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	175499	A. BUILDING _____ B. WING _____	C 12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT MISSION	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00176685 #KS00176696, #KS00176697. #KS0076616, #KS00176544, and #KS00176497. The 2567 was sent electronically on 01/10/23.	F 000		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in	F 626		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/10/2023

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§ 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 36 residents. The sample included four residents reviewed for admissions, discharge and transfers. Based on record review and interviews, the facility failed to permit Resident(R)1 to return to the facility after a hospitalization while his appeal was ongoing. This placed R1 at risk for impaired ability to receive his required care and services.

Findings included:

- R1's Electronic Medical Record (EMR) listed diagnoses of: left sided hemiparesis and hemiplegia following a cerebral vascular accident (limited or total immobility of ones left side caused by a stroke, lack of blood flow to the brain), neuralgia/neuritis (severe pain due to damaged nerves that causes severe burning pain), and chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs).

The "Quarterly Minimum Data Set" (MDS) assessment dated 10/19/22 documented the resident had a Brief Interview for Mental Status score of 13 which indicated R1's cognition was intact. The assessment recorded R1 was incontinent of bowel and bladder, had upper and lower extremity impairment on one side, and required extensive to total assistance with most

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activities of daily living (ADLs). The assessment documented R1 did not have a discharge plan and made no requests to discuss discharging from the facility.

R1's "Care Plan" dated 10/26/22 recorded R1 wished to stay in the skilled nursing facility and the anticipated length of stay was simply stated "long term care."

Review of R1's EMR recorded R1 paid privately for facility services since 06/01/21

R1's EMR recorded a "Social Services Progress Note" dated 06/10/22 at 12:33 PM which documented R1's responsible party was informed that referrals were sent to several other communities due to R1's non- payment. The note documented R1 understood.

Review of R1's paper file revealed documentation of a letter from the facility given to R1, and forwarded to R1's responsible party and the State Long Term Care Ombudsman (LTCO). The letter was dated 10/21/22 and documented the facility's intent to transfer/discharge the resident on 11/21/22 due to failure to pay for services after a reasonable and appropriate notice to pay. Continued review revealed a document dated 10/25/22 from the Kansas Office of Administrative Hearings noting receipt of a request for a fair hearing (appeal) on the matter of the involuntary discharge due to non payment. R1's paper file revealed other documents which noted the sending of pre-hearing questionnaires and a video pre-hearing conference scheduled for 12/06/22 at 11:00 A.M.

A "Progress Note," dated 11/28/22 at 01:06 PM

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documented: R1 was transferred to the hospital for a skin condition with bleeding.

A "Discharge Plan, Instructions and Recapitulation of Stay" dated 11/28/22 , located in the EMR under the assessments tab, was incomplete, and just noted the resident was transferred to the hospital. R1's vital signs and R1's personal belongings remained in R1's room.

A "Social Services Progress Note" dated 11/28/22 at 03:42 PM recorded a Transfer/Discharge and bed hold was sent with R1 and mailed to R1's representative.

A "Progress Note," dated 12/03/22 at 02:30 PM documented R1 returned from R1's hospital stay.

A late entry "Progress Note," dated 12/04/22 at 05:06 PM, documented R1 was sent out due to a change in his level of consciousness, fatigue, inability to stay awake, fever, facial grimace, and grunting.

On 12/09/22 "Complaint Intake KS00176697" recorded Social Work Consultant II reported to the State Agency (SA) that R1 admitted to the acute care hospital on 12/05/22 for sepsis (the body's extreme response to an infection). When Consultant II attempted to arrange R1 to readmit to the facility, the facility told Consultant II an involuntary discharge notice was issued in October 2022 and the facility would not allow R1 back to the facility.

Interviewed on 12/27/22 at 09:53 AM, Administrative Nurse D verbalized she did not know R1's whereabouts. Administrative Nurse D stated she last heard R1 was at the hospital and

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the facility was not allowing R1's return due to the facility was unable to care for R1. Administrative Nurse D was unable to say what cares R1 needed that the facility was unable to provide. Administrative Nurse D stated R1 returned on Saturday, 12/03/22. He was very ill and continued to worsen and was then sent back to the hospital. Administrative Nurse D stated there were multiple concerns from R1's family and R1 had a fall in July (2022) and since then, the facility was unable to meet R1's needs. There was a hearing scheduled for 12/06/22, but Administrative Nurse D did not know if this was conducted. R1 had been given a thirty-day discharge notice prior to hospitalization. Administrative Nurse D confirmed the notice of involuntary discharge was given on 10/21/22 with a discharge date of 11/21/22.

Interviewed on 12/27/22 at 11:58 AM Social Services Designee (SSD) X stated she was not involved with the notifications of involuntary discharge; those were provided by Administrative Staff A and the business office. SSD X stated Administrative Staff A was in communication with R1 and his family. SSD X called a representative at the hospital and was informed R1 was admitted to another long-term care facility.

On 12/27/22 Administrative Staff A was not available for interview.

The facility did not provide a policy related to resident's transfers and/or discharge.

The facility failed to permit R1 to return to the facility after hospitalization while his appeal was ongoing. This placed R1 at risk for impaired ability to receive his required care and services.

