| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265355 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/09/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Life Care Center of Grandview | 6301 East 125th St Grandview, MO 64030 |

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F 0644

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579

Based on interview and record review, the facility failed to coordinate assessments with the Pre-Admission Screening and Resident Review (PASARR - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) program under Medicaid (a joint federal and state program that gives health coverage to some people with limited income and resources ) which ensures appropriate placement of residents with known or suspected of having mental impairments when the staff failed to refer one sampled resident (Resident #48) with a newly diagnosed mental disorder to a level two review out of 23 sampled residents. The facility census was 115 residents.

Review of a facility policy titled Pre-admission Screening Assessment Resident Review, reviewed 9/2023, showed:

-A negative level one screening permitted an admission to proceed unless a possible serious mental disorder or intellectual disability arose later.

-Any resident with a new or possible serious mental disorder or related condition must be referred, by the facility, to the appropriate state-designated mental health or intellectual disability authority for review.

1. Review of Resident #48's Admission Record showed:

-An admitted [DATE].

-A diagnosis of schizophrenia (a serious mental disorder that affects a person's ability to think, feel and behave clearly) with an onset date of 1/17/24.

-A diagnosis of vascular dementia (brain damage caused by multiple strokes).

Review of the resident's Level One Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability or Related Condition dated 1/16/24 showed the resident did not have a current, suspected or history of a major mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) including schizophrenia on this date.

