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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 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** 42955 Based on interview, and record review, the facility failed to ensure two sampled residents (Resident #508) were free from abuse when on 6/2/24 Resident #507 hit Resident #508 which resulted in Resident #508 having an injury to his/her bottom lip and a bruise over the left eye out of 19 sampled residents. The facility census was 115 residents. The Administrator was notified on 6/7/24 of the past noncompliance which began on 6/2/24. The facility completed education on resident abuse and interventions for all staff and residents. The deficiency was corrected on 6/4/24. Review of the facility's Abuse and Neglect policy, undated, showed: -Each resident had the right to be free from abuse, neglect, misappropriation resident property, and exploitation. -This included, but was not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint. -Resident's must not be subjected to abuse by anyone including other residents. 1. Review of Resident #508's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 3/21/24, showed the resident was severely cognitively impaired. Review of the Resident #508's face sheet, undated, showed the resident diagnoses included: -Dementia (loss of memory, language, problem-solving and other thinking abilities), cognitive communication deficit (difficulty expressing thoughts and ideas), and generalized muscle weakness. Review of Resident #508's care plan, dated 12/23/23, showed: -The resident had impaired cognitive ability and though processes related to dementia. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #508's Preadmission Screening and Resident Review (PASRR, DA-124C - a required form to be submitted for any resident who requested admission to a Medicaid certified bed regardless of the resident payment source; this included dually certified beds both Medicare and Medicaid) dated 2/23/24, showed: -The resident was diagnosed with anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress). -The resident exhibited moderate abnormal thought processes. -The resident required a secure unit for safe wandering. Review of Resident #507's quarterly MDS dated [DATE], showed: -The resident was severely cognitively impaired. -The resident was severely cognitively impaired without behaviors. Review of Resident #507's face sheet, undated, showed the resident was diagnosed with: -Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), -Cognitive communication deficit. -Generalized muscle weakness. Review of Resident #507's care plan dated 5/8/24, showed: -The resident had the potential to be physically aggressive related to dementia (loss of memory, language, problem-solving and other thinking abilities). -Interventions included: --Providing coloring sheets. --Placed on 1:1 observation. --Monitor and report any signs or symptoms of posing danger to self or others. --Take outside when possible. --Turn on music when resident was anxious. --Lab draws to rule out infection. -The resident had impaired cognitive ability/thought processes related to dementia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included: --Administer medications as ordered. --Ask yes/no questions. --Cue, reorient and supervised as needed. Review of Resident #508's Physical Aggression Received form, dated 6/2/24, showed: -The resident was in his/her wheelchair in the dining area. -Resident #507 tried to sit on the resident. -The resident put his/her hands up to stop Resident #507 from sitting on him/her. -Resident #507 turned around and hit the resident causing a scratching on the lip which was treated with a cold wet cloth. -As a result, the resident slid out of his/her wheelchair. -The resident was transported to the emergency room for evaluation. Review of Resident #507's Physical Aggression Initiated form, dated 6/2/24, showed: -The resident was trying to sit on Resident #508. -Resident #508 told him/her no. -The resident turned around and hit Resident #508 in the face and mouth. -The resident hit Resident #508 again which caused him/her to slide out of wheelchair. -The resident was unable to give a description of why or what happened. -There were no predisposing environmental factors. -The predisposing physiological factors included confusion and impaired memory. Review of the facility's incident investigation, dated 6/2/24, showed: -On 6/2/24 at approximately 1:30 P.M. the Director of Nursing (DON) was notified of an altercation between Resident #507 and #508. -Certified Nursing Assistant (CNA) A was interviewed and reported he/she was assisting another resident and upon coming down the hall he/she saw Resident #507 attempting to sit on Resident #508's lap with Resident #508 saying 'No' and Resident #507 striking Resident #508. CNA A was unable to get to the residents quick enough to stop the incident but did remove Resident #507 from the area. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA C was interviewed and reported he/she was at the nurses station speaking to Certified Medication Technician (CMT) A regarding residents' medications. CNA C looked up and saw Resident #507 strike Resident #508 and saw Resident #508's wheelchair roll back, and the resident slid to the floor. He/she immediately went to intervene. -CMT A was at the nurses station documenting when he/she saw Resident #507 trying to sit on Resident #508's lap. Resident #508 said 'No' and began to stand up and Resident #507 struck Resident #508 in the face. CMT A said it happened very quickly and he/she was unable to get to the residents in time to stop the situation. -Immediate action taken: --Resident's separated. --Resident #507 was placed on 1:1 observation until sent to emergency room (ER) for evaluation. -Resident #508 was transported to the ER for evaluation of injuries. -Root cause analysis: --Resident #507 had a history and was care planned for mood problems related to heightened startled response. --Due to Resident #507 being startled when Resident #508 said 'No', Resident #507 reacted by striking Resident #508. -It was determined that Resident #507 was not attempting to hurt Resident #508 and responded only due to being startled. During an interview on 6/6/24 at 10:10 A.M., Certified Nurses Assistant (CNA) A said: -He/She was helping another resident and, on the way back down the hall he/she was coming around the nurse station and saw Resident #507 try to sit on Resident #508. -Resident #508 was sitting at the lunch table. -Resident #507 was in the dining room also. -Resident #507 approached Resident #508 and tried to sit on his/her lap, Resident #508 put his/her hands up and said No, then Resident #507 turned around and closed fist hit Resident #508. -He/She saw Resident #507 hit Resident #508 one time. -He/She dropped everything and ran over there. -He/She redirected Resident #507 and CNA C helped Resident #508. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She took Resident #507 to their room and asked him/her what happened and why he/she hit Resident #508 and he/she said he/she didn't know why. -Resident #508 was confused and asked what he/she did to get hit. During an interview on 6/7/24 at 8:19 A.M., CNA C said: -He/She was standing at the nurses station talking to CMT A about resident medications and scheduling dinner and showers and planning the evening. -He/She saw resident #507 moving to sit on resident #508. -He/She went to help separate them by taking resident #507 away and walked down the hall with resident #507. During an interview on 6/7/24 at 11:06 A.M., CMT A said: -He/She was sitting at the desk charting when Resident #508 and Resident #507 were in the middle of the dining room. -Resident #507 was trying to sit on Resident #508 and Resident #508 said no no no -CNA C told Resident #507 that they cannot sit on Resident #508. -Resident #507 turned around to walk away, turned back again and started hitting Resident #508 in her face. -CNA A was in the dining room and was able to intervene first. -He/She thought Resident #507 was going to hit the aide. -Resident #507 hit Resident #508 which caused Resident #508's to bleed. During an interview on 6/7/24 at 3:07 P.M., the Administrator said: -The facility investigation showed Resident #507 hit Resident #508 in the face when Resident #508 startled Resident #507. -He/She did not believe the incident was defined as abuse. MO00237042 MO00237029

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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** 37576 Based on interview, and record review, the facility staff failed to ensure the safe storage and accountability of a resident's narcotic medication (controlled substance medications that can cause physical and mental dependence) card by failing to verify and sign for the delivery of medications to the East Nurses Station resulting in the missing of 30 tabs of Oxycodone HCL (Hydrochloride) (a narcotic pain medication) 10 milligrams (mg) for one sampled resident (Resident #500) out of three sampled residents. The facility census was 116 residents. The Administrator was notified on 6/7/24 of the past noncompliance which began on 5/11/24. The facility in-serviced all nursing staff on the facility drug diversion policy. The deficiency was corrected 5/29/24. Review of the facility's policy from the pharmacy titled Skilled Nursing Facility Pharmacy Services and Procedures Manual dated January 2022 showed: -Facility staff should sign the