STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265308	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Mark Care Center	11221 North Nashua Drive Kansas City, MO 64155

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review, the facility failed to ensure one resident and/or representative of five residents (Resident (R) 78) reviewed for unnecessary medications, out of a total sample of 25 residents, was informed of the risk and benefits of a physician ordered antipsychotic medication. This failure placed the resident and/or representative at risk of not knowing the risks and benefits of the use of medications. Finding included. Review of the Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R78 was admitted to the facility on [DATE] with Alzheimer's disease and major depressive disorder. Review of an 08/02/23 Physician Order located in the Orders tab of the EMR revealed, Abilify [an antipsychotic medication used as an add-on treatment for adults with major depressive disorder] 5 mg [milligrams] at bedtime. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 09/29/23 revealed R78 had a Brief Interview of Mental Status (BIMS) of 11 out of 15 which indicated she was moderately impaired in cognition for daily decision-making and was administered an antipsychotic medication daily during the observation period. Review of the Resident Documents tab and the Nursing Progress Notes tab of the EMR did not document that R78 or her representative was informed of the risks and benefits prior to initiating a new Physician Order for the Abilify. During an interview on 04/09/24 at 8:32 AM, R78 was asked if she was aware of the Physician Order for the Abilify and why she was being administered the medication. R78 stated, When I first came here, I was pretty depressed, but I am not aware of what Abilify is for. During an interview on 04/11/24 at 1:21 PM, Unit Manager (UM) 1 was asked if there had been documentation that the risks and benefits were explained to R78 or her representative when Abilify was initiated. UM1 stated, There is no consent obtained for the use of the medication. The facility did not provide a policy.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observation, interview, and record review, the facility failed to maintain a clean and comfortable environment for one of 25 sample residents (Resident (R) 67). Findings include: Review of R67's Face Sheet, located in the electronic medical record (EMR) under the Resident tab, revealed R67 was initially admitted on [DATE] with diagnoses that included Gillain-Barre syndrome, chronic congestive heart failure, chronic obstructive pulmonary disease, major depression, anxiety disorder, and delusional disorder. Review of R67's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R67 was cognitively intact. During an observation and interview on 04/08/24 at 11:10 AM, R67 was observed in bed. The sliding door track was observed to have a heavy build-up of dirt and grime and there were four small black ants roaming from the door to under the bed. The head of the bed was observed to be raised at an approximate 80 degrees angle which allowed for observations of the floor under the bed and the bed frame. There was a heavy build-up of dirt and dust in the corner of the room, under the bed, and dirt on the bed frame. R67 stated, They clean, but it could be better, the door is dirty on the floor. They're good here. I do spill things, because I'm weak, shaky. During observation of R67's room on 04/09/24 at 9:14 AM while R67 had a visitor, the room remained in the same condition with the dirt and dust. During a telephone interview on 04/09/24 at 3:10 PM, R67's family member (F2) stated, I have seen a few ants, the room could be cleaned better. I have no idea when an exterminator comes. During an observation on 04/11/24 at 11:18 AM, R67's floor had dirt, dust, and debris under the bed, a heavy buildup of dirt and debris in the track of the sliding glass doors, and three ants crawling on the floor next to the sliding glass door. During an interview on 04/11/24 at 8:55 AM, the Administrator stated she was unaware of the ants in R67's room. The Administrator stated, the exterminators currently come every other week and every week in the late spring and summer. During an interview on 04/11/24 at 12:55 PM, the Activity Director (AD), overseeing the housekeeping staff, stated, we do spring cleaning, take the blinds down, steam clean, clean refrigerators, and move the furniture. We haven't started that yet. The AD stated, we have to be sensitive to [R67's] wishes as she does not want the housekeepers to do too much. When asked if there was a care plan to address R67's wishes and the need to clean the room, the AD said, no, we don't have a plan. The AD said she was unaware of the ants or the dirt in the track of the sliding glass door.