(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 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's medical record showed no documentation of a Level II evaluation or a referral/notification to the appropriate state-designated agency for review.<br><br>During an interview on 5/6/24 at 10:00 A.M., the Social Services Director said he/she would expect an evaluation to be completed to determine if the resident needed a Level II PASARR after the new diagnosis of schizophrenia on 1/17/24 to ensure the resident's needs could be met by the facility.<br><br>During an interview on 5/7/24 at 12:24 P.M., the Regional Director of Nursing said a facility social worker should have been doing all PASARR coordination around the time of the resident's admission and that he/she would have expected a follow up to be conducted after the residents new diagnosis of schizophrenia. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469<br><br>Based on interview, and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASARR - a federally mandated program that requires all states to prescreen all people regardless of payer source or age seeking admission to a Medicaid certified nursing facility) for one sampled resident (Resident #5) out of 23 sampled residents. The facility census was 115 residents.<br><br>Review of the facility PASARR policy last reviewed on 9/25/23 showed:<br><br>-The facility will ensure that potential admissions are screened for possible serious mental disorders or intellectual disabilities and related conditions.<br><br>-The Level I PASARR will be completed prior to admission to the facility.<br><br>1. Review of Resident #5's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:<br><br>-Depression.<br><br>-Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs(an abnormal high level of activity or energy).<br><br>-Dementia (a group of thinking and social symptoms that interferes with daily functioning).<br><br>Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 1/16/24 showed:<br><br>-He/She was originally admitted to the facility on [DATE].<br><br>-He/She was most recently admitted to the facility on [DATE] following many admissions to the hospital.<br><br>-He/She had dementia.<br><br>-He/She had depression.<br><br>-He/She had bipolar disease.<br><br>Review of the resident's medical record on 5/2/24 at 10:57 A.M. showed no documentation a Level I PASARR had been completed.<br><br>During an interview on 5/2/24 at 2:07 P.M. the Social Service Director said:<br><br>-He/She could not find a PASARR for the resident.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Should be done within 72 hours of admission.<br><br>-The Social Worker should have done it.<br><br>-The nurses could have done it.<br><br>During an interview on 5/3/24 at 1:27 P.M. Social Service Assistant said:<br><br>-This resident's PASARR was not done.<br><br>-A PASARR should have been completed before or as soon as the resident came into the facility.<br><br>-Some of the PASARRs were not done or were not completed.<br><br>-A copy of the PASARR should have been downloaded into the resident's computer chart.<br><br>During an interview on 5/7/24 at 12:25 P.M. the Director of Nursing (DON) said:<br><br>-PASARR should have been completed at the time of admission.<br><br>-The Social Worker should have been responsible for ensuring the PASARR was completed.<br><br>-The facility was without a Social Worker for about a month.<br><br>-The MDS Coordinator was now assisting the Social Worker to ensure that all of the residents had a PASARR.<br><br>-This one was missed. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955<br><br>Based on observation, interview and record review, the facility failed to provide continuity of resident care by not reviewing and revising resident comprehensive care plans (a document that specified health care and supported needs and outlined how the facility met resident requirements) for two sampled residents (Resident #114 and Resident #9) out of 22 sampled residents and three closed records. The facility census was 115 residents.<br><br>Review of the facility's Care Planning-Baseline, Comprehensive and Routine Updates policy, dated 1/4/24, showed:<br><br>-The comprehensive care plan included a problem/focus statement, measurable goals, and interventions.<br><br>-The comprehensive care plan must be updated with each Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) and periodically.<br><br>-Care plans defined the resident's problems, risks, and issues.<br><br>-Care plans clearly stated the resident's issues and psychosocial strengths, problems, needs, deficits, and concerns.<br><br>1. Review of the Resident #114's annual MDS dated [DATE], showed:<br><br>-The resident scored a zero on the Brief Interview for Mental Status (BIMS-an assessment tool that showed a score between zero and 15 which showed the resident's mental status. This tool helped determine the resident's attention, orientation, and ability to register and recall new information. These items were crucial factors in care planning decisions).<br><br>--This showed the resident was severely cognitively impaired.<br><br>Review of the resident's progress notes, showed:<br><br>-On 1/5/24 the Care Management team noted the resident was resistant to engaging with therapy.<br><br>--The resident was provided encouragement several different ways at different times of the day.<br><br>--The resident reported he/she did not need therapy.<br><br>--The resident had minimal appetite.<br><br>Review of the resident's care plan, dated 1/16/24, showed:<br><br>-No risks, problems, issues, concerns, or deficits related to care, medication and treatment refusals were noted on the electronic care plan.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -A paper copy of the care plan was requested and not received.<br><br>Review of the resident's progress notes, showed:<br><br>-On 1/18/24 the resident had a severely poor appetite for several days.<br><br>--He/She had increased confusion and complained of generalized pain.<br><br>--He/She completely refused to eat or drink.<br><br>-On 1/17/24 the family was informed the resident continued to not eat and spit out his/her medication.<br><br>-On 1/24/24 the resident refused his/her morning medication and breakfast. Staff and family attempted to feed resident. Resident spit out food on the floor. The nurse practitioner was notified.<br><br>--The resident refused care, refused most oral intake.<br><br>-On 1/23/24 The resident refused to eat dinner or drink any fluids. When Certified Nursing Assistant (CNA) attempted to feed the resident he/she tried to knock the food out of the CNA's hand.<br><br>--Attempted to give resident morning medication with breakfast. Resident refused breakfast and morning medication.<br><br>--The resident took off his/her gown.<br><br>--The resident was combative with staff changing him/her.<br><br>-On 1/25/24 the resident refused to eat dinner or drink fluids.<br><br>--The resident's family stated that the resident's biggest hobby was watching old western shows on TV.<br><br>--Staff reported no signs of depression however he/she had not been eating. --His/Her family brought in some of his/her favorite foods to eat and take his/her medications.<br><br>-On 1/26/24 The resident changed his/her brief with family present. He/she tore his/her brief up and threw it on the floor.<br><br>-On 1/31/24 The resident refused dinner and refused fluids that was offered to him/her. This nurse educated res about drinking fluids and eating.<br><br>-On 2/1/24 The resident refused to eat or drink any fluids during dinner time and refused his/her medication.<br><br>--He/She yelled at nurse and asked to leave the room.<br><br>During an interview on 5/2/24 at 1:34 P.M., Certified Medication Technician (CMT) A said:<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The nurses document resident behaviors on the Medication Administration Record (MAR)/Treatment Administration Record (TAR).<br><br>-He/She reported any unusual behaviors to the nurse.<br><br>-The care plan had behavior information on it.<br><br>During an interview on 5/2/24 at 1:51 P.M., CNA B said:<br><br>-He/She did not document any behaviors.<br><br>-He/She reported anything out of the ordinary to the nurses who put it on the MAR/TAR.<br><br>-Care plans and the Kardex (an informational filing system that was used as a quick reference for nurses) had resident information, like behaviors.<br><br>During an interview on 5/2/24 at 2:13 P.M., Licensed Practical Nurse (LPN) A said:<br><br>-The Kardex showed the resident's behaviors.<br><br>-He/She did not pull up the Kardex but stated it should have have resident behaviors on it.<br><br>-He/She documented on the MAR/TAR any abnormal behaviors or signs/symptoms of medication side effects.<br><br>-Nurses were able to update the care plan if needed.<br><br>39469<br><br>2. Review of Resident #9's Admission collection tool dated 7/27/23 showed he/she had broken teeth.<br><br>Review of the resident's Quarterly MDS dated [DATE] showed:<br><br>-His/Her BIMS score was 15 out of 15 indicating he/she was cognitively intact.<br><br>-No dental issues was checked.<br><br>Review of the resident's Care Plan dated 3/6/24 did not address the resident's broken teeth.<br><br>Review of the resident's dental visit on 3/20/24 showed:<br><br>-He/She was missing the following teeth, (1,16,17, 31, and 32).<br><br>-He/She had root tips (broken teeth) on on the following teeth, (3, 5, 8, 14, 19, 29).<br><br>-He/She had palatal [NAME] (a boney growth on the roof of your mouth).<br><br>-He/She had trauma to the left lateral border of the tongue from broken teeth.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 5/1/24 at 1:06 P.M. during initial tour showed the resident had broken/black teeth.<br><br>During an interview of 5/1/24 at 1:13 P.M. during initial tour the resident said:<br><br>-He/She had seen the dentist and was supposed to have all of his/her teeth extracted.<br><br>-He/She has had bad teeth for many years.<br><br>During an interview on 5/2/24 at 2:25 p.m., CNA F said:<br><br>-He/She has to set the resident up for oral cares.<br><br>-The resident does not have any dental issues.<br><br>-He/She did not know if the resident had broken or missing teeth.<br><br>During an interview on 5/2/24 at 2:30 P.M., CMT C said:<br><br>-The resident did not have any dental issues.<br><br>-He/She did not know if the resident had any teeth.<br><br>-It would have been in the resident's care plan.<br><br>-The resident's care plan did not show any dental issues.<br><br>During an interview on 5/2/24 at 2:40 P.M. Registered Nurse (RN) A said:<br><br>-He/She did not know if the resident had any teeth.<br><br>-He/She did not know if the resident had any dental issues.<br><br>-If they were missing teeth or had broken teeth that should have been care planned.<br><br>-It was not in the resident's care plan and should have been.<br><br>During an interview on 5/3/24 at 1:30 P.M. Social Service Assistant (SSA) A said:<br><br>-If the resident had broken or missing teeth that should have been in their care plan.<br><br>-It was not documented in the resident's care plan.<br><br>-Nursing, Social Services, or MDS should have ensured dental issues were in the care plan.<br><br>3. During an interview on 5/7/24 at 12:24 P.M., the Director of Nursing (DON) said:<br><br>-Resident #9's dental issues should have been documented on the care plan.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Resident #11's refusals of food, medication and/or treatments and cares should be documented on the care plan.<br><br>-Care plans should be updated by the MDS Coordinator.<br><br>-They can also be updated by risk management, any nursing staff, or social services.<br><br>-The care plan was used to show the care the residents received.<br><br>-It gave a picture of the resident and their needs<br><br>-The care plans were updated quarterly and as needed.<br><br>-It was important to update the care plan to provide current information regarding the resident. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469<br><br>Based on observation, interview, and record review, the facility failed to ensure staff applied a brace to a resident's hand for one sampled resident (Resident #13) out of 23 sampled residents. The facility census was 115 residents.<br><br>Review of the facility's policy, Splints and Braces, dated 1/16/24 showed:<br><br>-The use of a supportive and protective device designed for a patient's upper extremity, such as a sling, brace, or splint, helps provide support, facilitate functional use, reduce pain, maintain alignment, correct deformities, or provide protection for a healing injury.<br><br>-Documentation associated with supportive and protective devices of the upper extremity includes:<br><br>--Length of time the patient wore the device.<br><br>--Patients ability to apply and tolerate the device.<br><br>--Wearing schedule and monitoring the patient's skin integrity.<br><br>1. Review of Resident #13's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:<br><br>-Hemiplegia (complete weakness on one side of the body) and Hemiparesis (partial weakness on one side of the body) following Cerebral Infarction (a disruption of blood flow to the grain which can cause parts of the brain to die off) affecting left side.<br><br>-Need for assistance with personal care.<br><br>-Muscle weakness.<br><br>-Spastic Hemiplegia left side (muscle tightness and involuntary contractions in the limbs and extremities on one side of the body).<br><br>-Contracture, left elbow, left wrist, and left hand (a fixed tightening of muscle, tendons, or ligaments).<br><br>Review of the resident's Quarterly Minimum Data Set (MDS a federally mandated assessment tool completed by the facility for care planning), dated 3/12/24 showed:<br><br>-He/She had Hemiplegia or Hemiparesis.<br><br>-He/She had functional limitation in range of motion (the extent of limit to which a part of the body can be moved).<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Upper extremity (shoulder, elbow, wrist, hand), no impairment was checked.<br><br>-He/She had had a Cerebral Vascular Accident (CVA-stroke (interruption of blood flow to the brain).<br><br>-His/Her Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating he/she was cognitively intact.<br><br>Review of the resident's 3/28/24 care plan showed:<br><br>-He/She had an activity of daily living self-care performance deficit.<br><br>-He/She had contracture to his/her left elbow, wrist, and hand related to CVA.<br><br>-Staff was to apply left hand splint on for six to eight hours, on at breakfast and off after dinner.<br><br>Review of the resident's May 2024, Physician's Order Sheet showed an order for staff to apply splint/brace to left resting hand. Apply to left hand for six to eight hours, on at breakfast, off after dinner, dated 10/13/20.<br><br>Observation on 5/1/24 at 3:08 P.M. during initial tour showed:<br><br>-The resident's left hand was contracted.