delivery log as proof of delivery before pharmacy delivery representative leaves facility. -Once received by facility staff, medical record documents should be separated by room number and collated according to facility room number and name. -Facility should store controlled substances in a separate compartment within the locked medication carts and should have a different key or access device. -Facility should ensure that controlled substances are only accessible to licensed nursing, pharmacy, and medical personnel designated by facility. -After receiving controlled substances and adding to inventory, facility should ensure that controlled substances are immediately placed into a secured storage area (i.e., a safe, self-locked cabinet, or locked room, in all cases in accordance with applicable Law). 1. Review of Resident #500's Admission Record showed he/she was readmitted on [DATE] with the following diagnoses: -Acquired absence (amputation) of right leg below knee. -End stage renal disease (ESRD-The kidneys have stopped working well enough to survive without dialysis or a kidney transplant). -Dependence on renal dialysis (process of cleansing the blood by passing it through a special machine - necessary when the kidneys are not able to filter the blood). Review of the resident's Physician's Order Summary (POS) dated June 2024 showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oxycodone HCL tablet 10 mg give one tablet by mouth (PO) every four hours as needed (PRN) for pain rated 4-6 related to other chronic pain dated 2/8/2024. Review of the pharmacy pink delivery manifest sheet dated 5/11/23 and signed by RN B showed: -Two narcotic medications filled from the pharmacy on 5/11/24 at 3:39 P.M. including Oxycodone Immediate Release 10 mg, 30 tabs for Resident #500. -RN B did not check mark either medication as received. Review of the facility's investigation of the drug diversion dated 5/13/24 - 5/17/24 showed: -Registered Nurse (RN) B signed for a narcotic that pharmacy reported sent and facility unable to locate on evening shift Saturday May 11, 2024. -RN B said he/she signed for a blue bag from pharmacy and did not open it and locked it in his/her cart. -A copy of the pharmacy's pink delivery receipt signed by the driver showed: --Two narcotic medications filled from the pharmacy on 5/11/24 at 3:39 P.M. including Resident #500's 30 tablets of Oxycodone 10 mg. --The pharmacy driver signed but did not date or time when delivered. -A copy of the pharmacy's pink delivery receipt signed by RN B showed: --Two narcotic medications filled from the pharmacy on 5/11/24 at 3:39 P.M. including Resident #500's 30 tablets of Oxycodone 10 mg. --RN B signed and dated as received on 5/11/24 at 9:25 P.M. --RN B did not check mark each medication to verify the delivery matched the delivery receipt and that each medication was received in the delivery. -A copy of the pharmacy's shipment summary. --Delivered to the facility on [DATE] at 9:33 P.M., and signed by RN B. -The former Director of Nursing's (DON) statement of incident dated 5/13/24 showed: --Licensed Practical Nurse (LPN) A reported a full card of Resident #500's Oxycodone Immediate Release was missing. --The former DON checked every card from pharmacy, each med room, each unit, and each shred box but was unable to locate the narcotic card. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--RN B, who signed the pharmacy sheet for the medication on 5/11/24, was immediately suspended and taken off the schedule pending investigation. --He/She spoke with pharmacist who reported that the narcotic could have been delivered in a blue bag instead of red bag. --Red bags are used for narcotic delivery. --RN B reports that he/she signed for a blue bag from pharmacy Saturday evening and put it in his/her cart because he/she was busy. --Blue bag location unknown after that. -Nursing staff educated to open all packages from pharmacy to ensure no narcotics are in a blue bag and to ensure they are reading the pharmacy delivery sheet that they sign when accepting medications. -RN B's statement dated 5/13/24 no time noted showed: --It was an extremely busy evening. --He/She was trying to finish glucometer scans. --The delivery driver came up to him/her and he/she had to stop what he/she was doing. --He/She did not count the bag of meds. --He/She put them in the second drawer on the right side of the cart until he/she could get them put away. --He/She did not remember anything unusual about the evening except being so busy. Review of the in-service on signing in medications and narcotics from the pharmacy was given by the Pharmacy's General Manager on 5/29/24 showed 15 nursing staff attended. During an interview on 6/5/24 at 11:40 A.M., CMT C said: -When a