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F 0600 Level of Harm - Minimal harm or potential for actual harm 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** 40902 Based on record review, interview, and policy review, the facility failed to protect the resident's right to be free from physical abuse by a resident for one resident of four residents (Resident (R) 51) reviewed for abuse out of a sample of 25 residents. R96 bit R51's arm after R51 reached for a blanket R96 was using. Findings include: Review of R96's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R96 admitted to the facility on [DATE] with diagnoses including frontotemporal neurocognitive disorder, dementia, impulse disorder, and delusional disorder. Review of R96's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/19/24 revealed a "Brief Interview for Mental Status (BIMS)" was unable to be completed due to R96 rarely being understood. Review of R96's care plan, located under the "Care Plan" tab of the EMR and dated 05/19/23, revealed "The resident has socially inappropriate/disruptive and aggressive behaviors." Interventions in place were to monitor agitation or aggression towards others, avoid over stimulation, and maintain a calm environment. Review of R51's "Admission Record," located in the "Profile" tab of the EMR, revealed R51 admitted to the facility on [DATE] with diagnoses including Alzheimer's and dementia. Review of R51's quarterly MDS" with an ARD of 03/01/24 revealed a "BIMS" was unable to be completed due to R51 rarely being understood. Review of R51's care plan, located under the "Care Plan" tab of the EMR and dated 12/04/20, revealed "The resident has potential for alteration in mood and had periods of agitation and aggression." Interventions in place were to monitor for changes in mood and behavior and observe for changes in mental status. Review of a "Nurse's Note" written by Registered Nurse (RN) 1, located in the EMR under the "Notes" tab and dated 03/21/24 at 5:50 PM, documented R51was bitten by R96 when reaching for a blanket on the couch R96 was using. R51's right forearm had teeth marks and an instant bruise but the skin was not open. The residents were separated and R96 was placed on 15-minute checks. R51 did not display signs or symptoms of pain or discomfort. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/24 at 11:48 AM, Licensed Practical Nurse (LPN) 1 stated R96 was not cooperative with care most of the time and preferred to sleep on the couch during the day. LPN1 stated if R96 saw something she wanted she would just grab it and take it; R96 would go into other resident rooms and get into their beds, and staff had to constantly watch her. LPN1 stated R96 would become combative when staff took something away from her. LPN1 stated staff tried offering her sweets and drinks and sometimes she was receptive but not always; staff tried to keep her away from other residents. LPN1 stated R96 was very unpredictable but she did not usually initiate any aggression, but she would respond if she someone approached her. LPN1 stated R96's aggression was more towards staff during care than towards residents. During an interview on 04/09/24 at 12:39 PM, Certified Medication Technician (CMT) 1 stated R96 was very difficult, and staff never knew what her behavior would be like. CMT1 said R96 bites sometimes and has tried to bite staff and bit another resident. CMT1 stated staff redirect R96 with cookies and stuff, but it did not always work. CMT1 stated R96 was usually in the television (TV) room and liked being on the couch and staff would keep an eye on her. CMT1 said R96 behaviors were usually directed at staff and did not cause issues with other residents. During an interview on 04/09/24 at 1:35 PM, Certified Nursing Assistant (CNA) 1 said R96 liked to keep to herself and spent most of her day lying on the couch in the common area/TV room. CNA1 said R96 did not eat in the dining room with the others because she got irritated fast; it took two staff to provide any care due to her behavior. CNA1 stated, on 03/21/24, she was R96 assigned CNA but was in the room with another resident when the biting incident occurred. CNA1 stated when she came out of the other resident's room, she was informed by the nurse that R96 was on 15-minute checks. CNA1 did not remember there being anything about her behavior prior to the incident occurring but thought R96 got upset since another resident touched the blanket she was using on the couch. During an interview on 04/09/24 at 1:45 PM, RN1 stated R96 did was she wanted to, and that staff tried to keep on eye on her. RN1 stated they offer her extra snacks or place her on 15-minute checks if needed to monitor her. RN1 stated she did not witness the incident on 03/21/24 but she heard someone say "Ouch" and she looked over and saw R51 leaning back up and away from R96. RN1 went over to where R96 was sitting on the couch and R51 was next to the couch in her wheelchair and observed R51 had the blanket she remembered R96 had earlier. RN1 assumed R51 took the blanket from R96, and she asked what happened and R51 said R96 bit her. RN1 stated both residents were immediately separated and R96 was placed on 15-minute checks. RN1 documented the incident and bite mark in a progress note and reported it to the night nurse, but she has not worked back at the facility since the incident occurred. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 10:16 AM, Unit Manger (UM) 1 said R96 was very mobile but did not interact verbally or socialize with other residents. UM1 stated after R96 was initially admitted to the facility in 2023 she was sent out for a psychiatric stay and returned, but it took a while for her to adjust to the facility. UM1 stated they adjusted her medications, and she started coming out of her room, her appetite improved, and she was gaining weight. UM1 stated it really feels it was such an unfortunate situation that occurred with R96 and R51. UM1 said R96 did not initiate the incident but that unfortunately when R51 came into R96 personal space R96 reacted because she was unable to respond appropriately to those types of situations. UM1 stated staff know to keep a close eye on R96, and they were to monitor R96 for any subtle changes in behavior. UM1 stated they try to keep her engaged as much as she allows, and