<br><br>-He/She was not wearing a brace.<br><br>During an interview on 5/1/24 at 3:11 P.M. the resident said:<br><br>-He/She was supposed to have a brace on his/her left hand.<br><br>-The brace was in his/her nightstand.<br><br>-He/She was not able to put the brace on by herself/himself.<br><br>-He/She has asked staff to put the brace on him/her and they did not do it.<br><br>Observation on 5/2/24 at 9:50 A.M. showed the resident did not have the brace on his/her left arm.<br><br>Observation and interview on 5/3/24 at 11:50 A.M. showed:<br><br>-The resident did not have the brace on his/her left arm.<br><br>-He/She had asked the Certified Nursing Assistant (CNA) to put the brace on his/her arm.<br><br>-The CNA said he/she would be back to put the brace on him/her, that was two hours ago and the CNA never came back to put the brace on him/her.<br><br>Observation on 5/6/24 at 10:00 A.M. showed the resident did not have the brace on his/her left arm.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/6/24 at 11:00 A.M. Registered Nurse (RN) A said:<br><br>-He/She thought the resident was supposed to have a brace or sling on his/her left hand during the day.<br><br>-He/She had not seen a brace on the resident for a few weeks.<br><br>-He/She had not seen the brace on the resident today and he/she should have had it on by this time.<br><br>-He/She did not know if the resident had a brace in his/her room.<br><br>-The resident would not have been able to put the brace on by himself/herself.<br><br>-Staff should have documented on the Treatment Administration Record (TAR) that they had applied the brace.<br><br>-The CNA's or Restorative Aide (RA) should have put the brace on the resident at breakfast and take it off after dinner.<br><br>-The Charge Nurse was ultimately responsible for ensuring treatments such as the brace were being done.<br><br>Review of the resident's May 2024 TAR showed:<br><br>-Splint/brace to left resting hand, apply to left hand for six to eight hours, on at breakfast, off after dinner.<br><br>--No documentation this was completed by the staff.<br><br>-Assess pain level and circulation every shift.<br><br>-Assess skin integrity around and under the splint/brace. Document + or - for skin integrity, dated 10/13/20.<br><br>-There was a line for Day, Evening, or Night shift to assess the skin.<br><br>-There was a line to assess pain level.<br><br>-There was no line to document applying or removing the splint.<br><br>During in interview on 5/7/24 at 9:30 A.M., CNA E said:<br><br>-None of the residents wear a sling or brace on their arm.<br><br>-The resident did not have a brace for his/her arm.<br><br>-If the resident needed a brace for his/her arm, the nurse would have told him/her.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265355 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/09/2024 |
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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -If the resident had a brace he/she would have put it on him/her when they got him/her dressed for the day.<br><br>-If the resident had a brace for their arm it would have been documented on the TAR that it was applied to the resident.<br><br>During an interview on 5/7/24 at 10:00 A.M., Certified Medication Technician (CMT) B said:<br><br>-If a resident had an order for a sling or brace it should have been applied by the staff.<br><br>-The CNA should have applied the brace when they got the resident dressed for the day.<br><br>-He/She has not seen the resident with a brace on his/her arm.<br><br>-The staff has not been applying the brace to this resident.<br><br>-The brace should have been in the care plan.<br><br>-The nurse was responsible to ensure the resident had the brace on.<br><br>During an interview on 5/7/24 at 10:52 A.M., RN C said:<br><br>-He/She had not seen the resident with a brace on his/her hand.<br><br>-The staff was responsible for applying the brace.<br><br>-The CNA or RA should have applied the brace when they dressed the resident.<br><br>-Staff should have documented on the TAR when they applied the brace and when it was taken off.<br><br>-It does not look like that has been done only assessing the resident for pain and assessing the skin.<br><br>-The Charge Nurse was ultimately responsible for ensuring the the resident had a brace on if the physician had ordered it.<br><br>During an interview on 5/7/24 at 12:25 P.M. the Director of Nursing said:<br><br>-He/She would have expected the staff to put a sling or brace on a resident if there was a physician's order to do so.<br><br>-The CNAs, RA, or nurse could have applied a brace to the resident.<br><br>-They should have document applying the brace in the Progress Notes.<br><br>-He/She was ultimately responsible to ensure treatments such as a brace were done by the staff. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409<br><br>Based on observation, interview, and record review the facility failed to accurately complete comprehensive fall investigations to include fall prevention measures that were in place to prevent falls, documentation of root cause analysis and any pertinent details of the incidents and environmental surrounding of the falls for one sampled resident (Resident #61), who was a risk for falls out of 23 sampled residents. The facility census was 115 residents.<br><br>A fall investigation policy was requested and was not received at the time of exit.<br><br>Review of the facility's Fall Management policy dated 12/4/23 showed:<br><br>-To promote patient safety and reduce patient falls by proactively identifying, care planning and monitoring of patients fall indicators.<br><br>-With any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls.<br><br>-Identify environmental hazards and individual resident risk of and accident, including supervision. Evaluate/analyze the hazards and risk and eliminate them, if possible and if not possible reduce them as much as possible.<br><br>-The interdisciplinary team will review any additional fall risk indicators and revise the resident care plan as indicated.<br><br>1. Review of Resident #61's Admission Face Sheet showed the following diagnoses:<br><br>-Dementia (is 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) with other behaviors disturbance.<br><br>-Lack of coordination.<br><br>-Cognitive communication deficit.<br><br>Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 4/18/24, showed he/she:<br><br>-Had severe cognitive impairment.<br><br>-He/she was rarely table to understand others and make his/her needs known.<br><br>-Had two non-injury falls during look-back period.<br><br>-Dependent on facility staff for transfer and care assistance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Fall Care Plan revised on 4/18/24 showed:<br><br>-The resident was at risk for falls.<br><br>-The resident had an actual fall. He/She had unsteady gait and was found lying on the floor.<br><br>-Interventions in place included place floor mats on side of bed on floor at night and when he/she in bed.<br><br>-On 4/18/24 the resident had a fall and was sent to hospital for evaluation and treatment. Upon returned from hospital a nursing assessment was completed and therapy was notified of the resident fall.<br><br>-NOTE: Did not find documentation of any new preventative fall interventions initiated after his/her fall on 4/18/24.<br><br>Review of the resident's Health Status Note dated 4/19/24 at 3:30 A.M. showed the resident had an unwitnessed fall out of his/her bed. The note did not include any interventions that had been in place to prevent the resident's fall.<br><br>Review of the resident's Fall Risk Report completed by the Director of Nursing (DON) dated 4/19/24 at 4:41 A.M. showed:<br><br>-The resident had an unwitnessed fall in his/her room.<br><br>-It was reported to this writer, the DON, that the resident had an unwitnessed fall out of his/her bed and had hit his/her head.<br><br>-The resident was unable to give a description of what happen.<br><br>-Had no documentation under predisposing environmental factors and situation factors.<br><br>-Resident Predisposing Physiological Factors had checked marks by confused, drowsy and impaired memory.<br><br>-Had documented no notification found under section for agencies or people notified.<br><br>-Had no documentation of the resident's fall preventive measure prior to fall and any fall intervention put in place after his/her fall.<br><br>-Had no documentation of a fall follow-up investigation was completed and no final root cause documentation.<br><br>-NOTE: The incident report/investigation did not have detail comprehensive investigation to include but not limited to details of the observation of the resident surrounding, positioning of the resident and if his/her bed was in lowest position or if his/her fall mats were in place at the time of the resident fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Fall Risk assessment dated [DATE] showed a post fall score of 18 which indicated the resident high risk for falls.<br><br>Observation on 5/2/24 at 11:00 A.M. the resident's room showed:<br><br>-Had two fall mats on each side of his/her bed.<br><br>-He/She had low air loss mattress that did not have any added soft side parameter barriers.<br><br>Observation of the resident on 5/2/24 at 11:01 A.M. showed:<br><br>-He/She was sitting specialized wheelchair in dining area with plastic building blocks in front of him/her on the table.<br><br>-Wheelchair was unlocked and he/she had non-skid socks on.<br><br>Review of the resident's unwitnessed Fall Risk Report dated 5/6/24 at 6:33 A.M. showed:<br><br>-The resident had an unwitnessed fall in his/her room.<br><br>-Nursing description: The resident was lying on floor on his/her back when the nurse entered the room, the floor free of clutter, fall mats in place and bed alarm within reach.<br><br>-Resident had no verbal response to his/her fall.<br><br>-Marked no if resident taken to hospital.<br><br>-Had documented no injury observed at time of incident.<br><br>-He/She had a pain scale level of 10 out of 10 (10 being worst pain).<br><br>-NOTE: The resident had just fallen the morning of 5/6/24.<br><br>--The injury sites documentation was not accurate placement with any current injuries noted.<br><br>--Did not have details of surroundings and if the bed was in lowest position. No detail on position of the resident when found, and if was call light in reach.<br><br>Review of the resident's Alert Note dated 5/6/24 at 7:56 A.M. showed:<br><br>-The resident had fallen out of his/her bed onto the floor.<br><br>-The resident's roommate had found him/her on floor.<br><br>-The note did not include any interventions in place to prevent falls.<br><br>Observation and interview of the resident on 5/6/24 at 9:40 A.M. showed:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She was sitting in a wheelchair located at the table in the special dining area.<br><br>-He/She denied pain.<br><br>-He/She said he/she had rolled out of his/her bed.<br><br>-He/She was able to answer basic questions and was alert to name.<br><br>-The charge nurse entered the dining area and began assessment of the resident to include vital signs and neuro checks.<br><br>Observation of the resident's room on 5/6/24 at 9:46 A.M. showed:<br><br>-He/She had two fall mats on each side of the bed.<br><br>-The resident's roommate said he/she was in the room when resident had fallen earlier that morning. He/She had heard the resident fall but did not see him/her fall.<br><br>-The resident's roommate said he/she thought the resident was possibly trying to reach for something. He/She was not sure if the resident's bed was in the lowest position to ground or if fall mats were on the ground.<br><br>-The resident's bed was a Low Air Loss Mattress (LAM) and a fall mat on floor located on each side of his/her bed.<br><br>Observation of the resident's bed on 5/6/24 at 1:29 P.M. showed he/she did not have a bed alarm in place.<br><br>During an interview on 5/6/24 at 9:57 A.M. with Certified Nursing Assistant (CNA) D said:<br><br>-The resident had fallen during night shift on 5/6/24.<br><br>-He/She was not aware of the resident's previous fall on 4/19/24.<br><br>-The resident fall preventive measure was, while the resident in bed, his/her bed should be in lowest position with fall mats on each side of the bed.<br><br>-He/She was not aware of the resident's bed was position at time of fall or if fall mats were in place at time of the fall for either fall.<br><br>During an interview on 5/6/24 at 12:48 P.M., Registered Nurse (RN) A said:<br><br>-The resident had fallen out of bed that morning, and vitals were completed.<br><br>-He/She was not aware of the resident's previous fall on 4/19/24.<br><br>-He/She not aware of new fall prevention measures put in place.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident should have fall mats in his/her room and bed in lowest position when in bed.<br><br>-The fall investigation or report should include complete details of the resident's fall.<br><br>-Incident report or fall risk completed with detail of what happened, positioning of the resident, and any injury noted.<br><br>-DON would be responsible for competing the DON investigation.<br><br>-He/She not aware of the resident or any other resident with bed or chair alarms.<br><br>During an interview on 5/6/24 at 1:25 P.M., Certified Medication Technician (CMT) A said:<br><br>-The resident's fall prevention measures were a LAM, high/low bed, and fall mats.<br><br>-He/She was not aware of any use of bed alarms at the facility.<br><br>-The resident normal stays up in a wheelchair most of the day.<br><br>-When he/she is in bed, the bed should be in the lowest position to the ground with fall mats in place.<br><br>During an interview on 5/7/24 at 10:20 A.M., CNA C said:<br><br>-If he/she found a resident on the ground or had witnessed falls, he/she would stay with the resident and have another staff get the nurse.<br><br>-The nurse would complete an assessment of the resident and document findings.<br><br>-If he/she witnessed a fall he/she would write a witness statement.<br><br>-The nursing staff were responsible for documentation of the fall incident.<br><br>-When the resident was in bed, the bed should be placed in the lowest position to the ground with fall mats on each side of his/her bed.<br><br>-The CNA's would ask nursing staff or look at the CNA task sheet on how to care for the resident and if the resident was on fall precautions.<br><br>During an interview on 5/7/24 10:32 A.M., the Wound Nurse said:<br><br>-He/She would assess the resident that was found on the ground by checking vital signs, assess for any injury, notifying the resident's physician, family member and DON.<br><br>He/She would obtain any witness statements and document findings in the risk management for falls with a detail note of the event.<br><br>(continued on next page) |