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included four residents at risk for non-pressure related skin issues. Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice which included consistent and accurate assessment of the skin when Resident (R)1 developed an abscess or lesion (damage or abnormal change in the tissue of an organism, usually caused by disease or trauma) on R1's genitals. This deficient practice placed the resident at risk for delayed identification and treatment and related complications. Findings included: - R1's Electronic Medical Record (EMR) listed diagnoses of: left sided hemiparesis and hemiplegia following a cerebral vascular accident, (limited or total immobility of ones left side caused by a stroke, lack of blood flow to the brain), neuralgia and neuritis, (severe pain due to damaged nerves that causes severe burning pain) and chronic obstructive pulmonary disease, (COPD- a chronic inflammatory lung disease that	F 684		

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causes obstructed airflow from the lungs).

The "Quarterly Minimum Data Set" (MDS) assessment dated 10/19/22 documented the resident had a Brief Interview for Mental Status score of 13 which indicated R1's cognition was intact. The assessment recorded R1 was incontinent of bowel and bladder, had upper and lower extremity impairment on one side, and required extensive to total assistance with most activities of daily living (ADL). The assessment documented R1 was at risk for pressure ulcers but had no pressure ulcers at present. The MDS documented moisture associated skin damage (MASD) but no open lesions, venous stasis ulcers and/or surgical wounds and R1 received pressure reduction cushions, medications and ointments as prevention.

The " ADL Care Area Assessment (CAA)" dated 05/22/22 documented R1 required nearly total assistance with ADLs, was evaluated as a poor candidate for rehabilitation, but would be periodically re-screened for decline and/or potential gains. The CAA for pressure ulcers recorded R1 had no pressure injuries.

R1's "Care Plan" dated 10/26/22 recorded a potential for impairment to skin integrity related to incontinence and decreased mobility and directed staff to administer treatments as ordered and monitor for effectiveness. The "Care Plan" lacked any specific information in any area (i.e. ADL, urinary incontinence, nutrition) to address any recent lesions, abscess, or other areas of concern with R1's skin.

The "Physicians Order Sheet" (POS) documented an order dated 07/04/22 for Xarelto

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(anticoagulant medication used to treat and prevent blood clots) tablet 15 milligrams (mg) 1 tablet by mouth one time a day for blood clot prevention. This medication was discontinued on 11/30/22.

Review of the R1's most recent weekly skin assessment dated 11/13/22 documented: scarred pink tissue on R1's left and right buttocks from old wounds. The weekly skin assessment lacked any other skin disruptions.

R1's clinical record lacked evidence the facility performed a skin assessment between 11/13/22 and the 11/28/22 (15 days).

A "Progress Note," dated 11/28/22 at 01:06 PM documented R1 was found in bed by an aide, and when the aide went to do a brief change, R1's brief was soaked in blood; R1 was last changed four hours previous at 06:00 AM. R1's pad inside the brief, and the brief, were soaked with blood. R1 was transferred to the hospital and Consulting Practioner HH and R1's family were notified.

A subsequent "Progress Note," dated 11/28/22 at 03:48 PM documented the resident's hospital transfer was due to an excessive amount of blood in his brief from skin area on the scrotum.

The hospital "Discharge Summary" dated 12/03/22 documented R1 was brought from the nursing home on 11/28/22 with a left scrotal injury with bleeding. R1 was on Xarelto and bleeding persisted despite dressings at the nursing home. In the emergency room a sacral (tailbone) ultrasound showed a lesion to R1's left inferior scrotum. R1's scrotum did not bother him

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however it had recurrent bleeding. Urology (physician specializing in study of the urinary system) was consulted and performed a skin tag removal and suturing of the wound on 12/02/22.

Interviewed on 12/27/22 at 02:33 PM, Administrative Nurse D stated she was unaware of any skin lesions until 11/28/22 when the resident presented with a skin tag or something and it bled and the resident was hospitalized. Administrative Nurse D stated she believed the nurse applied a pad inside the brief due to the bleeding but it soaked through the pad. Administrative Nurse D acknowledged the documentation of R1's wound was a poor description and lacked documentation of any potential cause. Administrative Nurse D stated since October 2022 some staff had to be let go and the interdisciplinary team (IDT) identified problems with skin assessments in the Quality Assurance Performance, Improvement meetings. Administrative Nurse D stated a performance improvement plan (PIP) was being developed to address this issue.

During a telephone interview on 12/27/22 at 03:30 PM, R1's representative acknowledged being notified on 11/28/22 of R1's bleeding and subsequent hospitalization.

The facility's "Skin Checks" Policy" revised 03/2022 documented the staff nurse or wound care nurse will implement weekly skin checks, for all residents; The nurse will assess the individual residents skin from head to toe to determine if there are any new or additional skin issues present; Any new wounds and or skin conditions will be assessed by the nurse finding the wound or skin issue; and the nurse will also pass

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F 684	Continued From page 9 information on in report and add information to the communication board for continued monitoring and follow-up. . The facility failed to provide treatment and care in accordance with professional standards of practice which included consistent and accurate assessment of the skin when R1 developed an abscess or lesion on his genitals. This deficient practice placed the resident at risk for delayed identification and treatment.	F 684		