she was and is still receiving ongoing psychiatric services. UM1 said she felt 15-minute checks were appropriate because R96 did not initiate aggression and kept to herself mainly and felt R96, along with the other residents, were safe. UM1 stated staff were always present in the common areas and monitored all the residents when they were in there. During an interview on 04/11/24 at 12:26 PM, the Director of Nursing (DON) stated they have done medication adjustments and there was a recent GDR on R96. The DON stated R96 was sent out for psychiatric evaluation again after the bite incident since she did not feel it would have been appropriate to keep her in the facility when she was displaying aggressive behaviors towards other residents. A review of the facilities policy titled "Policy / Procedure - Nursing Administrative" dated October 2023 revealed, Residents have the right to be free from mental, physical, sexual, and verbal abuse, neglect, misappropriation of property, and exploitation. This policy defines conduct that may be resident abuse, neglect, exploitation, or misappropriation of property and prohibits staff from engaging in any such conduct, as well as sets forth procedures for reporting complaints, concerns, or incidents. MO00233571

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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** 40902 Based on record review, interview, and policy review, the facility failed to report an injury of unknown origin to the State Survey Agency (SSA) and failed to report a resident-to-resident altercation to the Abuse Coordinator and the SSA within two hours for two residents out of four residents (Resident (R) 96 and R51) reviewed for abuse out of a sample of 25. Findings include: 1. Review of R96's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed admission to the facility on [DATE] with diagnoses including frontotemporal neurocognitive disorder, dementia, impulse disorder, and delusional disorder. Review of R96's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/19/24 revealed a Brief Interview for Mental Status (BIMS) was unable to be completed due to R96 rarely being understood. Review of the facility's Event Report dated 10/24/23 revealed R96 was in the television (TV) area sitting on sofa when she was noted to have small purplish bruised area below left eye. R96 was unable to state how she received the bruise and denied any pain. During an interview on 04/09/24 at 11:48 AM, Licensed Practical Nurse (LPN) 1 said she did not remember what she did when she discovered R96 had a black eye on 10/24/23 but she should have reported that it to the Director of Nursing (DON) and completed a report on it. During an interview on 04/11/24 at 12:26 PM, the DON, who shared abuse coordinator responsibilities with the Administrator, stated she could not remember R96's black eye on 10/24/23. The DON stated it should have been reported to the SSA but the facility had not reported it. 2. Review of the facility's Event Report dated 03/20/24 revealed there was an altercation at 2:30 PM. The day nurse heard the R96 call out, ouch, ouch!' loudly from the North hallway and observed another resident hitting her on the right arm 2 times as they were standing/walking. The were immediately separated, no discoloration or sign of discomfort is noted in /on her right arm. When questioned R96 gave no response and walked on up the hallway. During an interview on 04/10/24 at 1:45 PM, LPN4 said after the incident with R96 occurred she reported it to the unit manager. Review of a Nurse's Note, located in the EMR under the Notes tab written by Registered Nurse (RN) 1 and dated 03/21/24 at 5:50 PM, indicated R51 was bitten by R96 when reaching for a blanket on couch R96 was using. Review of the facility's Intake Report Confirmation dated 03/22/24 revealed the incident was reported to SSA on 03/22/24 at 8:45 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/11/24 at 12:26 PM, the DON said she was not made aware of the bite incident until the following morning, and it should have been reported to her when the incident occurred. The DON stated she was unaware that abuse incidents that did not result in a major injury were supposed to be reported within two hours and that was why the 03/20/24 was not reported until 03/022/24. A review of the facilities policy titled Policy/Procedure - Nursing Administrative dated October 2023 revealed, It is the policy of this facility to ensure that all incidents of potential abuse, neglect, exploitation or potential crimes against residents (staff-to-resident; resident-to-resident; visitor/family-to-resident; or unwitnessed injuries) that occur in the facility are reported to the [State Survey Agency (SA)] within prescribed timeframes, consistent with Section 1150B of the Act. The facility will report immediately, but not later than 2 hours after forming the suspicion of an incident that results in serious bodily injury. The facility will report all suspicions or incidents of abuse/neglect/exploitation/crimes not resulting in serious bodily injury within 24 hours. MO00233571

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and policy review, the facility failed to conduct a thorough investigation for an injury of unknown origin and a resident-to-resident altercation for two residents of four residents (Resident (R) 96 and R51) reviewed for abuse out 25 sampled residents. Failure to thoroughly investigate injuries of unknown origin and resident-to-resident altercations could place vulnerable residents at risk. Findings include: 1. Review of R96's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed admission to the facility on [DATE] with diagnoses including frontotemporal neurocognitive disorder, dementia, impulse disorder, and delusional disorder. Review of R96's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/19/24 revealed a Brief Interview for Mental Status (BIMS) was unable to be completed due to R96 rarely being understood. Review of R96's care plan, located under the Care Plan tab of the EMR and dated 05/19/23, revealed The resident has socially inappropriate/disruptive and aggressive behaviors. Interventions in place were to monitor agitation or aggression towards others, avoid over stimulation, and maintain a calm environment. Review of the facility's Event Report dated 10/24/23 revealed R96 was in the television (TV) area sitting on sofa when R96 was noted to have small purplish bruised area below left eye. R96 was unable to state how she got the bruise and denied pain. During an interview on 04/09/24 at 11:48 AM, Licensed Practical Nurse (LPN) 1 said she did not remember what she did when she discovered R96 had a black eye on 10/24/23 but she should have reported that it to the Director of Nursing (DON) and completed a report on it. During an interview on 04/11/24 at 12:26 PM, the Director of Nursing (DON) stated she could not remember R96's black eye on 10/24/23 but it should have been investigated. The DON confirmed there was no investigation, and they were not able to determine how the bruise occurred. 