STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 19016 Based on interview and record review, the facility failed to ensure a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, Form CMS-10055) was provided for two of two residents (Residents #75 and #89) who resided at the facility, to inform them that skilled services may not be paid by Medicare, Part A; the amount of their potential financial liability if they decided to continue to receive services; and applicable claim appeal rights. The facility census was 112 residents. Review of the facility's SNF Liability Notice Policy, dated 1/1/18 and revised 1/9/25, showed: -If the facility believes during a resident's stay that Medicare will not pay for skilled nursing or rehabilitative services the facility will notify the resident/legal representative in writing and explain: --Why specific services may not be covered. --The beneficiary's potential liability for payment for non-covered services. --The beneficiary's right to have a claim submitted to Medicare and standard claim appeal rights that apply if the claim is denied by Medicare. -This notice will be fulfilled by use of the SNF ABN (Form CMS - 10055). The facility: --Must keep a copy of the SNF ABN, Form CMS-10055 on file. --Must file a claim when requested by the beneficiary. --May not charge the resident for Medicare covered Part A services while a decision is pending. 1. Review of Resident #75's SNF Beneficiary Notification Review form showed: -The resident's last expected covered day for Medicare Part A services was 10/16/24. The resident had benefit days remaining for the year. -The facility initiated the discharge from Medicare Part A services and the resident continued to reside in the facility. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation the resident was asked if they wanted to continue services or that a SNF ABN was provided to the resident or representative. 2. Review of Resident #89's SNF Beneficiary Notification Review form showed: -The resident's last expected covered day for Medicare Part A services was 10/31/24. The resident had benefit days remaining for the year. -The facility initiated the discharge from Medicare Part A services and the resident continued to reside in the facility. -There was no documentation the resident was asked if they wanted to continue services or that a SNF ABN was provided to the resident or representative. 3. During an interview on 1/9/25 at 11:14 A.M. the Administrator said: -A former Social Services Associate (SSA) was responsible for providing beneficiary notices for residents ending Medicare Part A services and had benefit days remaining. -The former SSA never let anyone know he/she had questions related to the notices and didn't realize he/she needed to present the SNF ABN notice to residents who remained in facility after Medicare Part A services were expected to end. -The SNF ABN notices were never provided for Residents #75 or #89 and there was no documentation they were asked if the residents wanted to continue services. During an interview on 1/13/25 at 10:47 A.M. SSA A said: -He/She and the previous SSA were responsible for presenting the Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123 and the SNF ABN, Form CMS-10055 to residents when Medicare, Part A was no longer expected to pay for services and there were benefit days remaining. -A SNF ABN form was supposed to be provided when the resident continued to stay in the facility. -The previous SSA, who had provided Residents #75 and #89 with beneficiary notices, had not worked very long at the facility and was trained by a Social Worker who was now retired. -He/She wasn't aware the previous SSA hadn't provided the SNF ABN form as required. During an interview on 1/13/25 at 1:35 P.M. the Administrator said the SNF ABN was required when Medicare Part A services were expected to end and the resident continued to reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on interview and record review, the facility failed to review and revise a resident's person-centered care plan when it failed to address a pressure injury (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for one sampled resident (Resident #18) out of 23 sampled residents. The facility census was 112 residents. Review of the facility's policy, Care Plan-Baseline and Comprehensive revised 1/3/23, showed: -The comprehensive assessment and resulting care plan were completed through work of an interdisciplinary care plan team. -The Minimum Data Set (MDS- A federally mandated assessment instrument completed by facility staff for care planning) nurse (Registered Nurse (RN)/Licensed Practical Nurse (LPN)) facilitated the care plan decision making. -The care plan would include conditions that affected the resident's health and safety, which included, but were not limited to alterations in skin. -The comprehensive care plan needed to be updated as problems, interventions, and goals changed for the resident. -The charge nurse updated the care plan in the Electronic Medical Record (EMR) after acute events, including, but not limited to, alterations in skin and new diagnosis. -The care plans were to be individualized to each resident's health status. -The care plans were to be accurate regarding a resident's health status. 