals. The care plan noted staff should honor her requests and preferences. The plan noted that she was on a mechanical soft textured diet. On 08/15/22 at 08:00AM R11 reported that the facility sometimes served the food cold. She noted that the food was good but sometimes served cold. On 08/16/22 at 07:55AM R11 was observed setting at a table in the dining room. R11 had her breakfast of French toast, a sausage patty, and a bowel of grits. R11 stated that she was not going to eat them because the food was cold. Activities Staff ZZ asked R11 why she was not eating her breakfast and if she would like another plate. R11 stated that she was given a cold plate and already asked staff to replace it five minutes ago. A temperature test revealed the food to be around 55 degrees Fahrenheit. Activities Staff ZZ notified the kitchen and was able to retrieve another plate for R11. R11 reported that the new plate was good and had no further concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/17/22 at 11:45AM Dietary Staff DD stated that dietary staff are expected to review the resident's diets and ensure that the all food served is palatable and reflective to the resident's diets. She stated that staff were expected to temperature test all food before meal service and the food should be held at temperature using steam tables. A review of the facility's Resident Food Preferences policy revised 07/2017 indicated that all residents will be assess by the dietician, nursing staff, and physician to identify the nutritional needs of each resident. The policy noted the facility will identify issues related to the resident's preferences, orders, and risks associated with the resident's diet and provide food that is palatable and nutritional. The facility failed to ensure safe and palatable food temperatures for R11 during meal services. This deficient practice placed the resident at risk for malnutrition and decrease psycho-social wellbeing.

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 54 residents. The sample included 22 residents with two residents reviewed for food served to meet individual needs of residents. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 4's physician ordered requirements related to his food preparation. This deficient practice placed R4 at risk for choking and malnutrition. Findings included: - The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of right sided hemiplegia (paralysis of one side of the body), right sided hemiparesis (muscular weakness of one half of the body), need for assistance with personal cares, muscle weakness, dysphagia (difficulty in swallowing food or liquid), and aphasia (condition with disordered or absent language function). R4's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted that he required supervision and set-up only for eating. The MDS noted that had no weight loss within the last six months. The MDS noted that he required a mechanically altered diet. A review of R4's Communication Care Area Assessment (CAA) dated 03/09/22 indicated that he had aphasia but at times could make his needs known. A review of R4's Feeding Tube CAA dated 03/09/22 indicated that he was receiving fluid and nutrition via his PEG tube (feeding tube inserted through the abdominal wall into the stomach). The CAA indicated monthly weight checks, periodic dietary evaluations, and regular changing and replacements of the tube to avoid complications related to his diagnoses. R4 had not triggered for Nutrition or Activities of Daily Living (ADL's) in the CAA. R4's Care Plan created 02/07/22 indicated that he was at risk for impaired nutrition or malnutrition related to his medical diagnoses. The care plan noted that he required assistance from one staff for eating. The plan noted that staff were to provide one to one assistance and supervision for the duration of his meals. A review of R4's Speech Therapy discharge note revealed that he had services from 3/1/22 through 4/21/22. The note indicated that he had reached his maximum potential and discharged from the services on 04/21/22. The note indicated that the speech pathologist indicated a good prognosis depending on a consistent staff follow through of the dietary plan. The discharge instruction recommended of a mechanical soft/grounded diet. A review of R4's Physicians Orders revealed a dietary order started 06/09/22 for R4 to receive a regular diet with his food cut up into small bite size pieces before being served. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/16/22 at 07:34AM R4 ate his breakfast. He struggled to get the food on his spoon and had no assistance from staff during the entirety of the meal. On 08/16/22 at 12:46 PM R4 ate a pork sandwich in the dining room for lunch. The sandwich was whole and not cut up for him. R4 struggled to hold the sandwich but managed to eat the entire meal by himself. R4 did not have staff assistance provided during his meal. A review of R4's dietary ticket for lunch on 08/16/22 revealed that his food was to be cut into small bite sized portions. The ticket did not show that R4 required one to one assistance or supervision during his meals. On 08/22/22 at 07:33AM R4 was served a whole bagel for breakfast. R4 consumed part of his meal and returned to his room. R4 did not have staff assistance throughout the meal. On 08/17/22 at 11:39AM Dietary Staff BB stated that each resident should be served based on their individual dietary needs and