2. Review of R51's "Admission Record," located in the "Profile" tab of the EMR, revealed R51 admitted to the facility on [DATE] with diagnoses including Alzheimer's and dementia. Review of R51's quarterly MDS" with an ARD of 03/01/24 revealed a "BIMS" was unable to be completed due to R51 rarely being understood. Review of R51's care plan, located under the "Care Plan" tab of the EMR and dated 12/04/20, revealed "The resident has potential for alteration in mood and had periods of agitation and aggression." Interventions in place were to monitor for changes in mood and behavior and observe for changes in mental status. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Event Report dated 03/20/24 revealed there was an altercation at 2:30 PM. The day nurse heard the R96 call out, ouch, ouch!" loudly from the North hallway and observed another resident hitting her on the right arm 2 times as they were standing/walking. The residents were immediately separated, no discoloration or sign of discomfort is noted in /on her right arm. When questioned R96 gave no response and walked on up the hallway. During an interview on 04/10/24 at 1:45 PM, LPN4 said after the incident with R96 occurred she reported it to the unit manager. During an interview on 04/11/24 at 12:26 PM, the DON said she did not have an investigation into the resident-to-resident altercation or witness statements surrounding the incident. A review of the facilities policy titled Policy / Procedure - Nursing Administrative dated October 2023 revealed, all allegations, observations, or suspected cases of abuse, neglect, misappropriation of property or Exploitation, or Injuries of Unknown Sources will be thoroughly investigated by the facility. MO00233571

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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** 32513 Based on record review, interview, and facility policy, the facility failed to revise the care plan of two of 25 sampled residents (Resident (R) 66 and R55). R66 did not have a revision to the care plan for a diagnosis of Post Traumatic Stress Disorder (PTSD). R55's care plan was not updated to include the use of her specialized wheelchair. This failure created an increased risk for the residents to receive care and services not appropriate for their current clinical condition. Findings include: Review of R66's electronic medical record (EMR) Profile tab, indicated R66 was admitted on [DATE]. R66's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/02/24 revealed R66's Brief Interview for Mental Status (BIMS) score of 14 of 15 which indicated R66 was cognitively intact. Per the MDS, R66 had a diagnosis of PTSD, R66's total severity score for depression during the assessment period equaled a six out of ten score and indicated R66 had little interest or pleasure in doing things seven to eleven days; felt down, depressed, or hopeless two to six days; trouble falling or staying asleep, or sleeping too much seven to eleven days; feeling tired or having little energy two to six days during the assessment period. During an interview on 04/08/24 at 10:46 AM, R66 stated that she was feeling tired and that she was not interested in participating in activities. Review of R66's care plan with last conference date of 02/06/24, located in the EMR Care Plan tab, revealed no care plan for the diagnosis or problems related to PTSD and no interventions related to PTSD. During an interview on 04/10/24 at 12:36 PM, the Social Services Director (SSD) stated she was not aware that R66 had an added diagnosis of PTSD and that she did not write a care plan for the diagnosis. 2. Review of the Face Sheet, located in the Face Sheet tab of the EMR revealed R55 was admitted to the facility on [DATE] with Alzheimer's disease and dementia. Review of the annual MDS, located in the MDS tab of the EMR, with an ARD of 02/09/24 revealed R55 had a staff assessed BIMS score of three out of 15 which indicated she was severely impaired in cognition. Per the MDS, R55 had one-side lower extremity Range of Motion (ROM) impairment and was dependent on staff for all activities of daily living (ADLs). Review of the 05/01/20 ADLs Functional Status Care Plan, located in the Care Plan tab of the EMR and revised on 02/22/24 revealed, . Self-care deficit with self-performance of adls [sic] related to impaired mobility . An 08/17/23 Approach revealed, [R55] is leaning more in her w/c [wheelchair], lay down in the afternoons. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/08/24 at 9:08 AM, R55 was seated in a specialized wheelchair (tilt-n-space) which was tilted back in a reclining position, in the common area. R55 was not interviewable. Cross-reference F684: Quality of Care. During an interview on 04/10/24 at 10:14 AM, Licensed Practical Nurse (LPN) 3 stated, [R55's] wheelchair was provided by hospice, and she has had that specialized wheelchair for about four to six months. Review of the entire Comprehensive Care Plan, located in the Care Plan tab of the EMR did not show and update/revision to include the specialized wheelchair. During an interview on 04/10/24 at 10:45 AM, Unit Manager (UM)1 confirmed that the Care Plan had not been revised/updated to include the specialized wheelchair. Review of the facility policy titled MDS and Care Planning Guidelines, dated 10/01/15, indicated the policy of the facility was to use the most current Centers for Medicare & Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual, and any published interim RAI manual errata documents, as the authoritative guide for establishing and maintaining resident care plans that included measurable goals and time frames be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being. 36917