1. Review of Resident #18's quarterly MDS dated [DATE], showed: -The resident was readmitted to the facility on [DATE]. -The resident had moderate cognitive impairment. -The resident had a Stage III pressure injury (a full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling). -The resident was at risk for pressure injuries. Review of the resident's care plan dated 5/8/24 to present, showed: -The resident had a diagnosis of pressure injury to his/her left buttock, stage III. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a diagnosis of pressure injury to his/her right buttock, stage III. -Note: The resident's pressure injuries were not addressed on his/her care plan as a problem nor did the pressure injuries have goals or interventions. During an interview on 1/8/25 at 11:35 A.M., the resident said he/she believed he/she had pressure injuries on his/her bottom. During an interview on 1/13/25 at 10:44 A.M., Certified Nurse Assistant (CNA) A said the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) were responsible for updating a resident's care plan when needed. During an interview on 1/13/25 at 11:48 A.M., the MDS Coordinator said: -Everyone was responsible for updating a resident's care plan when needed. -The facility wound nurse was responsible for ensuring that a resident's pressure injury was on his/her care plan. -A resident's care plan should reflect a pressure injury and be updated when a pressure injury was found on a resident, as soon as possible. During an interview on 1/13/25 at 12:00 P.M., LPN A said: -The MDS Coordinator was responsible for updating a resident's care plan when needed. -A resident's care plan needed to reflect if a resident had a pressure injury. -A resident's care plan should be updated if a resident acquired a new pressure injury. -The nurses looked at a resident's care plans when performing treatments on a resident's pressure injury. During an interview on 1/13/25 at 12:12 P.M., facility wound care nurse said: -The resident did have pressure injuries on his/her buttocks area. -The MDS Coordinator was responsible for updating a resident's care plan when needed. -Pressure injuries should be addressed on a resident's care plan. -He/she was unaware of the facility's policy on the time frame to address a pressure injury on a resident's care plan. During an interview on 1/13/25 at 1:33 P.M., the Administrator said: -If a pressure injury was found by a nurse, that nurse would be responsible for updating a resident's care plan to address the pressure injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she would expect a resident's pressure injury to be addressed on his/her care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on observation, interview, and record review, the facility failed to ensure respiratory equipment such as Continuous Positive Airway Pressure (CPAP - a method of noninvasive ventilation assisted by a flow of air delivered at a constant pressure throughout the respiratory cycle) masks were cleaned and stored in a sanitary condition for one sampled resident (Resident #18); and failed to ensure respiratory face masks and tubing were kept covered when not in use for one sampled resident (Resident #412) out of 23 sampled residents. The facility census was 112 residents. A CPAP equipment storage policy was requested by the facility and not provided. Review of the facility's policy titled Oxygen Administration reviewed on 7/24/24 showed: -The oxygen cannula/mask should be stored in a plastic bag when not in use. -Oxygen supplies were replaced weekly (every seven days). Label and date supplies. 1. Review of Resident #18's admission Minimum Data Set (MDS- A federally mandated assessment instrument completed by facility staff for care planning) dated 1/26/24, showed: -The resident had moderate cognitive impairment. -The resident was using a CPAP machine on admission to the facility and while a resident at the facility. Review of the resident's care plan dated 5/8/24 to present showed: -The resident had a diagnosis of Obstructive Sleep Apnea (a condition that occurs when the airway becomes narrow as the muscles relax during sleep which reduces oxygen in the blood and causes arousal from sleep). -The resident was unable to maintain his/her oxygen saturation levels while sleeping and used a CPAP machine. Observation on 1/8/25 at 11:37 A.M. showed: -The resident's CPAP machine and mask were laying on his/her dresser. -The CPAP mask was not covered. During an interview on 1/8/25 at 11:40 A.M., the resident said: -He/she used the CPAP machine at night. -He/she never recalled the staff placing the CPAP mask in a bag when not in use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/9/25 at 10:51 A.M., showed: -The resident's CPAP machine and mask were laying on his/her dresser. -The CPAP mask was not covered. Observation on 1/13/25 at 10:35 A.M., showed: -The resident's CPAP machine and mask were laying on his/her dresser. -The CPAP mask was not covered. During an interview on 1/13/25 at 10:44 A.M., Certified Nursing Assistant (CNA) A said: -The charge nurse was responsible for storing the CPAP machine and mask when not in use in a resident's room. -He/she was unaware of the proper storage policy for CPAP equipment and mask but he/she believed the mask was supposed to be stored in a plastic bag. During an interview on 1/13/25 at 12:00 P.M.,Licensed Practical Nurse (LPN) A said: -The charge nurses were responsible for proper storage of CPAP mask and equipment