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| | 265355 | A. Building<br>B. Wing | 05/09/2024 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Fall documentation should include the surroundings, position of bed and resident, and any old and new interventions that were put in place.<br><br>-During the facility morning meeting, the facility staff would review any falls and the resident's current plan of care. At that time they would discuss if staff needed to make any changes to the resident's care plan or further evaluation.<br><br>During an interview on 5/7/24 at 10:56 A.M., Licensed Practical Nurse (LPN) B said:<br><br>-Fall risk incident reports should include a detailed description of the event to include the resident's position, any fall prevention measure that were in place at the time of the fall, such as bed low position fall mat in place and document any injury and immediate actions taken.<br><br>-Staff would complete the resident's fall assessment and treat any injury as needed.<br><br>-Staff should document the fall in the resident's nursing notes and fall risk incident and gather any witness statements.<br><br>During interview on 5/7/24 at 12:23 P.M., DON, Regional Director Services, and Assistant Director of Nursing (ADON) said:<br><br>-He/She would expect nursing staff to have a detailed and accurate comprehensive incident report sand fall investigations.<br><br>-Nursing would be responsible to complete and document the resident's initial head toe assessment, environment assessment, outcome and complete risk management reports.<br><br>-Nursing staff can also document the resident's incident in a detail progress note.<br><br>-Nursing would be responsible for completing the fall comprehensive investigation report and the DON would complete his/her investigation which would include review of the nursing investigation, document follow-up findings or root cause and any fall preventative measure which may have been put in place after the resident fall.<br><br>-During the morning clinic meeting, the team would review fall incidents and update the resident's care plan at that time.<br><br>-He/She would expect documentation to be accurate, comprehensive, and follow-up investigation completed.<br><br>-For fall investigation on 4/19/24 was a final report and he/she did not have any additional information at time of exit. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469<br><br>Based on interview, and record review, the facility failed to ensure a resident who had a feeding tube and took food orally was getting adequate nutrition by not recording how much the resident took in orally and did not weigh him/her on a regular basis for one sampled resident (Resident #96) out of 23 sampled residents. The facility census was 115 residents.<br><br>Review of the facility's policy, Resident at Risk, dated 4/25/23 showed:<br><br>-Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as usual body wight.<br><br>-Acceptable parameters of nutritional status refers to factors that reflect an individual's nutritional status was adequate such as weight, food/fluid intake,<br><br>-Artificial nutrition and hydration were medical treatments and refer to nutrition that was provided through routes other than the usual oral route, typically placing a tube directly into the stomach, the intestine, or a vein.<br><br>-The facility establishes a consistent method of weighing residents, verifying weights upon admission, monitoring weights over time to identify weight loss or gain, verifying weights when changes occur, determining interventions, and reassessing interventions when appropriate.<br><br>-Team members may have made recommendations to the resident's physician including but not limited to frequency of monitoring weights.<br><br>-Review weights on new admissions weekly for the first four weeks after admission to establish a baseline, then monthly after that unless otherwise indicated.<br><br>1. Review of Resident #96's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:<br><br>-Gastrostomy status (an opening into the stomach from the abdominal wall,made surgically for the introduction of food).<br><br>-Anoxic brain damage (a complete lack of oxygen to the brain which results in the death of brain cells after four minutes of oxygen deprivation).<br><br>-Autistic disorder( a serious developmental disorder that impairs the ability to communicate and interact).<br><br>-Dysphagia (a difficulty in swallowing food or liquids).<br><br>Review of the resident's care plan on 5/6/24 at 12:20 P.M., dated 2/9/24 showed:<br><br>-He/She was on tube feedings.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Did not address when or how often the resident should have been weighed.<br><br>Review of the resident's Physician's Order Sheet dated May 2024 showed:<br><br>-There was no order to weigh the resident.<br><br>-He/She was on a regular diet with puree texture (a pudding-like texture that was smooth, blended or pureed), Nectar (a consistency of slightly thicker liquid than water)/mildly consistency.<br><br>-One to one assistance, small bites, slow rate, sit upright 90 degrees for nutrition, dated 9/15/23.<br><br>-Enteral feed order- two times a day Jevity (a calorically dense, fiber fortified therapeutic nutrition) 1.5 at 50 milliliters (ml) per hour for 12 hours via pump, dated 9/15/23.<br><br>Review on 5/6/24 at 12:30 P.M. of the resident's weights on the computer program showed the following weights for this year:<br><br>-On 1/15/2024 the resident weighed 111.9 pounds (Lbs).<br><br>-On 1/22/2024 the resident weighed 110.2 Lbs.<br><br>-On 2/6/2024 the resident weighed 111.6 Lbs.<br><br>-On 2/15/2024 the resident weighed 112.3 Lbs.<br><br>-On 2/21/2024 the resident weighed 113.1 Lbs.<br><br>-On 2/27/2024 the resident weighed 111.9 Lbs.<br><br>-On 3/13/2024 the resident weighed 112.4 Lbs.<br><br>-On 3/19/2024 the resident weighed 112.9 Lbs.<br><br>-On 4/4/2024 the resident weighed 112.5 Lbs.<br><br>-On 4/9/2024 the resident weighed 113.0 Lbs.<br><br>-There was no documentation since 4/9/2024.<br><br>During an interview on 5/6/24 at 1:00 P.M. Certified Nursing Assistant (CNA) E said:<br><br>-There was a certain person who weighs the residents.<br><br>-He/She did not know who it was or if they were working.<br><br>-The nurse would have told staff if a resident needed to be weighed that shift.<br><br>(continued on next page) |