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observation, interview, and record review, the facility failed to ensure two residents of 25 sampled residents (Resident (R) 55 and R67) received care and treatment in accordance with professional standards of practice. The facility failed to ensure a wheelchair headrest was placed to support R55's head and that the foot pedal was applied to support her left leg. In addition, the facility failed to obtain a dermatology appointment for R67 in a timely manner, due to a skin condition that caused excessive itching. Finding included. 1. Review of the Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R55 was admitted to the facility on [DATE] with Alzheimer's disease. Review of the annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/09/24 revealed R55 had a staff assessed Brief Interview of Mental Status (BIMS) of three out of 15 which indicated she was severely impaired in cognition. Per the MDS, R55 had one-side lower extremity range of motion (ROM) impairment and was dependent on staff for all activities of daily living (ADLs). Cross-reference: F657: Care Planning. During an observation on 04/08/24 at 9:08 AM, R55 was seating in a specialized wheelchair (tilt-n-space) which was reclined. The head rest was angled away from her head, and she was observed with her head leaning back without support while reclining. In addition, the left leg was dangling without support of the leg pedal. During an interview on 04/10/24 at 10:14 AM, Licensed Practical Nurse (LPN) 3 was told of the observations regarding R55 while in her wheelchair with the head rest and leg pedal not being utilized. LPN3 stated, I am sure it wasn't. LPN3 confirmed R55 was to have the head rest to support her head and the leg pedal to support her left leg. LPN3 further stated that hospice provided the wheelchair approximately four to six months ago and has far as she was aware. LPN3 confirmed R55's head was not being supported with the head rest. LPN3 was asked if there was a leg pedal for her left leg. She stated, Yes, it has been supported, but I don't know where it [leg pedal] was. During an interview on 04/10/24 at 10:16 AM, Certified Nursing Assistant (CNA) 2 was asked if there was a foot pedal for R55's left leg. CNA2 stated, There is supposed to be one but, I don't know where it is. CNA2 left to look for the foot pedal. At 10:30 AM, CNA2 returned with a foot pedal and applied it to the wheelchair. CNA2 stated, Night shift gets her up and they should be putting it on. CNA2 was asked when you come on shift, and you notice that the leg pedal was on her wheelchair, what do you do. CNA2 stated, It was the night shifts responsibility and I do check. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 1:47 PM, the Rehabilitation Director (Rehab D) stated, In the past we utilized the U pillow for her neck and have been working with her on loosening her neck muscles. The Rehab D was asked what her expectation was regarding ensuring the head rest and leg pedal were being utilized. The Rehab D stated, I expect that the foot pedal be on at all times when she is up in the wheelchair and the head rest is positioned behind her head. 2. Review of R67's Face Sheet, located in the EMR under the Resident tab, revealed R67 was initially admitted on [DATE] with diagnoses that included Gillain-Barre syndrome (an auto immune condition) and pruritus (itching). Review of R67's annual MDS with an ARD of 02/16/24 revealed a BIMS score of 15 out of 15, which indicated R67 was cognitively intact. During an observation and interview on 04/08/24 at 11:10 AM, R67 was observed in bed with oxygen in place. R67 stated, There's bugs in here that keep biting me, look at my chest and my back. R67's upper chest and upper back were observed to have two reddened and scabbed areas on the front and back. R67 stated, I'm not crazy, they bite me all the time, on my legs too. When asked what the bite felt like, R67 said, like a sharp prick and then itchy. Review of the Progress Notes, located under the Resident tab in the EMR, revealed a nurse's note, dated 04/05/24, which read ABT [antibiotic therapy] completed for skin infection. During an interview on 04/09/24 at 10:40 AM, R67 stated, They think I'm crazy, they want me to see a psychiatrist, I said no, I really want to see a dermatologist. R67 stated, I have not ever seen a dermatologist. I've only had this problem since I came here [facility]. During a telephone interview on 04/09/24 at 3:10 PM, R67's family member (F2) stated, I believe [R67] is being bit by bugs. F2 was unaware if R67 had seen a dermatologist. Review of the most recent Weekly Skin Assessment, located in the EMR under the Observations tab and dated 04/10/24, noted, skin is warm and dry. Continues with itchy rash areas upper arms, back, chest, buttocks, and upper thighs. The interventions and treatments was noted as N/A [not applicable]. Review of a Care Plan Progress Note, dated 02/28/24 and located in the EMR under the Resident tab, revealed Seroquel was increased on 2/11. [R67] continues with delusions of thinking she has bugs or lice on her skin & will scratch self, causing sores and scabs, on Hydroxyzine [an antihistamine to relieve itching] for itching. Review of the Progress Notes, located in the EMR under the Resident tab, revealed a nurses' note dated 03/10/24 which read, The resident C/O [complains of] itch on her right shoulder. I assessed her noting red scabbed/rash area on the right shoulder, on the upper back, neck, a few on the left shoulder, and left arm. She states, 'I want to see a dermatologist.' She has a history of skin/rash issues. The information is put on the 24 hour nursing report to contact Nurse Practitioner and a note is on Dr. [doctor] list. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 1:43 PM, the Assistant Director of Nursing (ADON) confirmed R67's skin concerns. The ADON was not aware R67 had requested to see a dermatologist on 03/10/24. The ADON stated, I thought they had discussed that on one of her recent hospitalization s for upper respiratory care, but was unaware of the outcome. There were no orders obtained for a dermatologist appointment as of 04/10/24 at the time of survey. On 04/10/24 at 3:20 PM, the ADON accompanied the surveyor to R67's room to discuss her skin concerns and request to see a dermatologist. R67 stated last night was really bad, the itch, all over my legs, I couldn't sleep. R67 denied ever seeing a dermatologist at the hospital or the facility. During an interview on 04/11/24 at 9:36 AM, the Social Service Director (SSD) stated, [R67] has a long-standing concern with her skin. Staff have not been able to determine that she is being bitten by bugs. I offered for her to visit with a psychiatrist, and she adamantly refused. The SSD was unaware of R67's request to have an appointment with a dermatologist. 32513