when not in use in a resident's room. -CPAP masks were supposed to be stored in a plastic bag when not in use. During an interview on 1/13/25 at 1:33 P.M., the Administrator said: -The staff that removed a resident's CPAP mask was the one responsible for the proper storage of the mask when not in use. -He/she would expect that a CPAP mask that was in a resident's room and not in use be stored in a plastic bag. 51303 2. Review of Resident #412's Face Sheet showed he/she was admitted on [DATE] with diagnoses that included: -Pulmonary embolism (a blockage in a lung artery caused by a blood clot that travels from another part of the body). -Pneumonia (inflammation of one or both lungs with consolidation). -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Emphysema (a chronic lung condition that damages and enlarges the lungs' air sacs, causing breathing difficulties. -Acute and chronic respiratory failure, (a situation where a patient with a pre-existing chronic respiratory condition like emphysema experiences a sudden and significant worsening of their breathing difficulties often triggered by an acute event like an infection) with hypoxia (the absence of enough oxygen in the tissues to sustain bodily functions). Review of the resident's care plan dated 12/17/24 showed: -The resident was unable to maintain oxygen saturation above 92% and required oxygen therapy with interventions to include: --Administer oxygen therapy as ordered. --Change tubing weekly and as needed. --Check/fill humidifier if present. --Observe for signs of breathing difficulty, irregular breathing pattern, high respiratory rate, low oxygen saturation, dusky color, cool/moist skin. --Report abnormal findings to physician as indicated. Review of the resident's admission MDS dated [DATE] showed: -He/She was cognitively intact. -He/She was receiving oxygen. Review of the resident's Physician Order (PO) listing dated January 2025 showed: -Keep tubing off the floor. -Oxygen at 2 liters per nasal cannula (NC) continuous. -Oxygen at 2 to 4 liters per minute per nasal cannula as needed for shortness of breath. Observation on 1/7/25 at 12:14 P.M. showed: -The resident was up in his/her recliner with the oxygen on at 2 liters per NC. -The oxygen tubing was lying on the floor. -The nebulizer mask was on the heat register and not bagged. Observation on 1/9/25 at 10:38 A.M. showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was in his/her recliner with eyes closed and oxygen was noted on at 2 liters per NC. -The oxygen tubing was on the floor. -The nebulizer mask was at the bedside not bagged. -The nebulizer bag was dated 1/1/25. Observation on 1/9/25 at 11:51 A.M. showed: -The resident was out of his/her room. -The nebulizer mask was on the heat register not bagged. -The nasal cannula tubing was bunched up under the handle of the concentrator and not bagged. Observation on 1/13/25 at 8:59 A.M. showed: -The resident was resting in his/her recliner with oxygen on at 2 liters per NC. -The nebulizer mask was open to air and lying on the heat register. -The oxygen tubing and plastic bag for the NC was on the floor. -The oxygen tubing for supplement oxygen tank on the back of the wheelchair was in a bag dated 1/2/25. --NOTE: This was more than seven days. Observation on 1/13/25 at 12:44 P.M. showed: -The resident was up in his/her recliner with oxygen on at 2 liters per NC. -The oxygen tubing and storage bag were on the floor. During an interview on 1/13/25 at 12:07 P.M. LPN B said: -Oxygen was an order and only nurses change the tubing and were responsible to bag when not in use. -Oxygen storage was the responsibility of the nurse. -CNA's do not touch the respiratory tubing. -Tubing or respiratory bags found on the floor would be changed with new tubing/bag. During an interview on 1/13/25 at 1:33 P.M. the Administrator said: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The staff member that removed the oxygen tubing or nebulizer mask was responsible for placing it in the bag. -Oxygen tubing and nebulizer mask(s) were to be stored in a dated zip lock bag when not in use. -Respiratory tubing/equipment was changed weekly and as needed. -The night shift supervisor was responsible for the weekly change of respiratory tubing and dated the bags. -He/She expected if oxygen tubing or the bag was on the floor it would be changed out for new tubing and bag. -The night shift supervisor was responsible to audit oxygen tubing was changed weekly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51305 Based on observation, interview, and record review, the facility failed to ensure infection control standards of practices including hand hygiene were incorporated during wound care for one sampled resident (Resident #77); and failed to ensure Enhanced Barrier Precautions (EBP-strategy to decrease transmission of infections and/or cross-contamination during high-contact care activities for residents in nursing homes that include wearing gowns, gloves and at times a face mask) were used for one sampled resident (Resident #19) with a Foley catheter (a tube with retaining balloon passed through the urethra into the bladder to drain urine) out of 23 sampled residents. The facility census was 112 residents. Review of the facility's Hand Hygiene policy review dated 2/19/2024 showed: -Proper hand hygiene is used for the prevention of transmission of infectious