preferences. She stated that staff should be reviewing the dietary tickets to ensure that the residents are receiving the proper diet. She stated that the ticket information is comprised from the resident's orders and care plan information. On 08/17/22 at 11:45AM Dietary Staff DD stated that each resident's meal is prepared based on their specific dietary needs listed on the ticket. She stated that before she serves the meals, she checks what is on the ticket and verifies that the resident is getting the correct diet. She stated that if something is incorrect on the ticket she would check with the nurse and dietary manager. On 08/23/22 the facility's Registered Dietician was called but did not return the call . A review of the facility's Dental Soft (Mechanical Soft) policy dated 2022, provided by the facility indicated the residents on a mechanical soft diets must have food prepared and served based upon the resident's dietary orders and prepared further based upon the recommendations of the speech pathologist. The policy noted that diet should be modified based on the resident's changing abilities. A review of the facility's Resident Food Preferences policy revised 07/2017 indicated that all residents will be assess by the dietician, nursing staff, and physician to identify the nutritional needs of each resident. The policy noted the facility will identify issues related to the resident's preferences, orders, and risks associated with the resident's diet. The policy noted that each diet will be assessed by the interdisciplinary team for reviewed by the facilities Quality Assessment and Performance Improvement (QAPI) committee to identify widespread concerns about meal service and food preparation. The facility failed to prepare and serve R4's meals specific to his needs when staff failed to ensure R4's food was cut into small, bite size pieces per his physician's dietary order. This deficient practice placed R4 at risk for complication related to choking and malnutrition.

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45668 The facility identified a census of 54 resident and one kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to equipment cleaning, food storage, and dining service. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns. Findings included: - On 08/15/22 at 07:05 AM an initial walk-through of the facility's kitchen and food storage area revealed the dishwasher temperature log for August 2022 was missing evidence the temperature was checked for 8/1-8/8, 8/10, and 8/14. A review of the walk-in refrigerator log revealed that August 2022 was missing evidence of temperature checks on 8/12 and 8/13. The July 2022 log lacked evidence of evening shift checks of the walk-in refrigerator temperatures for 7/7-7/13 . The juice dispenser station had a large puddle of spilled juice,sticky and starting to dry, at the base of the table it sat on. On 08/15/22 at 07:10 AM The fryer station oil was dark brown with food items and residue floating at the top of the oil. On 08/15/22 at 07:12 AM an inspection of the walk-in refrigerator revealed the following food items opened and undated: bag of pickles, ranch dressing (one gallon), jalapeno ranch dressing (one gallon), two bags of bagels, bag of lettuce, and a half eaten strawberry pie. The storage racks within the walk-in refrigerator contained undated metal pans of mashed potatoes, and gravy. On 08/15/22 at 07:15 AM an inspection of the walk-in freezer unit revealed a water leak or condensation at the base the air condition unit. The storage rack below the area contained icicles on the food from the dripping. On 08/17/22 at 11:45 AM Dietary Staff DD stated that staff are expected to maintain clean and sanitary work areas within the kitchen. She stated that staff should be inspecting to kitchen and equipment every shift while they are working and reporting any concerns to her. She stated that staff are required to complete food service within a professional manner and treat each resident with respect and dignity. She reported that the facility has had difficulty with food deliveries recently, but staff can just tell her what was needed. She reported that she could go out to the store and buy it easily for the resident's meals. A review of the facility's Dishwashing machine Use policy revised 03/2010 stated that the operator will check the dishwashing machine for proper concentrations of sanitizer solution and document the results in an approved facility log. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Refrigerator and Freezers revised 12/2014 noted that monthly tracking sheets will be posted for all refrigerators and freezers with recorded temperatures. The policy noted that supervisors will inspect the refrigerator and freezer units monthly for excess condensation and other maintenance needs. A review of the facility's Food Storage revised 10/2017 policy noted that staff will maintain clean food sanitation at all times. The policy noted that all food preparation areas and equipment will be maintained in a clean serviceable manner. The facility failed to maintain sanitary dietary standards related to equipment cleaning and temperature checks,and food storage. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 54 residents. The sample included 22 residents. Based on observation, record review and interviews, the facility failed to provide administrative services in a manner that enabled effective and efficient use of resources to attain/maintain each resident's highest practicable physical, mental and psychosocial well-being, as evidenced by the quantity and severity of deficiencies cited on the health resurvey. This had the potential to affect all 54 residents. Findings Included: - On [DATE] at 08:35 AM, during the Entrance Conference, Administrative Nurse D identified herself as the facility's Director of Nursing (DON) in title only. Based on observations, record review, and interviews, the facility failed to ensure residents remained free from abuse and failed to protect residents from further abuse. On [DATE], Resident (R) 40 pushed R42 out of a chair and caused R42 to fall on the floor. R42 received an abrasion and hematoma (a bad bruise that occurs when an injury causes blood to collect and pool under the skin) to his right temple from the fall. R40 was started on an antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions) on [DATE], but the facility did not implement any behavioral interventions related to the incident or protective measures to prevent further incidents. On [DATE], R40 approached R6, stood over him, and spoke loudly to him. R40, a former boxer, then punched R6 multiple times in the face. R6 tried to block the punches and threw his coffee cup at R40. R40 went for emergent evaluation for aggressive behaviors on [DATE] and returned to facility on [DATE]. The facility placed R40 on a different unit but failed to implement further interventions to address R40's behaviors. These failures placed the residents in immediate jeopardy. The facility further failed to prevent resident-to-resident abuse when R14, who had a history of aggressive behaviors towards other residents on the unit, shoved R42 causing him to fall. R14 also struck an unidentified resident on the backside, which precipitated a physical altercation between R14 and the unidentified resident. (refer to F600) Based on observations, record reviews, and interviews, the facility failed to report an occurrence of potential abuse and/or neglect, for Resident (R) 37 who had a fracture of unknown origin, to the State Agency (SA) as required. The facility further failed to report resident to resident abuse involving R14. This deficient practice placed the resident at risk for unresolved and ongoing abuse, a decrease in psychosocial well-being, and further injuries. (refer to F609) (continued on next page)

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 37 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility staff failed to identify and investigate a fracture of unknown origin as potential abuse or neglect. R37 was dependent on staff for activities of daily living (ADLs), non-ambulatory, and cognitively impaired. R37's clinical record lacked documentation of recent falls or trauma. On [DATE], staff documented R37 hollered in pain when staff attempted to provide cares and then transferred to the acute care hospital, where it was determined R37 had an acute impacted transverse fracture (broken bone at a right angle to the axis of the bone) of the distal (away from the farthest point of origin or attachment) femur (thigh bone). Upon learning of the fracture, the facility failed to identify the serious injury of unknown origin as a potential abuse or neglect situation and failed to initiate an investigation to attempt to determine the cause of the fracture. The facility failed to implement protective measures. This deficient practice placed R37 in immediate jeopardy. The facility further failed to investigate a resident to resident altercation and initiate protective measures when R14 struck an unidentified resident on the back side, precipitating a fight, and later shoved R42 to the ground. (refer to F610) Based on observation, record review, and interviews, the facility failed to maintain dignified care practices for Resident (R) 47, R12, and R101. This deficient practice placed the residents at risk for embarrassment and decreased psychosocial well-being. (Refer to F550) Based on observation, record review, and interviews, the facility failed to provide assistance with meals for Resident (R)4. This deficient practice placed R4 at increased risk for progressive loss of independence with eating and related complications such as malnutrition. (Refer to F676) Based on observations, record review, and interviews, the facility failed to provide consistent bathing for Resident (R) 37, R40, R47 and R11. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for affected residents. (refer to F677) Based on observation, record review, and interviews, the facility failed to assess or treat an identified pressure area on R101's sacrum (large triangular bone between the two hip bones) and failed to ensure pressure relieving measures were in place on bilateral (both) lower extremities. This placed R101 at an increased risk for pressure ulcer development and delayed healing to current pressure injuries. (refer to F686) Based on observation, interview and record review, the facility failed to provide adequate services and positioning devices to prevent decreased range of motion and mobility for Resident (R)101. This deficient practice placed R101 at increased risk for ROM decline, contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and discomfort. (Refer to F688) Based on observations, record review, and interviews, the facility failed to provide adequate supervision to prevent accidents and elopement (when a cognitively impaired resident leaves the facility without staff knowledge), for Resident (R) 46. The facility failed to provide adequate supervision during smoking for R2, R5, R7, and R33 who were documented as needing supervision with smoking. The facility failed to implement fall prevention interventions following a fall for R42. This deficient practice placed the affected residents at increased risk for accidents and/or injuries. (Refer to F689) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, record review, and interviews, the facility failed to provide Resident (R)11 with a person-centered toileting program, to ensure maintenance of as much normal bladder function as possible. Furthermore, the facility failed to ensure appropriate cares and services for R12's suprapubic catheter (tube inserted through the abdomen into the bladder to drain urine) when the facility failed to properly anchor the catheter tubing and keep the catheter tubing from coming into direct contact with the floor. These deficient practices placed R11 at increased risk for impaired health related to incontinence and placed R12 at increased risk of catheter related complications. (Refer to F690) Based on observation, record review, and interviews, the facility failed to implement relevant nutritional interventions to prevent continued weight loss for Resident (R)14, who had a significant weight loss. The facility further failed to weigh weekly as ordered by the physician. The facility failed to identify residents preferred snacks and add to the plan of care to ensure availability and failed to identify opportunities to fortify non-cereal foods the resident consistently consumed, in order to prevent further loss. This deficient practice placed the residents at risk for complications with unplanned weight loss and malnutrition. (Refer to F692) Based on observation, record review, and interviews, the facility failed to provide consistent tube feedings and water boluses as ordered by the physician for Resident (R)4. This deficient practice placed R4 at risk for malnutrition and complications related to his feeding tube (tube inserted through the abdominal wall into the stomach). (Refer to F693) Based on observation, record review, and interviews, the facility failed to store oxygen (O2) tubing (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) properly for Resident (R) 101. Furthermore, the facility failed to change the oxygen tubing weekly as ordered for R21. This deficient practice placed R101 and R21 at increased risk for development of respiratory complications. (Refer to F695) Based on observations, record reviews, and interviews, the facility failed to ensure Resident (R) 37 received the necessary nursing services to prevent and manage pain. This deficient practice placed R37 at increased risk for untreated pain and related complications. (Refer to F687) Based on observations, record reviews, and interviews, the facility failed to educate Resident (R) 37's Durable Power of Attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) on the risks versus benefits of using side rails and failed to obtain consent from the DPOA to utilize side rails on R37's bed. This deficient practice had the risk for accidents and/or hazards and miscommunication between the DPOA and facility. (Refer to F700) Based on observation, record review, and interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for, Resident (R) 31, who has a history of striking himself in the head. This placed the resident at risk for further decline of his emotional and mental wellbeing. (Refer to F740) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, record review, and interviews, the facility failed to ensure staff possessed the skills and knowledge necessary when nursing staff allowed Resident (R)42 to have four staples remain inserted in his scalp for 70 days past the recommended removal date. The facility additionally failed to identify, assess, and document the staples in his head during the 70 days. This deficient practice placed R42 at risk for infections and pain. (Refer to F726) Based on record and interview, the facility failed to provide a Registered Nurse (RN) services for at least eight consecutive hours, seven days a week. This placed all residents in the facility at risk for decreased quality of care. (Refer to F727) Based on observations, record review, and interviews, the facility failed to notify the physician as ordered when blood glucose (BG) was outside of parameters for Resident (R) 2 and R40; failed to provide bowel monitoring for R37; and failed to provide consistent bowel monitoring and failed to administer an as needed (PRN) laxative (medication used to loosen stool or stimulate a bowel movement) for R1; failed to ensure medications had indications of use for R1, and failed to obtain BG levels as ordered for R11. This deficient practice had the risk for unnecessary medication use and physical complications for all residents affected. (Refer to F757) Based on observations, record review, and interviews, the facility failed to provide consistent behavior monitoring for Resident (R) 2 and R40 who received psychotropic (any drug that affects brain activities associated with mental processes and behavior) medications and failed to ensure a stop date for an as needed (PRN) antianxiety (class of medications that calm and relax people with excessive anxiety[mental or emotional reaction characterized by