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|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident's weight should have been documented in the computer system under weights.<br><br>-A person who had a feeding tube should have been weighed daily.<br><br>-The weight should have been documented on the computer.<br><br>During an interview on 5/6/24 at 1:10 P.M. Certified Medication Technician (CMT) C said:<br><br>-It would show up on the Medication Administration Record if the resident needed to have been weighed.<br><br>-The staff should have documented on the computer what the weight was under weights.<br><br>-The Restorative Aide was supposed to have weighed the residents.<br><br>-He/She did not know if that person was here today.<br><br>-The resident should have been weighed weekly.<br><br>-He/She verified the resident had not been weighed since 4/9/24.<br><br>-He/She verified there was no physician's order for how often the resident should have been weighed, maybe weekly.<br><br>During an interview on 5/6/24 at 1:20 P.M. Registered Nurse (RN) A said:<br><br>-There was someone who was assigned to weigh the residents.<br><br>-He/She did not know who that person was.<br><br>-He/She did not know if that person was working today.<br><br>-If that person was not working he/she did not know how it would have been conveyed to them that nursing staff should have weighed the resident.<br><br>-Resident weights would have been documented on the computer system.<br><br>-The last weight was on 4/9/24.<br><br>-The resident does take food and if he/she doesn't eat a certain percent of his/her meal then he/she gets a tube feeding.<br><br>-The resident should be weighed at least weekly.<br><br>-There was no physician's order for how often the resident should have been weighed.<br><br>-There was no documentation in the care plan which showed how often the resident should have been weighed.<br><br>(continued on next page) |

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

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/7/24 at 12:55 P.M. the DON said:<br><br>-The resident had a feeding tube and should have been weighed weekly.<br><br>-There was an Restorative Aide (RA) who was supposed to weigh the residents.<br><br>-The RA has been sick lately.<br><br>-A CNA or nurse could have weighed the resident.<br><br>-The Charge Nurse was responsible to ensure the residents were weighed per the physician's order.<br><br>-There was no physician's order how often to weigh the resident.<br><br>-If there was no order they would weigh the resident monthly.<br><br>-He/She and the Assistant DON have done audits to ensure weights were done. |

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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** 39469

Based on observation, interview, and record review, the facility failed to ensure resident's oxygen equipment was stored in a sanitary condition when not in use, failed to ensure oxygen tubing was changed out weekly, failed to ensure residents had water in the humidifiers on the oxygen concentrator for three sampled residents, (Resident #5, Resident #9, and Resident #51) out of 23 sampled residents. The facility census was 115 residents.