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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. 32513 Based on observation, interview, record review, review of the facility policy, the facility failed to ensure one of four residents (Resident (R) 34) reviewed for range of motion (ROM) limitation out of 25 sample residents received appropriate services to increase her ROM and/or prevent a decrease in her ROM. This failure placed the resident at risk for increased contractures and a diminished quality of life. Findings included. Review of the Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R34 was admitted to the facility 03/11/21 with diagnoses that included a stroke with right-sided hemiplegia (paralysis on one side of the body) and cerebral palsy. Review of the quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 03/15/24 revealed R34 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated she was cognitively intact for daily decision-making and did not receive restorative therapy. Per the MDS, R34 had functional limitations in range of motion on one side for both the upper and lower extremities. Review of the Pain Care Plan, located in the Care Plan tab of the EMR revealed, Potential alteration in comfort r/t [related to] right hand contracture, hx [history] of back pain. A 12/29/23 approach included, [R34's] right hand is contracted, keep washcloth in palm as tolerated. The Comprehensive Care Plan did not show any additional problems/goals or approaches for the the right hand and foot contractures. During an interview on 04/08/24 at 10:58 AM, R34 was observed seated in her wheelchair in the common room. R34's right arm was bent at the elbow with her forearm on her chest. R34's right hand was contracted with her fingers closed around a washcloth. R34's right foot was angled inward. R34 stated she was able to propel her wheelchair with her left foot. R34 was asked if she received exercises for her hand and foot to prevent decline in her contracture. R34 stated, No, I don't receive any exercises, but I would like to. During an interview on 04/10/24 at 2:00 PM, the Assistant Director of Nursing (ADON) was asked if R34 was on a restorative program. She stated, We do not have [R34] on a restorative program. All we have is for the nurses to put the washcloth in her hand. During a follow-up interview on 04/11/24 at 8:30 AM, the ADON was asked if there was a nurse who was responsible for the restorative program. The ADON stated, No, it's mostly the nurses in leadership. The ADON was asked if leadership had determined if R34 had declined or improved in the ROM. The ADON stated, I have not assessed her, I would assume the 'MDS' nurse would assess the contractures. The ADON further stated, To the best of my knowledge [R34] has not been assessed for (restorative) exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 04/11/24 at 8:42 AM, the MDS Coordinator (MDSC) was asked if she had assessed R34's contractures during the observation period for improvement or decline. The MDSC stated, I only document that she has the contractures, I don't assess. Review of an undated facility policy titled, Criteria for RNA [restorative nurse aid] program, revealed, . The RNA program is a means of providing restorative treatment to those residents identified as . resident who exhibit a potential for decline . Residents are referred to RNA services when they are in need, but not necessarily limited to, the following: contracture management . Referrals to the RNA program may be made by nursing, PT [physical therapy], OT [occupational therapy], ST [speech therapy], and physicians, as well as through the MDS process, CNA [certified nursing assistant], and family/resident input .

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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** 32513 Based on observation, interview and record review, the facility failed to ensure one of two residents (Resident (R) 44) reviewed for respiratory care out of 25 sampled residents received care consistent with professional standards of practice. The facility failed to ensure R44's nebulizer tubing and pipe were placed into a covered bag to minimize spread of pathogens. This failure placed R44 at risk for infection. Findings included. Review of the Face Sheet located in the Face Sheet tab in the electronic medical record (EMR) revealed R44 was admitted to the facility on [DATE] with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD). Review of a 10/19/23 Physician Order located in the Orders tab of the EMR revealed, Ipratropium-albuterol [DuoNeb-a medication used to aid in shortness of breath] 0.5mg [milligrams]-3mg (3 ml) per nebulized inhalation four times a day. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/16/24 revealed R44 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15 which indicated R44 was moderately intact in cognition. Review of the 08/17/23 Respiratory Care Plan revealed, respiratory distress r/t [related to] acute respiratory failure, COPD, and recurrent aspiration pneumonia AEB [as evidenced by] need for use of oxygen at night. An 09/11/23 Approach revealed, Provide nebulizer treatments, inhalers. During an observation on 04/08/24 at 9:25 AM, revealed an oxygen concentrator next to his bed. There is a nebulizer machine observed on his bedside table and the pipe and cannister was laying on the table without a barrier and not inside a bag. During an interview on 04/10/24 at 12:38 PM, Licensed Practical Nurse (LPN) 3 stated, Nebulizer masks and pipes are to be bagged when not in use. LPN 3 confirmed the R44's nebulizer mask was not bagged. A policy for storing respiratory equipment was requested but not provided.