apprehension, uncertainty and irrational fear], nervousness, or tension) for R1. This deficient practice had the risk for unnecessary medication use and physical complications for all residents affected. (Refer to F758) Based on observations, record reviews, and interviews, the facility failed to discard expired insulin (medication used to treat a chronic condition that affected the way the body processed blood sugar) and failed to properly store and date insulin. This deficient practice had the risk for physical complications and ineffective treatment for affected residents. (Refer to F761) Based on observation, record review, and interviews, the facility failed to ensure staff practiced standard infection control practices regarding appropriate cleaning and disinfecting of shared equipment and storing of clean linens, to prevent the spread of infection. This had the potential to increase the residents' risk for transmission of infectious disease. (Refer to F880) Based on record review and interviews, the facility failed to ensure principles of antibiotic stewardship were followed to ensure antibiotics were used in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance in an ongoing, proactive manner. (refer to F881) Based on record reviews and interviews, the facility failed to offer and administer or obtain a signed declination for the COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death) booster vaccination for Resident (R) 2. This deficient practice had the risk for unwarranted complications related to COVID-19 and the risk to spread illness and infection to the residents. (Refer to F887) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 05:18 PM Administrative Nurse D stated the Certified Nurse Aides were responsible for bathing. Administrative Nurse D said she was unfamiliar with the facility's policy on disinfecting shared equipment. She said Administrative Nurse E was the facility's designated Infection Preventionist and handled all components of the facility's Infection Prevention and Control Program. Administrative Nurse D verified she was unable to answer specific questions regarding wound and skin care because Administrative Nurse E was responsible, as the facility's wound care nurse. Administrative Nurse D stated the facility staff had become lax on contacting the physician and have not been good at behavior monitoring. Administrative Nurse D stated R37's fracture was not looked at from an abuse perspective as there was no indication or any abuse or neglect. Administrative Nurse D refused to answer any further questions and left the interview. On [DATE] at 01:11 PM Administrative Staff A stated the staffing coordinator or unit manager made sure there was RN coverage and the facility typically made a good faith effort to have RN coverage. She stated that when Administrative Nurse D provided RN coverage, Administrative Nurse D did not clock in or out because she was not on the facility's payroll. The facility failed to provide administrative services in a manner that enabled effective and efficient use of resources to attain/maintain each resident's highest practicable physical, mental and psychosocial well-being, as evidenced by the quantity and severity of deficiencies cited on the health resurvey. This had the potential to affect all 54 residents.

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	175176	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 42966 The facility identified a census of 54 residents. The facility failed to ensure the Facility Assessment was reviewed and updated annually. This deficient practice had the risk for missed services and resources for the residents of the facility. Findings included: - The Facility Assessment provided by facility on 08/15/22, documented the date of assessment or update as 07/21/20 and the date assessment was last reviewed with Quality Assurance (QA)/Quality Assurance Performance and Performance (QAPI) was 07/27/21. On 08/22/22 at 01:11 PM Administrative Staff A stated that she was responsible for reviewing and updating the Facility Assessment. The facility's Facility Assessment policy, last revised October 2018, directed a facility assessment was conducted annually to determine and update the facility's capacity to meet the needs of and competently care for the residents during day-to-day operations. The QAPI committee was responsible for reviewing facility and resident information quarterly to determine if a facility reassessment was warranted. The facility failed to ensure the Facility Assessment was reviewed and/or updated annually. This deficient practice had the risk for missed services and resources for the residents of the facility.