new narcotic medication comes from the pharmacy, it comes with a narcotic count sheet. -The count sheet is put into the narcotic book under the resident's name. -The count sheet shows the date the medications were delivered at the top left hand. -The pharmacy delivers medications during the 3-11 evening shift. Review of resident #500's Oxycodone Immediate Release 10 mg narcotic sheets on 6/5/24 at 11:50 A.M., showed no documentation of a narcotic count sheet delivered on 5/11/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 11:55 A.M., LPN C said: -When pharmacy delivers medications, the person receiving verifies and signs that it is correct. -A nurse or a CMT can receive and sign for medications. -The receiving staff should open the package of medications when it comes and count with the pharmacy delivery person to be sure all medications and counts are correct. -Receiving staff should count all medications no matter what color bag they come in. -Staff put the narcotic medications in the front of medication locked box in the cart so the next shift sees they are there. -The staff receiving new narcotic medications counts them with the next on-coming staff. -Narcotics come just one card per narcotic per resident and all go into the medication cart lock box. -Put the narcotic medication cart in the medication cart lock box and put the count sheet in the narcotic book. -All narcotic medications come with a count sheet with the amount on the card. -The count sheet shows the date the medications were delivered on the top of it. During an interview on 6/5/24 at 2:11 P.M., RN B said: -He/She worked the evening shift which was 3:00 P.M. to 11:00 P.M., on the East side 200 hall. -The pharmacy delivery person walked up to him/her with a blue bag that medications come in. -He/She knew he/she didn't have time to count medications and looked down 400 hall on the other side of the nurse's station to see if that nurse was in sight to take the delivery. -He/She did not see anyone. -He/She took the bag and looked the delivery person in the eye and told him/her I'm going to have to trust you I don't have time to check them off. -The blue bag usually does not have narcotics in them. -He/She put the bag in the third drawer of the medication cart and locked it. -The delivery person handed him/her the paper to sign as to what was delivered. -He/She did not look at or read the delivery sheet, he/she just signed the paper. He/She did not verify with the pharmacy delivery person the medications that were received in the delivery bag. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had never accepted any pharmacy deliveries before without opening the bag and counting to verify what was delivered before signing. -Medication deliveries were always correct in the past. -Protocol was to always count what was delivered and put medication in the med cart and the count sheet in the narcotic book. -If do not have time to put all medications away after verifying medications are correct with pharmacy, put them in the locked narcotic box until have time to put in right spot for each resident and papers in the book. -Around 11:00 P.M., he/she took the blue bag from the medication cart and put the one medication card away. -He/She did not remember what the medication was or if it had a naroctic sheet. -He/She had no idea that there was supposed to have been a narcotic card that was not there. -He/She did not verify the medication with the shipping manifest. -Counted after 11:00 P.M., with the oncoming nurse and everything was correct at that time. -The next day a CMT, believes it was CMT E, was working with him/her and went to give a resident, believes it was for resident #500, pain medication and there was no narcotic pain medication for the resident. -The CMT called the pharmacy to reorder the narcotic and the pharmacy said it had already been delivered. -The pharmacy said he/she was the person who signed for the delivery of the medications. -The former DON came in and they started looking through the medication carts, treatment carts, and everywhere and the missing medication was not found. During an interview on 6/6/24 at 9:28 A.M., the Pharmacy General Manager said: -All drug deliveries to facilities have a manifest that prints out on a pink sheet for controlled substances. -The controlled drugs go into a red sealed bag. -When the driver gets to the facility, he/she scans it by phone as delivered to the facility. -The nurse opens the sealed bag and verifies the delivered medications by checking each drug in the bag and signing the copy of the manifest in the bag. -Each drug on the manifest has a check box to be checked by receiving nurse. (continued on next page)

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