diseases. All healthcare personnel are required to perform hand hygiene in accordance with Centers for Disease Control and prevention (CDC) recommendation. -Reduce transmission of organisms from resident to resident, resident to staff, staff to resident. -All associates are required to perform hand hygiene by using alcohol-based hand rub or wash with soap and water for the following: --Immediately before touching a resident/patient. --After touching a resident/patient or the residents /patients immediate environment. --Before and after using gloves. --When going from a soiled body site to a clean body site on the same patient. Review of the facility's policy Infectious Disease-Precautions dated 10/3/24, showed: -The facility would ensure that the resident/associate environment remains as free of communicable/infectious disease as possible. -EBP was a strategy to reduce the spread of Multi-Drug Resistant Organisms (MDRO- microorganism that are resistant to multiple classes of antibiotics and antifungals). -EBP required the use of a gown and gloves for certain residents during high contact care activities. -Residents with indwelling medical devices (Foley catheters) should be placed on EBP during high contact resident care activities. -High contact resident care activities included care or use of urinary catheters. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #77's Admission Record showed the resident was admitted on [DATE], with the following diagnoses: -An unstageable pressure injury (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) of the right heel. -Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 7/18/24 showed the resident: -Had Dementia. -Was at risk for pressure injury. -Had an unstageable pressure injury. -The resident was severely cognitively impaired. Review of the resident's Physician Order Sheet (POS) dated 1/9/25 showed: -New pressure injury to the right heel. --Monitor for heel suspension boots or bunny boots being placed on the resident's feet at all times. -New pressure injury to his/her right lateral foot. -New pressure injury to his/her left medial foot. -Pressure injury on the resident's right heel apply Santyl (an ointment used to remove damaged tissue from chronic skin ulcers) and cover with silver alginate and an abdominal (ABD) pad then wrap, daily until the wound had healed. -Deep tissue injury (a type of pressure injury that occurs when soft tissue is damaged by pressure or shear forces. It can appear as a discolored area of skin, a blood-filled blister, or a combination of both) to the left medial foot. Apply skin prep to intact skin, cover with an ABD pad then wrap, daily until the wound had healed. -Deep tissue injury to the right lateral ankle that had opened. Apply Santyl cover with silver alginate and an ABD pad, daily until the wound had healed. -Traumatic injury to his/her right knee. Apply Santyl cover with a dry 2x2 gauze. Apply skin prep around the wound and secure the dressing with foam tape, daily until the wound had healed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Care Plan dated 1/9/25 showed: -The resident was at risk for skin problems. -He/she had acquired a Stage III (a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure injury on his/her right heel. -He/she had acquired a laceration to his/her right lower leg. Observation on 1/13/25 at 9:06 A.M. showed Registered Nurse (RN) B: -Set up wound care supplies on a table with a barrier, including scissors. --The scissors were not cleaned prior to putting them on the table. -Put on a gown. -Entered the resident's room and washed his/her hands. -Put a trash bag into the trash can. --Did not wash or sanitize his/her hands. -Put on gloves. -Placed a barrier under the resident's feet and legs. -Removed the resident's bunny boots. -Removed dressings from the resident's right knee. --Did not wash or sanitize his/her hands. -Removed the ACE wrap from the resident's left leg. -Cut the old dressing off of the resident's left leg. --Did not wash or sanitize his/her hands. --Did not sanitize the scissors. -Removed the ACE wrap from the resident right leg. -Cut the old dressing off of the resident's right leg. --Did not wash or sanitize his/her hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Did not sanitize the scissors. -Obtained a package of sanitary wipes, opened the package and removed a wipe, wet it and applied soap. -Washed the resident's left and right leg and right knee with the wipe. -Obtained a new wipe and again wet it with water. -Wiped off the resident's left and right leg and right knee with the wipe. -Removed gloves, washed his/her hands and put on new gloves. -Applied skin prep around the resident's right knee wounds, applied Santyl and silver alginate then covered with gauze pad and foam tape. --Removed his/her gloves, put hand in his/her pocket to obtain the keys to the treatment cart, opened the resident's room door, obtained more supplies from the treatment cart, closed the resident's door and placed the supplies on the table. ---Did not wash or sanitize his/her hands, put on new gloves. -Applied Santyl and silver alginate to the resident's right ankle and heel wounds then covered them with a gauze pad, ABD pad and wrapped the resident's right leg with gauze wrap and then the ACE wrap. --Did not wash or sanitize his/her hands. ---Moved the table with his/her gloved hands and then continued with wound care with the same gloves on. -Applied skin prep to the resident's left ball of foot under the great toe covered with an ABD pad and wrapped the resident's left leg with gauze wrap and then the ACE wrap. -Removed the barrier from under the resident's feet and legs. -Put the bunny boots back on the resident. -Put all unused supplies on the top of the treatment cart. --Did not sanitize the scissors and put the back into the treatment cart. During an interview on 1/13/25 at 11:58 A.M. RN B said: -He/she had not had any in servicing on wound care. -He/she worked with the Nurse Practitioner every 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