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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** 32513 Based on interview, record review, and review of facility policy, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS-a test that rates involuntary muscle movements on residents who are administered antipsychotic medications) assessment for one resident (Resident (R) 78) and failed to have a stop date and diagnosis for use of an as needed (PRN) psychotropic medication for one resident (R59) out of five residents reviewed for unnecessary medications in a total sample of 25 residents. This failure placed residents at risk for unrecognized side effects and a diminished quality of life. Findings included. 1. Review of the Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed, R78 was admitted to the facility on [DATE] with Alzheimer's disease, dementia, and major depressive disorder. Review of an 08/02/23 Physician Order located in the Orders tab of the EMR revealed, Abilify [an antipsychotic medication used as an augmentation with an antidepressant medication] 5 mgs [milligrams] at bedtime. Review of the AIMS assessment, located in the Observations tab of the EMR revealed the assessment was not performed upon initiating the antipsychotic medication but not until 09/28/23 (57 days later.) Review of a 2023 MatrixCare Observation Guide provided by the Director of Nursing (DON) revealed, Form: AIMS-Abnormal Involuntary Movement Scale . Discipline: Nursing . Timeframe: At admission, readmission, and quarterly if resident has orders for psychotropic medication . Activation Date; 11/2/2014. Review of the quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 09/29/23 revealed R78 had a Brief Interview of Mental Status (BIMS) score of 11 out of 15 which indicated she was moderately impaired in cognition and was administered antipsychotic and antidepressant medications daily during the observation period. Review of the 10/21/23 Psychotropic Medication Care Plan, revealed, High risk for adverse reactions noted r/t [related to] use of psychotropics d/t [due to] dx [diagnosis] of depression, insomnia, & Hallucinations. A 10/21/23 approach revealed, Administer Psychotropic medications as ordered: Abilify, started on 8/2/23 for Hallucinations. During an interview on 04/11/23 at 11:18 AM, Unit Manager (UM) 1 was asked if an AIMS assessment had been done when the Abilify was initiated. UM 1 stated we do them quarterly and September was on her quarterly cycle but not at the time the medication was started. UM 1 was asked to provide an AIMS assessment for the previous quarter. No assessment was provided to the survey team prior to exit. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the Face Sheet located in the Face Sheet tab of the EMR revealed R59 admitted to the facility on [DATE] with diagnoses that included stroke and diabetes. Review of an 03/08/24 Physician Order located in the Orders tab of the EMR revealed, Lorazepam [an antianxiety medication] 0.5mg PRN-open ended for discontinue date and no diagnosis for the use of the medication. Review of a significant change MDS, located in the MDS tab of the EMR, with an ARD of 03/14/24 revealed, R59 had a staff assessed BIMS score of two out of 15 which indicated she was severely impaired in cognition. Review of the April 2024 Medication Administration Record (MAR) revealed the Lorazepam order date was changed to 04/10/24 however, there was no diagnosis listed for the use of the medication. During an interview of 04/11/24 at 8:55 AM, Licensed Practical Nurse (LPN) 3 was asked about the Physician Order for the Lorazepam dated, 03/08/24 without an end date listed. LPN3 stated, I was not aware that hospice medication for psychotropics, like Lorazepam, needed an end date. LPN3 was asked why the Physician Order for Lorazepam did not have a diagnosis for the use of the medication. LPN3 stated, I wasn't aware of this. LPN3 was asked why the order was changed on 04/10/24 and was this due to a new Physician Order. LPN 3 stated, No, I just changed it because it needed to PO [by mouth]. LPN3 was asked if the pharmacist had addressed this issue with R59's Lorazepam. LPN3 stated, It's not in the pharmacy book for physician review. During an interview on 04/11/24 at 9:06 AM, the Consultant Pharmacist stated, I became aware of the physician order for the Lorazepam did not have an end date on 04/02/24. I wrote up a recommendation for the facility to obtain an end date for the medication. The Pharmacist was asked if she was aware, when she reviewed the medication order, that there was no diagnosis for the use of the medication. She stated, Yes, I fight with hospices all the time about this. There is a diagnosis for palliative care though. The Pharmacist was asked if palliative care is adequate diagnosis for the use of a psychotropic. She stated, No, it's not. Review of the undated facility policy titled, Pharmacy Consultant Expectations Policy & Procedure Related to Unnecessary Drug Use, revealed, . Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for its use, or in the presence of adverse consequences which indicate the dose should be reduced . PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure an insulin pen was removed from one medication cart after 28 days for one of 18 Kwik pens (Resident (R) 46) that were observed for open date and expiration date on three of three nurse medications. This failure to ensure insulin pens were removed from the medication cart timely, placed the resident at risk for receiving ineffective medication and health complications. Findings included: During an observation with Registered Nurse (RN) 3 on [DATE] at 3:08 PM, the 200 Hall nurse medication cart revealed three Kwik pens. Review of R46's Kwik pen revealed an open date of ,d+[DATE], and the expiration date was smudged as not to be legible. RN3 was asked when was the last time R46 had received insulin from this Kwik pen. RN3 stated, On [DATE] when his blood sugar was 375. RN3 confirmed the Kwik pen was expired. Review of the Physician Orders located in the Orders tab of the electronic medical record (EMR) revealed the following insulin order. Humalog Kwik Pen U-100 (insulin lispro-short-acting insulin) give four units, subcutaneous if BS (blood sugar) was greater than 300. During an interview on [DATE] at 8:27 AM, the Director of Nursing (DON) was asked what her expectation was regarding expired insulin Kwik pens. The DON stated, My expectation is that insulin pens be removed from the cart and not given if they are expired. Review of the manufacturer's website Humalog.com revealed, . Opened Humalog prefilled pens must be thrown away 28 days after first use, even if they still contain insulin . Review of an undated policy titled, Medication Storage, revealed, . No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. All such drugs must be returned to the issuing Pharmacy or destroyed in accordance with established guidelines.