Review of the facility's policy, Oxygen Administration/Safety/Storage/Maintenance, dated 9/26/23 showed:

-Oxygen would have been administered in accordance with physician's orders.

-Change oxygen supplies weekly and when visibly soiled.

-Equipment should have been dated when setup or changed out.

-Humidifier bottles should have been dated and replaced every seven days regardless of the water level.

-Store oxygen and respiratory supplies in a bag labeled with the resident's name when not in use.

1. Review of Resident #5's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block air flow making it hard to breathe).

Review of the resident's Quarterly Minimum Data Set (a federally mandated assessment tool completed by the facility for care planning) dated 1/16/24 showed:

-He/She had a medically complex condition.

-He/She had COPD.

-Did not show he/she was on oxygen or respiratory treatments.

-His/Her Brief Interview for Mental Status (BIMS) score was 15 out of 15 indicating he/she was cognitively intact.

Review of the resident's May 2024 Physician's Order Sheet (POS) showed the following orders:

-Oxygen one to four liters to keep oxygen saturation above 88% every shift, dated 4/4/24.

-Ipratropium-Albuterol (medication used to prevent difficulty breathing for people with COPD) Inhalation Solution 0.5-2.5 (3) milligram(mg)/3 milliliters (ml) one vial inhale orally every four hours for shortness of breath, dated 4/4/24.