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In service meetings could have happened when he/she had not been in the facility. -Meetings were conducted once a week to discuss resident wounds. -He/she should have washed his/her hands before working with the resident after touching the trash can. -He/she should have washed his/her hands between wounds. -He/she should have washed his/her hands after they had been soiled by touching objects in the room including the table and door and after putting his/her gloved hand into his/her pocket to get the treatment cart key to get more supplies. -He/she should have washed his/her hands before putting on gloves, and with glove changes. -He/she had training within the year about EBPs. During an interview on 1/13/25 at 12:19 P.M., RN A said: -Hands should be washed before working with a resident, between residents, and when going from a dirty to clean area. -Hands should be washed before wound care, before applying any ointments, and with glove changes. -Hands should be washed between different wounds. -Hands should be washed if they have been soiled. -In service meetings were held every few months. -Hand hygiene had been covered in the computer training's. -The manager would come by and have educational training talks with them every few months about different topics and he/she would sign a document stating they have discussed it. -Enhanced barrier precautions and transmission-based precautions were covered in the computer training's and the manager would discuss them. During an interview on 1/13/25 at 1:33 P.M., the Administrator said: -He/she expected staff to follow the hand washing policy. -He/she expected staff to wash their hands before providing wound care services. -He/she expected staff to wash their hands between wounds if the resident had multiple wounds. -He/she expected staff to wash their hands as much as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she expected staff to wash their hands every time they were soiled. 51150 2. Review of the Resident #19's admission MDS dated [DATE], showed: -The resident was admitted to the facility on [DATE]. -The resident was cognitively intact. -The resident had an indwelling Foley catheter. During an interview on 1/9/25 at 10:59 A.M., the resident said: -The staff changed his/her Foley catheter the previous evening. -The staff did not wear a gown while changing his/her Foley catheter the previous evening. -He/she was unaware if staff wore a gown during other previous catheter changes or cares. Observation on 1/13/25 at 9:43 A.M., of Foley catheter care by Licensed Practice Nurse (LPN) B, showed: -LPN B prepared his/her supplies and entered the resident's room. -LPN B did not apply a gown before entering the resident's room. -An EBP sign was posted outside of the resident's room. -The EBP sign posted outside of the resident's room stated that staff must wear gloves and a gown when performing cares on the resident. -An EBP cart with supplies was sitting in the hallway, approximately 50 feet from the resident's room. -LPN B proceeded to complete catheter care without a gown. During an interview on 1/13/25 at 9:57 A.M., LPN B said: -He/she would not have done anything differently when performing catheter care on the resident. -He/she felt that he/she performed the catheter cares correctly and applied the appropriate infection control measures during the cares. During an interview on 1/13/25 at 10:44 A.M., Certified Nurse Assistant (CNA) A said: -If a resident had certain infections, staff members were required to use EBP when giving resident cares. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265095	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Knox Village Care Center	600 NW Pryor Road Lees Summit, MO 64081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she had not been educated by the facility about when and how to use EBP. -EBP consisted of gloves, gown, and a mask. During an interview on 1/13/25 at 12:00 P.M., LPN A said: -EBP should be used when performing cares on residents with wounds and catheters. -He/she was educated by the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on EBP procedures. -When performing catheter care on a resident, the staff member should wear gloves and a gown. During an interview on 1/13/25 at 1:33 P.M., the Administrator said: -The facility was in the new phases of planning EBP procedures. -The staff was educated on the EBP policies. -The facility was in the process of deciding exactly when EBP should be used. -He/she would expect staff to use EBP when performing Foley catheter cares on a resident. -He/she would expect staff to wear both gloves and a gown when performing catheter cares on a resident.