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 54 residents. Based on observations, record review, and interviews, the facility failed to maintain an effective Quality Assessment and Assurance (QAA) program to identify quality issues and develop Performance Improvement Plans (PIPs). This deficient practice placed the residents at risk for a decrease in quality of care. Findings included: - The facility failed to maintain dignified care practices for Resident (R) 47, R12, and R101. This deficient practice placed the residents at risk for embarrassment and decreased psychosocial well-being (Refer to F550) The facility failed to ensure residents remained free from abuse and failed to protect residents from further abuse. The failure placed the resident in immediate jeopardy. (Refer to F600) The facility failed to ensure residents received the necessary protective oversight to prevent potential abuse and/or neglect when the facility staff failed to report a fracture of unknown origin as potential abuse or neglect to the State Agency. (Refer to F609) The facility failed to ensure R37 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility staff failed to identify and investigate a fracture of unknown origin as potential abuse or neglect. The facility further failed to investigate a resident to resident altercation and initiate protective measures when R14 struck an unidentified resident on the back side, precipitating a fight, and later shoved R42 to the ground (Refer to F610) The facility failed to ensure the Minimum Data Set (MDS- tool for implementing standardized assessment and for facilitating care management in nursing homes) was accurately coded. (Refer to F641) The facility failed to provide consistent bathing for R 37, R40, R47 and R11 which place the residents at risk for poor hygiene and decreased self-esteem and dignity for affected residents. (Refer to F677) The facility failed to assess or treat an identified pressure area on R101's sacrum (large triangular bone between the two hip bones) and failed to ensure pressure relieving measures were in place on bilateral (both) lower extremities. This placed R101 at an increased risk for pressure ulcer development and delayed healing to current pressure injuries. (Refer to F686) The facility failed to provide adequate supervision in order to prevent accidents and elopement, failed to provide adequate supervision during smoking, and failed to implement fall precaution interventions following a fall. (Refer to F689) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to provide R11 with a person-centered toileting program, to ensure maintenance of as much normal bladder function as possible and failed to ensure appropriate cares and services for R12's suprapubic catheter (tube inserted through the abdomen into the bladder to drain urine) when the facility failed to properly anchor the catheter tubing and keep the catheter tubing from coming into direct contact with the floor. These deficient practices placed R11 at increased risk for impaired health related to incontinence and placed R12 at increased risk of catheter related complications. (Refer to F690) The facility failed to implement effective interventions to prevent significant weight loss for R14. This deficient practice placed the residents at risk complications with weight loss and malnutrition. (Refer to F692) The facility failed to store oxygen (O2) tubing (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) properly for R101. Furthermore, the facility failed to change the oxygen tubing weekly as ordered for R21. This deficient practice placed R101 and R21 at increased risk for development of respiratory complications. (Refer to F695) The facility failed to ensure resident received necessary nursing services to prevent and manage pain. (Refer to F697) The facility failed to educate on risks/benefits of side rail use and failed to obtain consent for side rail use. (Refer to F700) The facility failed to ensure staff possessed the skills and knowledge necessary when nursing staff allowed R42 to have four staples remain inserted in his scalp for 70 days past the recommended removal date. The facility additionally failed to identify, assess, and document the staples in his head during the 70 days. This deficient practice placed R42 at risk for infections and pain. (Refer to F726) The facility failed to provide a Registered Nurse (RN) services for at least eight consecutive hours. (Refer to F727) The facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for, R31 who had a history of striking himself in the head. This placed the resident at risk for further decline of his emotional and mental wellbeing. (Refer to F740) The facility failed to act upon medication regimen reviews, failed to ensure Consultant Pharmacist (CP) identified and reported lack of behavior monitoring and bowel monitoring, and failed to ensure CP identified and reported lack of physician notification for blood glucose (BG) levels outside parameters as ordered. (Refer to F756) The facility failed to notify the physician as ordered when BG was outside parameters, failed to provide bowel monitoring, failed to administer as needed (PRN) laxative, failed to ensure indications for medication use, and failed to obtain ordered BG levels. (Refer to F757) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to provide consistent behavior monitoring and failed to obtain stop date for PRN psychotropic (any drug that affects brain activities associated with mental processes and behavior) medication. (Refer to F758). The facility failed to discard expired insulin (medication used to treat a chronic condition that affected the way the body processed blood sugar) and failed to properly store and date insulin. (Refer to F761) The facility failed to maintain sanitary dietary standards related to equipment cleaning, food storage, and dining service. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns. (Refer to F812) The facility failed to ensure staff practiced standard infection control practices regarding appropriate cleaning and disinfecting of shared equipment and storing of clean linens, to prevent the spread of infection. This had the potential to increase the residents' risk for transmission of infectious disease. (Refer to F880) On [DATE] at 03:47 PM Administrative Staff A stated QAA committee met at least quarterly and involved the Interdisciplinary Team (IDT), department head managers, the Pharmacist Consultant, a Certified Nurse Aide (CNA) or Certified Medication Aide (CMA), and the Medical Director or the Nurse Practitioner in his place. She stated the Medical Director was not at the QAA meeting in July and the last time he attended QAA was in March. She stated they discussed any issues that arise in IDT meetings and Quality Assurance and Performance Improvement (QAPI) meetings depending on the content. Administrative Staff A stated they collaborated as the QAPI committee, put a lot of PIPs in place, and found the best way to attack issues was as a team. The facility's QAPI Program- Governance and Leadership policy, last revised [DATE], directed the Administrator, Director of Nursing Services, Medical Director, Infection Preventionist, and representatives from Pharmacy, Social Services, Activity Services, Environmental Services, Human Resources, and Medical Records served on the committee. The policy directed the committee met at least quarterly or more often as necessary. The facility's QAPI Program- Feedback, Data and Monitoring policy, last revised [DATE], directed information obtained about the quality of care and services delivered to residents was evaluated and monitored by the QAPI committee in order to identify problems that were high risk, high volume, or problem prone and to guide decisions regarding opportunities for improvement. The policy directed the QAPI process focused on identifying systems and processes that may be problematic and could be contributing to avoidable negative outcomes related to resident care, quality of life, resident safety, resident choice or resident autonomy, and on making a good faith effort to correct or mitigate these outcomes. The facility failed to maintain an effective QAA program to identify quality issues and develop PIPs. This deficient practice placed the residents at risk for a decrease in quality of care.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42966 The facility identified a census of 54 residents. The sample included 22 residents. Based on record review and interview, the facility failed to ensure their Medical Director or designee attended the Quality Assessment and Assurance (QAA) Committee quarterly meetings. This placed the residents who resided in the facility at risk for decreased quality of care. Findings included: - The facility provided the QAA committee attendance rosters for 07/29/22 in which the Medical Director and/or designee did not attend. The last QAA committee meeting the facility's Medical Director and/or designee attended was noted on 03/23/22. On 08/22/22 at 03:47 PM Administrative Staff A stated QAA committee met at least quarterly and involved the Interdisciplinary Team (IDT), department head managers, the Pharmacist Consultant, a Certified Nurse Aide (CNA) or Certified Medication Aide (CMA), and the Medical Director or the Nurse Practitioner in his place. She stated the Medical Director and/or designee was not at the QAA meeting in July and the last time he attended QAA was in March. The facility's Quality Assurance and Performance Improvement (QAPI) Program- Governance and Leadership policy, last revised March 2020, directed the Administrator, Director of Nursing Services, Medical Director, Infection Preventionist, and representatives from Pharmacy, Social Services, Activity Services, Environmental Services, Human Resources, and Medical Records served on the committee. The policy directed the committee met at least quarterly or more often as necessary. The facility failed to ensure their Medical Director and/or designee attended the QAA Committee quarterly meetings. This placed the residents who resided in the facility at risk for decreased quality of care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41037 The facility identified a census of 54 residents. Based on observation, record review, and interviews, the facility failed to ensure staff practiced standard infection control practices regarding appropriate cleaning and disinfecting of shared equipment and storing of clean linens, to prevent the spread of infection. This had the potential to increase the residents' risk for transmission of infectious disease. Findings included: - On 08/16/22 at 09:30 AM on the 100 hallways in the unlocked shower room, observation revealed an uncovered clean linen cart, which contained folded sheets, pillow cases and gowns, sat next to uncovered trash cans and uncovered yellow biohazard bins that contained soiled linens. On 08/16/22 at 11:46 AM R47 sat on a blue lift sling in a wheelchair in the dining room. The sling straps rested on the floor and the back of the lift sling rested on the left side of the wheelchair wheel. On 08/16/22 at 02:01 PM Certified Nurse Aide (CNA) Q and CNA N transferred R101 into bed with a Hoyer lift (total body mechanical lift used to transfer residents). After the transfer was complete CNA O placed the lift in the hallway without disinfecting the lift. On 08/17/22 at 08:06 AM Staff prepared to transfer R47 from his Broda chair (specialized wheelchair with the ability to tilt and recline) to his bed. CNA PP and CNA M completed hand hygiene, donned gloves, and removed the Hoyer Lift from R47's