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's undated care plan showed:<br><br>-He/She had COPD.<br><br>-Staff would maintain oxygen settings as ordered.<br><br>Observation on 5/1/24 at 1:14 P.M. during initial tour showed:<br><br>-There was less than 1/4 inch of water in the humidifier, unable to humidify the oxygen going to the resident.<br><br>-There was no date on the humidifier container.<br><br>-There was no date on the oxygen tubing indicating when it was changed.<br><br>-The nebulizer mask (a delivery method of aerosol medications) was sitting on the bedside tray table, not in a bag, did not have a date written on it.<br><br>During an interview on 5/1/24 at 1:20 P.M. the resident said he/she did not know when the staff had changed out any of his/her breathing tubing, at least a couple of weeks.<br><br>2. Review of Resident #9's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:<br><br>-COPD.<br><br>-Dependence on supplemental oxygen.<br><br>-Sleep apnea (a serious sleep disorder in which breathing repeatedly stops and starts).<br><br>Review of the resident's Quarterly MDS dated [DATE] showed:<br><br>-He/She had a medically complex condition.<br><br>-He/She had COPD.<br><br>-He/She was on oxygen therapy.<br><br>-He/She was on non-invasive mechanical ventilator (when oxygen is given as breathing support by using a face mask under positive pressure).<br><br>-Continuous Positive Airway Pressure (CPAP- a machine that uses mild air pressure to keep breathing airways open while a person sleeps) was not checked.<br><br>-His/Her BIMS score was 15 out of 15 indicating he/she was cognitively intact.<br><br>Review of the resident's Care Plan dated 3/6/24 showed:<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She had oxygen therapy and CPAP related to COPD.<br><br>-Give medication as ordered by physician.<br><br>-CPAP as ordered.<br><br>Review of the resident's May 2024 POS showed the following orders:<br><br>-Change oxygen tubing and nebulizer circuit every Sunday night shift related to COPD, dated 7/30/23.<br><br>-Clean CPAP mask with warm soapy water, rinse, and air dry every date shift related to COPD, dated 10/18/23.<br><br>-Fill CPAP humidifier with sterile or distilled water every night shift for shortness of breath, dated 7/28/23.<br><br>-CPAP on while sleeping or napping and off while awake at bedtime for shortness of air, dated 7/28/23.<br><br>Observation on 5/1/24 at 1:04 P.M. during initial tour showed:<br><br>-There was no water in the resident's oxygen humidifier.<br><br>-There was no date on the resident's water container.<br><br>-The resident's CPAP mask was in a bag dated 4/18/24.<br><br>During an interview on 5/1/24 at 1:06 P.M. the resident said:<br><br>-He/She did not know when the staff changed out the oxygen supplies, at least two weeks.<br><br>-The staff does not put the CPAP mask on him/her at night, he/she has asked them to repeatedly.<br><br>-He/She wears oxygen at night.<br><br>Observation on 5/3/24 at 10:00 A.M. showed:<br><br>-There was no water in the resident's oxygen humidifier.<br><br>-There was no date on the resident's water container.<br><br>-The resident's CPAP mask was in a bag dated 4/18/24.<br><br>3. Review of Resident #51's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnosis:<br><br>-COPD.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Panlobular Emphysema (a disease of the lungs in which the air sacs in the lungs were permanently damaged).<br><br>-Dependence on supplemental oxygen.<br><br>Review of the resident's Annual MDS, dated [DATE] showed:<br><br>-His/Her BIMS score was 13 out of 15 indicating he/she was cognitively intact.<br><br>-He/She was medically complex.<br><br>-He/She had COPD.<br><br>-He/She was on oxygen therapy.<br><br>Review of the resident's care plan dated 3/28/24 showed:<br><br>-He/She had COPD.<br><br>-Staff was to change oxygen tubing weekly or as needed.<br><br>-Oxygen was to be at four liters per nasal cannula (tubing that was placed in a patients nose to deliver oxygen) continuously.<br><br>Review of the resident's May 2024 POS showed the following orders:<br><br>-Change the oxygen tubing and nebulizer water container ever Sunday night, dated 5/13/21.<br><br>-Oxygen at four liters per minute continuously per nasal cannula dated 5/13/21.<br><br>Observation on 5/01/24 at 1:17 P.M. during initial tour showed:<br><br>-The resident was wearing oxygen which was connected to a concentrator.<br><br>-The oxygen bag dated 4/18 was taped to the concentrator.<br><br>-There was no water in humidifier attached to the concentrator.<br><br>-He/She had a second oxygen tubing on his/her wheelchair attached to an oxygen tank.<br><br>-His/Her oxygen tubing that was on his/her wheelchair nasal cannula was a dirty brown in color.<br><br>-The oxygen tubing was wrapped around the handles of the wheelchair hanging down to the floor, not in a bag and not dated.<br><br>During an interview on 5/1/24 at 1:20 P.M. the resident said he/she did not know how often staff changed out his/her oxygen tubing, maybe monthly.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 5/3/24 at 10:04 A.M. showed:<br><br>-His/Her oxygen tubing was laying on of his/her bed on top of a bloody incontinent pad.<br><br>-Two Certified Nursing Assistants (CNA)s had just left the room after doing cares with the resident and moving him/her into his/her wheelchair.<br><br>Observation and interview on 5/03/24 at 11:12 A.M. during wound care with LPN C/Wound Care Nurse said:<br><br>-The oxygen tubing attached to the resident's concentrator was still sitting on the bloody incontinent pad.<br><br>-The nurse got the resident a new set of oxygen tubing.<br><br>-His/Her oxygen cannula should not have been laying on a dirty pad, the CNAs should have changed the oxygen tubing.<br><br>-The resident would sometimes take his/her oxygen off himself/herself.<br><br>-The nurse changed out the water container on the humidifier.<br><br>-The nurse did not date the new water container.<br><br>-He/She said the CNA's were not able to change out the water container as they were locked up.<br><br>-The facility did not add distilled water to the humidifier on the oxygen concentrator, they changed out the water container which came pre-loaded with distilled water.<br><br>-He/She was not sure how often the water container should have been changed out maybe when the staff noticed it was empty.<br><br>4. During an interview on 5/7/24 at 9:30 A.M. CNA E said:<br><br>-Oxygen when not in use should have been in a bag.<br><br>-There should have been a date written on the bag that the tubing was changed out.<br><br>-He/She did not know how often the oxygen tubing should have been changed out.<br><br>-Any staff member could have changed out the oxygen tubing if they saw it was dirty.<br><br>-The nurse was responsible for ensuring there was water in the humidifier.<br><br>-The water container for the humidifier comes pre-made with special water already in it and it was locked up somewhere.<br><br>During an interview on 5/7/24 at 10:00 A.M. Certified Medication Technician (CMT) B said:<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Oxygen tubing should not be on the floor or bed, it should be in a bag with the date it was changed out written on the bag.<br><br>-He/She did not know who was responsible for ensuring the tubing was changed out weekly.<br><br>-The nurse was responsible for ensuring there was distilled water in the oxygen humidifier.<br><br>-He/She did not know where it should have been documented at.<br><br>-The oxygen tubing should have been changed out weekly.<br><br>During an interview on 5/7/24 at 10:52 A.M. Registered Nurse (RN) C said:<br><br>-There should not have been oxygen tubing touching the floor or on a dirty pad.<br><br>-Oxygen tubing should have been stored in a bag with the date it was changed out written on the bag.<br><br>-Oxygen supplies should have been changed out on Sunday by the night shift.<br><br>-The nurses were responsible to change out the water container on the humidifier as it was pre-filled with distilled water and kept locked up.<br><br>-He/She looks at the oxygen equipment in the morning when he/she starts to work to ensure it was clean and did not need changed out.<br><br>-It was everyone's job to ensure the oxygen equipment was clean.<br><br>During an interview on 5/7/24 at 12:25 P.M. the Director of Nursing said:<br><br>-He/She would not have expected to see oxygen tubing on the floor, bedside stand or on a dirty incontinence pad.<br><br>-Oxygen tubing should have been changed out every seven days by the night shift.<br><br>-There should have been water in the humidifiers.<br><br>-The charge nurse on Sunday night was responsible to ensure the oxygen equipment was changed out.<br><br>-When the tubing or water was changed out, it should have a date written on it indicating when it was changed out.<br><br>-If this wasn't done the charge nurse on Sunday nights missed it. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>50579<br><br>Based on interview and record review, the facility failed to assess for, identify and provide supportive interventions for one sampled resident (Resident #18) with a diagnosis of Post-Traumatic Stress Disorder (PTSD, a mental disorder that develops in some people who have experienced a traumatic event), out of 23 sampled residents. The facility census was 115 residents.<br><br>Review of a facility policy titled Trauma-Informed Care, dated 8/22/23, showed:<br><br>-The facility would have used a multi-pronged approach to identify resident trauma including assessing for indicators upon admission, which would then be reviewed by the interdisciplinary team (IDT) to determine appropriate person-centered interventions to mitigate or eliminate triggers that may lead to re-traumatization.<br><br>-The facility should have collaborated with resident trauma survivors and, if appropriate, resident's family, friends, or other healthcare professionals to implement an individualized plan of care with interventions.<br><br>-The facility should have identified triggers that could re-traumatize residents with a history of trauma, attempting to do so even if a resident is reluctant to speak about possible triggers.<br><br>1. Review of Resident #18's Admission Record on 5/6/24, showed the resident had a diagnosis of PTSD, dementia with mood disturbances, major depressive disorder, borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships) and hemiplegia of the left side following intracranial hemorrhage (left sided paralysis stemming from a stroke).<br><br>Review of the resident's Trauma Informed Care assessment, dated 11/20/23, showed:<br><br>-The resident did not participate in the interview due to a cognitive deficit.<br><br>-A box was checked for Other under interview participants with no further information in the provided areas.<br><br>-A list of traumatic events including a generic any other event or stressful experience was noted to be unchecked.<br><br>-The Not Applicable box was checked, indicating none of the events listed had been experienced by the resident.<br><br>-No events, triggers, or detailed information about the resident's diagnosis of PTSD was given.<br><br>Review of the resident's care plan dated 4/15/24, showed the resident had:<br><br>-Potential to be physically aggressive, biting and kicking staff related to dementia.<br><br>-Impaired cognitive ability and thought processes.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Nonverbal communication.<br><br>-A risk for change in mood and behavior due to unnamed medical condition with interventions that included consulting with the resident's family regarding routine, providing medications as ordered, and getting a psychiatric consultation as needed.<br><br>Review of the resident's medical records showed no documentation of psychiatric consultations, triggers, interventions, or further assessments of the PTSD diagnosis.<br><br>During interview on 5/06/24 at 9:54 A.M., Certified Nursing Assistant (CNA) E said:<br><br>-The resident often hit his/her legs.<br><br>-The resident squeezed his/her legs together during personal cares and avoids the cares when possible.<br><br>-He/She was not aware of any PTSD diagnosis or any potential triggers.<br><br>During interview on 5/06/24 at 10:04 A.M., the Director of Social Services said:<br><br>-He/She would be responsible for conducting the trauma assessments for residents.<br><br>-A trauma assessment would include potential triggers.<br><br>-The care plan should reflect the potential triggers and any interventions to avoid these triggers.<br><br>-He/She would expect follow-up with the resident's family if the resident was unable to communicate previous traumatic experiences and potential triggers.<br><br>During interview on 5/06/24 at 10:33 A.M., Registered Nurse (RN) B said he/she was unaware of a diagnosis of PTSD or any potential triggers and was not aware of any refusals of care.<br><br>During interview on 5/07/24 at 12:24 P.M., the Director of Nursing (DON) said he/she would expect:<br><br>-The care plan to have reflected the resident's PTSD diagnosis along with triggers and interventions.<br><br>-Staff to have been aware of the residents PTSD status.<br><br>-A paper trail to show progression or worsening of the resident's PTSD status. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469<br><br>Based on interview and record review ,the facility failed to address the pharmacy's recommendation to the physician in a timely manner for one sampled resident, (Resident #23) out of 23 sampled residents. The facility census was 115 residents.<br><br>Review of the facility's policy, Medication Regimen Review (MMR), dated 8/17/23 showed:<br><br>-The Consultant Pharmacist would conduct MMR if required under a Pharmacy Consultant Agreement and would make recommendations based on the information available in the residents' health record.<br><br>-The Pharmacist would address copies of residents' MRR to the Director of Nursing (DON) and the attending physician and to the Medical Director.<br><br>-Facility staff should have ensured that the attending physician, Medical Director, and DON were provided with copies of the MRRs.<br><br>-Facilities should encourage the physician or other responsible parties who had received the MRR and the DON to act upon the recommendations contained in the MRR.<br><br>-For those issues that required physician intervention, the facility should encourage the physician to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected.<br><br>-The physician should have documented in the resident's health record that the identified irregularity had been reviewed and what, if any, action had been taken to address it.<br><br>-If the attending physician had decided to make no change in the medication, the attending physician should have documented the rationale in the residents' health record.<br><br>-Facility should have alerted the Medical Director where MRRs were not addressed by the attending physician in a timely manner.<br><br>-The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation.<br><br>-The facility should have maintained readily available copies of the Consultant Pharmacists reports on file in the Facility as part of the resident's permanent health record.<br><br>1. Review of Resident #23's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors).<br><br>-Dementia (a general decline in cognitive abilities that impacts a person's abilities to perform everyday activities).<br><br>Review of the resident's Progress Notes dated 3/21/24 showed:<br><br>-The pharmacy had made a recommendation Nuplacid was a antipsychotic and did the physician want to discontinue the medication.<br><br>-The resident was on three medications for Parkinson's.<br><br>-There was no documentation from the physician with an answer to the pharmacist's recommendation.<br><br>During an interview on 5/3/24 at 1:00 P.M. Registered Nurse (RN) A said:<br><br>-There was no documentation of an answer to the pharmacy note in the computer from the physician.<br><br>-If the pharmacy has a recommendation sometimes they would call the physician directly.<br><br>-The physician would just discontinue a medication.<br><br>-He/She did not know where it would be documented that the physician disagreed with the pharmacy recommendation for a different reason.<br><br>-The resident was still on the medication so he/she did not know what had happened.<br><br>During an interview on 5/3/24 at 1:30 P.M. the Assistant Director of Nursing (ADON) said:<br><br>-He/She did not see the MMR from pharmacy for the physician.<br><br>-He/She did not see a response from the physician.<br><br>-There should have been a response if they disagreed with the pharmacy recommendation within a week or so.<br><br>-There was no documentation that the physician saw or responded to the note.<br><br>During an interview on 5/6/24 at 10:45 A.M., Licensed Practical Nurse (LPN) D said:<br><br>-If the pharmacist had a recommendation, they contact the physician directly.<br><br>-If the physician agrees a medication should be discontinued, they write an order.<br><br>-If the physician wants to continue a medication he/she did not know where that would have been documented.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265355 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/09/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Life Care Center of Grandview | 6301 East 125th St Grandview, MO 64030 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She was not aware of how that was done.<br><br>During an interview on 5/6/24 at 10:55 A.M. Registered Nurse (RN) A said:<br><br>-The pharmacy contacts the physician directly if they have a recommendation.<br><br>-He/She did not know how that was done.<br><br>-He/She did not know where it was documented if the physician wanted to continue a medication against the pharmacy advice.<br><br>-The discrepancy should have been taken care of in a week or so.<br><br>-The Director of Nursing (DON) would have been ultimately responsible to ensure there was a response to the pharmacy recommendation.<br><br>-He/She did not see a response to the pharmacist's recommendation on the chart.<br><br>During an interview on 5/7/24 at 12:55 P.M. the DON said:<br><br>-The pharmacist review the resident's medications monthly.<br><br>-If the pharmacist had a recommendation, they email it to him/her.<br><br>-He/She prints the pharmacist's recommendation and gives it to the physician.<br><br>-The physician would document on the recommendation whether they agreed, disagreed, or there was an other reason usually within a week or so.<br><br>-This one was missed. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469<br><br>Based on observation, interview, and record review, the facility failed to ensure two sampled residents, (Resident # 9 and Resident #13) received dental services for broken teeth or missing teeth, and to provide a dental consultation for one sampled resident (Resident #27) who had a physician order for a consultation with an oral surgeon for dental extractions out of 23 sampled residents. The facility census was 115 residents.<br><br>Review of the facility's policy, Dental Services, dated 8/23/23 showed:<br><br>-The facility was responsible for assisting the patient in obtaining needed dental services, including routine dental services.<br><br>-The facility would have provided or obtained from an outside resource routine and emergency dental services to meet the needs of each patient.<br><br>-Must have a policy identifying those circumstances when the loss or damage of dentures was the facility's responsibility and may not charge a resident for the loss or damage of dentures was the facility's responsibility and may not charge a resident for the loss or damage of dentures in accordance with facility policy to be the facility's responsibility.<br><br>-If necessary, or if requested, assist the resident:<br><br>--In making appointments.<br><br>--By arranging for transportation to and from the dental services location.<br><br>-Must promptly, within three days, refer residents with lost or damaged dentures for dental services.<br><br>-Routine dental services refers to an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning minor partial or full denture adjustments, smoothing of broken teeth, taking impressions for dentures and fitting dentures.<br><br>-Arrangements would have been made promptly for routine and emergency dental services, including denture replacement when necessary.<br><br>-Patients would have been assisted with making appointment and arranging for transportation to and from the dentist's office if necessary.<br><br>1. Review of Resident # 9's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of severe protein-calorie malnutrition (when a person does not eat enough protein to meet nutritional needs.<br><br>Review of the resident's Admission collection tool dated 7/27/23 showed:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265355 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/09/2024 |