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38517 Based on observation, interview, and facility policy review, the facility failed to ensure air vents were clean, stored food was dated after opening and sealed from contamination, and staff wore hair restraints while in the kitchen. This had the potential to affect 98 of 99 residents who resided in the facility and consumed food prepared from the facility's kitchen. Findings include: 1. During an initial tour of the kitchen on 04/08/24 at 8:40 AM, with the Dietary Director (DD), the following observations were made: Walk-in Freezer and kitchen: a. One large clear bag, containing pork sausage links, was observed open and undated. b. One bag of pepperoni with saran wraps around the outside was observed open and undated. c. One large bag of frozen cheese raviolis was observed undated. d. One large box of turkey breakfast sausage was observed open and exposed to the air. e. Two large clear bags of French toast were observed undated. f. One large clear bag of tater tots was observed undated. g. One large clear bag of shredded hash brown, was observed undated. Walk-in Refrigerator and kitchen: h. One large bag of lettuce mix was observed undated. g. Three bags of 2 pounds of liquid eggs were observed undated. i. Ten-pound buckets of hard cooked eggs were observed with the top open and exposed to the air. Three air vents above the kitchen entrance appeared visibly dirty with thick dust particles attached to it. Three air exhaust system vents above the exit back door appeared dirty with visible dust particles on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/08/24 at 8:40 AM, DD stated the air exhaust system was to keep the bugs out of the kitchen when the door was opened. DD stated the system was visibly dirty with visible dust particles on it. DD stated maintenance was responsible for cleaning the system. DM stated the dirty vents could contaminate the food coming in and out of the kitchen. DD stated their expectation was for all items to be labeled and dated as needed. DD stated all dietary staff were responsible to ensure food items were labeled with a visible open date and food delivered should be kept in its original box which was dated on the outside. for items to stored, labeled, and dated appropriately. During an interview on 04/09/24 at 12:41 PM, Maintenance Staff (MS) stated he was not aware of the vents being dirty in the kitchen until today by DD. MS stated he was not aware of who was responsible for cleaning the vents. During an interview on 04/09/24 at 12:44 PM, the Administrator stated she expected dietary staff to notify them directly if things such as the vents needed to be cleaned. The Administrator stated she expected the vents in the kitchen to be cleaned at least monthly. The Administrator stated the vents being dirty could contaminate food with dirt particles. Review of the facility's policy titled Storage of Dry Food and Supplies, dated May 2015, revealed The Dietary Department will store dry food and supplies according to facility guidelines and state regulation. 2. During a follow-up tour of the kitchen on 04/08/24 at 12:10 PM, Dietary Staff (D1) was observed on the food serving line plating food without a beard restraint. D1 was observed with a full beard that appeared about 1 inch long. During an interview on 04/08/24 at 12:14 PM, DD stated their expectation was for staff to wear beard restraints the whole shift unless they go outside of the kitchen for break. During an interview on 04/09/24 at 11:05 AM, D1 stated they removed their beard restraint on 04/08/24 due to being unable to breath with it on. D1 acknowledged they were supposed to wear the beard restraint at all times to prevent hair contaminating the food. Review of the facility's policy titled Dietary Personnel Guidelines, dated May 2015 revealed 4. Hairnets or bouffant disposable caps should be worn at all times and should cover the entire head of hair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265308	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Mark Care Center	11221 North Nashua Drive Kansas City, MO 64155

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 38517 Based on observation and staff interview, the facility failed to ensure the reach-in refrigerator was properly maintained. This had the potential to affect 98 of the 99 residents who consume food from the kitchen. Findings include: 1. Observations during the tour of the kitchen on 4/08/24 at 8:40 AM revealed the reach-in refrigerator had a leak that resulted in about an inch of water holding at the bottom of the refrigerator. There was a cookie sheet with several condiments on it on the bottom shelf, the water was almost to the rim of the cookie sheet. There were several boxes of Jello that were visibly wet from the leak. The water was extending onto the floor when the doors were opened. 2. Observations during the tour of the kitchen on 04/09/24 at 10:54 AM revealed the reach-in refrigerator continued with the water build-up on the bottom shelf, one thick slice of cheese wrapped in saran wrap observed submerged in the water. Dietary Staff (DS) 2 was immediately interviewed. DS2 said that the reach-in freezer had been leaking for at least 6 months, and that the water would sometimes leak onto the floor. During an interview on 04/09/24 at 12:41 PM, Maintenance Staff (MS) stated he became employed with the facility February 19, 2024. MS stated they had logbooks kept at each nursing station so items that needed attention could written down. MS stated the logs were checked daily. MS stated he was notified about the refrigerator leaking today from the Administrator. During an interview on 04/09/24 at 12:44 PM, the Administrator stated they had been without a Maintenance Director for a few weeks now and she was the acting director. The Administrator stated they were notified yesterday by the DD that the snack refrigerator was leaking. The Administrator stated there were two maintenance books, one at each unit (1 & 2) and they should be reviewed daily by maintenance staff. The Administrator stated she expected dietary staff to notify them directly if things such as the refrigerator was broken. Record Review of the Maintenance Repair Log revealed on 08/10/23 there was standing water underneath cooler unit on the right side of the 2-door reach in refrigerator in the kitchen. The log did not indicate that the issue was repaired. During an interview on 04/10/24 at 9:44 AM, the DD said the facility had a visit from the state in August 2023 which they indicated the refrigerator should be fixed. The DD stated they did not get a violation it was just left as a concern and that was when they wrote the repair notice on the repair log.