bathroom. CNA PP pulled the rooms privacy curtain. CNA PP positioned the Hoyer lift in front of R47's chair and attached the slings. R47 was lifted and transitioned to the bed. The sling was removed from underneath R47 and placed on his chair. CNA PP walked over to R47 and immediately began pulling off R47's pants and incontinence briefs. CNA PP cleaned R47's groin and buttocks before placing a clean incontinence brief on him. R47's pants were pulled back up and he was repositioned in bed. Both CNA PP and CNA M wore the same pair of gloves throughout the entirety of the observation and failed to change gloves or complete hand hygiene in between the care tasks. On 08/18/22 at 03:20 PM CNA O stated shared equipment should be cleaned and disinfected nightly on night shift. CNA O stated hand hygiene should be completed between cares provided to the residents and when visibly soiled. On 08/18/22 at 04:06 PM agency Licensed Nurse (LN) H stated the shared equipment should be disinfected between each use. LN H said clean linens should not be stored with or by soiled linen or trash and hand hygiene should be preformed between any care provided to the residents, going in and out of the rooms, between passing medication and when visibly soiled. On 08/18/22 at 05:17 PM Administrative Nurse D stated soiled linens should not be stored with clean linen at any time. Administrative Nurse D stated she was not sure what the facility policy directed for disinfecting shared equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Laundry and Bedding, soiled policy last revised October 2018 documented clean linen are stored separately, away from the soiled linens, always. The Facility Cleaning and Disinfection of Resident-Care Items and Equipment policy last revised October 2018 documented durable medical equipment must be cleaned and disinfected before use by another resident. The facility failed to ensure staff practiced standard infection control practices regarding appropriate cleaning and disinfecting of shared equipment and storing of clean linens, to prevent the spread of infection. This had the potential to increase the residents' risk for transmission of infectious disease.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 41037 The facility identified a census of 54 residents. Based on record review and interviews, the facility failed to ensure principles of antibiotic stewardship were followed to ensure antibiotics were used in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance in an ongoing, proactive manner. Findings included: - Review of the Infection Control Log for tracking and trending infections from March 2022 through June 2022, lacked documentation of organism identifications and the infection being treated with antibiotics. The Infection Preventionist (IP) was not available to interview. On 08/18/22 at 05:17 PM Administrative Nurse D Stated Administrative Nurse E handled the antibiotic stewardship. The facility Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes policy last revised December 2016 documented antibiotic use and outcome data would be collected and documented on a facility approved antibiotic surveillance tracking form. The data would be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide stewardship. The IP would review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. The facility failed to proactively apply the principles of antibiotic stewardship, for the residents of the facility from March through June 2022 to ensure antibiotics were administered in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41037 The facility identified a census of 54 residents. The sample included five residents reviewed for COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death) vaccination review; the facility had no current COVID-19 positive residents. Based on record reviews and interviews, the facility failed to offer and administer or obtain a signed declination for the COVID-19 booster vaccination for Resident (R) 2. This deficient practice had the risk for unwarranted complications related to COVID-19 and the risk to spread illness and infection to the residents. Findings included: - R2 was admitted to the facility 03/21/18. R2's Immunizations tab recorded R2 received the first dose of the two-shot COVID-19 vaccination on 08/05/21 and the second dose on 08/26/21 . R2's clinical record lacked documentation the COVID-19 booster vaccination was offered. Review of R2's Electronic Medical Record (EMR), lacked evidence of a signed declination or consent for COVID-19 booster vaccination. Upon request, the facility was unable to provide a signed consent or declination for COVID-19 vaccination for R2. On 08/18/22 at 10:52 AM R2 stated he asked for the COVID-19 booster and was told by the staff he was not eligible. On 08/17/22 at 11:50 AM R2 laid in bed on his left side facing the wall. He appeared to be resting comfortably and without signs of distress. The Infection Preventionist (IP) was not available to interview. On 08/18/22 at 05:17 PM Administrative Nurse D Stated Administrative Nurse E handled the COVID-19 vaccination. The facility did not provide a COVID-19 vaccination policy. The facility failed to offer and administer or obtain a signed declination or consent for COVID-19 booster vaccination for R2. This deficient practice had the risk for unwarranted complications related to COVID-19 and the risk to spread illness and infection to the residents.