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| NAME OF PROVIDER OR SUPPLIER Life Care Center of Grandview | | STREET ADDRESS, CITY, STATE, ZIP CODE 6301 East 125th St Grandview, MO 64030 | |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She had broken teeth.<br><br>-He/She needed supervision or cueing while eating.<br><br>Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 8/10/23 showed:<br><br>-His/Her BIMS score was 15 out of 15 indicating he/she was cognitively intact.<br><br>-He/She was at risk for malnutrition.<br><br>-No dental issues was checked.<br><br>Review of the resident's Care Plan dated 3/6/24 showed:<br><br>-Did not address the resident's broken teeth.<br><br>-He/She needed extensive assistance with oral cares.<br><br>Review of the resident's dental visit on 3/20/24 showed:<br><br>-He/She had poor oral hygiene with heavy plaque build up.<br><br>-He/She was missing the following teeth, (1,16,17, 31, and 32).<br><br>-He/She had root tips (broken teeth) on on the following teeth, (3, 5, 8, 14, 19, 29).<br><br>-He/She had palatal [NAME] (a boney growth on the roof of your mouth).<br><br>-He/She had trauma to the left lateral boarder of the tongue from broken teeth.<br><br>-A full mouth x ray was completed.<br><br>-The dentist recommended the resident have extractions (teeth pulled) of teeth (3, 7, 8, 14, and 19).<br><br>-After extractions the dentist suggested the resident have impressions for an upper partial (dentures).<br><br>-The resident was in agreement with the plan.<br><br>Review of the resident's progress note dated 3/27/24 showed a consent signed for resident to have tooth extractions with the dentist.<br><br>Review of the resident's dental contract dated 3/27/24 showed he/she had signed an contract with an outside provider for tooth extraction on 3/27/24.<br><br>Review of the resident's May 2024 Physician's Order Sheet showed the following orders:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265355 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/09/2024 |
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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Regular diet, thin consistency, dated 7/27/23.<br><br>-May have dental care as needed, dated 7/27/23.<br><br>Observation during initial tour on 5/1/24 at 1:06 P.M. showed the resident had many broken or black teeth.<br><br>During an interview of 5/1/24 at 1:13 P.M. during initial tour the resident said:<br><br>-He/She had seen the dentist and was supposed to have all of his/her teeth extracted.<br><br>-The facility had not told him/her when or if there was an appointment to have his/her teeth extracted.<br><br>-He/She would like to have dentures so he/she could eat more.<br><br>-He/She could only eat certain foods and nothing hard like a raw carrot.<br><br>During an interview on 5/2/24 at 2:25 p.m. Certified Nursing Assistant (CNA) F said:<br><br>-He/She has to set the resident up for oral cares.<br><br>-The resident does not have any dental issues.<br><br>-They have to document that oral cares have been done in the computer.<br><br>During an interview on 5/2/24 at 2:30 P.M. Certified Medication Technician (CMT) C said:<br><br>-The resident did not have any dental issues.<br><br>-He/She did not know if the resident had any teeth.<br><br>-The Social Worker would have to make an appointment to see the dentist.<br><br>During an interview on 5/2/24 at 2:40 P.M. Registered Nurse (RN) A said:<br><br>-He/She did not know if the resident had any dental issues.<br><br>-He/She did not know if the resident had any teeth.<br><br>-The Social Worker would make an appointment to see the dentist.<br><br>-He/She could not find in the computer any appointment to see the dentist for extraction.<br><br>During an interview on 5/3/24 at 1:30 P.M. Social Services Assistant (SSA) said:<br><br>-The resident had seen the dentist in March and was to follow up with the dentist for tooth extraction.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -As of today there was no date scheduled for the resident to have his/her teeth extracted.<br><br>-There should have been at least a future date of an appointment for the extraction.<br><br>-Their office was responsible to ensure the residents saw the dentist when they needed to.<br><br>2. Review of Resident #13's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:<br><br>-Need for assistance with personal care.<br><br>-Hemiplegia and Hemiparesis following a cerebral infarction (Muscle weakness following a stroke-damage to the brain from an interruption of its blood supply).<br><br>Review of the resident's May 2024 POS showed the following order may have dental care as needed, dated 10/15/19.<br><br>Review of the resident's Admission Collection Tool dated 10/15/19 showed:<br><br>-He/She had teeth missing.<br><br>-He/She had dentures.<br><br>-He/She needed extensive assistance with hygiene.<br><br>-He/She had no upper teeth and was missing lower teeth.<br><br>-He/She wore full upper dentures.<br><br>-He/She wore partial lower dentures.<br><br>Review of the resident's Quarterly MDS dated [DATE] showed:<br><br>-He/She was medically complex.<br><br>-He/She had Hemiplegia.<br><br>-The dental status area was blank.<br><br>-His/Her BIMS score was 15 out of 15 indicating he/she was cognitively intact.<br><br>Review of the resident's care plan dated 3/28/24 showed:<br><br>-He/She required supervision for oral cares.<br><br>-He/She wore dentures.<br><br>-Staff was to coordinate arrangement for dental care, transportation as needed or as ordered.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Staff was to observe and report as needed any oral/dental problems needing attention.<br><br>Review of the resident's Inventory of Personal Effects Sheet dated 4/17/24 showed:<br><br>-Did not list dentures.<br><br>-The resident or Responsible party did not sign or date the paper.<br><br>Observation on 5/1/24 at 1:12 P.M. during initial tour showed:<br><br>-The resident had many broken or missing teeth.<br><br>-No denture box or dentures were observed.<br><br>During an interview on 5/1/24 at 1:13 P.M. the resident said:<br><br>-Had dentures when he/she came into the facility but had lost them.<br><br>-He/She would like to have dentures again.<br><br>-He/She had told the nurse maybe a couple of months ago.<br><br>-He/She could not recall which nurse he/she told about wanting new dentures.<br><br>During an interview on 5/2/24 at 2:25 p.m., CNA F said:<br><br>-He/She has to set the resident up for oral cares.<br><br>-The resident does not have any teeth or dentures.<br><br>-The resident had not told him/her that the resident wanted new dentures.<br><br>During an interview on 5/2/24 at 2:30 P.M., CMT C said:<br><br>-The resident does not have any teeth or dentures.<br><br>-The Social Worker would have to make an appointment to see the dentist.<br><br>-The resident had not told him/her that the resident wanted new dentures.<br><br>During an interview on 5/2/24 at 2:40 P.M., RN A said:<br><br>-He/She did not know if the resident had any teeth.<br><br>-The Social Worker would make an appointment to see the dentist.<br><br>-He/She did not know if the resident had any dental issues.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -If there was dental issues it should have been on their care plan.<br><br>-The resident had not told him/her that the resident wanted new dentures.<br><br>During an interview on 5/3/24 at 1:30 P.M., the SSA said:<br><br>-The resident's admission assessment did not show any issue with his/her teeth.<br><br>-There was no documentation that the resident had seen a dentist since he/she has been here and should have been seen.<br><br>-The resident only has a few teeth.<br><br>-They should have asked the resident if he/she wanted dentures annually.<br><br>-The resident had not told him/her that he/she wanted new dentures.<br><br>During an interview on 5/6/24 at 12:15 P.M., the SS Director said:<br><br>-The Social Service department should have ensured the Admission Inventory for the residents should have been completed upon admission.<br><br>-They have not been doing it.<br><br>-The resident or family member should have signed the inventory list verifying what belongings the resident came in with.<br><br>-If there was a dental issues it should have been care planned.<br><br>-If the resident wanted to see the dentist to see about getting dentures they should have made an appointment with the dentist as he/she is at the facility often.<br><br>-This resident should have been seen by the dentist but was missed.<br><br>-The resident had signed the permission sheet to have his/her teeth pulled so he/she could get dentures.<br><br>-The resident had not told him/her that the resident wanted new dentures.<br><br>3. During an interview on 5/7/24 at 10:52 A.M., RN C said:<br><br>-When a resident comes into the facility nursing does a full body assessment.<br><br>-They would look into the resident's mouth and document on the assessment any dental issues.<br><br>-If a resident had dental issues nursing would tell SS so that they could put them on the list to see the dentist.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -A dentist should look into the resident's mouth at least once a year.<br><br>-If there was an order to see an oral surgeon SS should have obtained a date for the appointment within a week.<br><br>-The SS Director was ultimately responsible to ensure the residents had seen a dentist annually and to have made any follow up appointments.<br><br>-He/She was not able to find any documentation for a follow up appointment for Resident #9.<br><br>-He/She was not able to find any documentation the dentist had seen Resident #13.<br><br>-He/She did not know if either of the residents had any teeth or dentures.<br><br>-Resident #13 had not told him/her that the resident wanted new dentures.<br><br>During an interview on 5/7/24 at 12:25 P.M. the Director of Nursing said:<br><br>-There should have been documentation in the chart that a resident had seen the dentist.<br><br>-It should have been documented in the progress notes or in SS notes.<br><br>-The MDS nurse should have done an oral assessment upon admission.<br><br>-SS was responsible to ensure the residents have dental appointments.<br><br>-If it took longer than a week to obtain a dental appointment there should have been documentation in the chart as to why it was taking so long to obtain the appointment.<br><br>-There was a document a few years ago stating Resident #13 did not want replacement dentures.<br><br>-The resident had not told him/her that the resident wanted new dentures.<br><br>-There was no documentation the dentist had seen Resident #13 since then.<br><br>-The dentist should have seen the resident and documented the visit in the chart at least annually.<br><br>-Nursing or the SS should have asked the resident it they wanted dentures at least annually.<br><br>-It was not done because they had a staffing change.<br><br>50579<br><br>4. Review of Resident 27's admission assessment, dated 10/6/23, showed the resident had missing natural teeth.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact and showed no issues with the residents oral or dental status.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Order Summary Report, dated 5/6/24, showed:<br><br>-A physician order for a referral to an oral surgeon that was placed on 3/25/24 and discontinued on 4/2/24.<br><br>-A physician order placed on 4/2/24 for a referral to an oral surgeon for tooth extractions.<br><br>During an observation and interview on 5/2/24 at 9:11 A.M., the resident was observed to have multiple missing and broken teeth, particularly in the front of his/her mouth. The resident said that the social services department had been working on getting him/her into an oral surgeon for a while, but he/she hasn't received an update.<br><br>During interview on 5/3/24 at 11:00 A.M., the Social Services Assistant said that the resident had been working with the Assistant Director of Nursing (ADON) to get an appointment with an oral surgeon and was unaware of the progress of the scheduling.<br><br>During interview on 5/03/24 at 11:10 A.M., the ADON said he/she tried getting the resident an appointment with the oral surgeon for about a month but was unsuccessful, the social services department then took over on working to get the resident an appointment and he/she was unaware of where they were at in the process.<br><br>During interview on 5/6/24 at 10:08 A.M., the Director of Social Services said the ADON was working on the appointment for the oral surgeon and was unaware of the progress of scheduling.<br><br>During interview on 5/7/24 at 12:24 P.M., the Director of Nursing said:<br><br>-The social services department was responsible for making dental appointments.<br><br>-There should have been documentation on the appointment making process.<br><br>-He/She would expect follow up on the appointment for the oral surgeon by this time.<br><br>During interview on 5/7/24 at 12:56 P.M., the ADON said he/she delegated the appointment making process around the 8th or 9th of April, just before going on vacation, and had worked on it for around a month prior to this. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>38452<br><br>Based on observation, interview, and record review, the facility failed to keep the Dry Storage (DS) room and walk-in freezer floors clean; failed to retain operable thermometers in all refrigerators to confirm adequate temperature ranges; failed to maintain sanitary and food preparation equipment; failed to change the deep fryer oil in a timely manner; and failed to maintain plastic cutting boards and utensils in good condition to avoid food safety hazards (cross-contamination), in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 115 residents with a licensed capacity for 172 residents at the time of the survey.<br><br>1. Observations on 5/1/24 between 10:32 A.M. and 11:05 A.M. during the initial kitchen inspection, showed the following:<br><br>-There was a strip of plastic, a sugar packet, a half & half creamer pod, and an iodized salt packet under the racks in the DS room.<br><br>-There was a small smudge of unknown residue on the blade of the manual can opener.<br><br>-A white handled spatula hanging on a utensil rack by the food preparation table had chipped edges on its blade.<br><br>-The light blue and red cutting boards were excessively scored to the point of plastic flaked off.<br><br>-There was paper and plastic trash under the racks in the walk-in freezer.<br><br>-The deep fryer oil had a multitude of crumbs floating on the top and was so black the bottom basket resting racks could not be seen.<br><br>Observation on 5/3/24 at 10:11 A.M. during the follow-up kitchen inspection, showed the following:<br><br>-There were pieces of plastic, paper, and a ketchup packet under the racks in the DS room.<br><br>-The same bit of unknown residue was on the manual can opener blade.<br><br>-The light blue, red, and yellow cutting boards were excessively scored.<br><br>-Paper and plastic trash were under the racks in the walk-in freezer.<br><br>During an interview on 5/3/24 at 10:13 A.M. the Dietary Services Manager (DSM) said the following:<br><br>-The deep fryer was used about twice a week and the oil was changed every other week.<br><br>-In the fall and winter, it was used more often so they tried to change the oil weekly then.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observations on 5/6/24 at 11:50 A.M. during the initial facility Life Safety Code (LSC) room-to-room inspections with the Maintenance Supervisor (MS) and the Administrator showed the white refrigerator in the Galley between the locked unit dining room and the rehab unit dining room did not have a thermometer in the bottom section.<br><br>During an interview on 5/6/24 at 11:53 A.M. the Administrator said that all the food and beverages in that white refrigerator were for the residents.<br><br>During an interview on 5/7/24 at 10:07 A.M. the DSM said the following:<br><br>-The dietary aides cleaned the floors twice a week after their food deliveries.<br><br>-Cooks and aides report damaged food preparation items to him/her and they are tossed out and replaced.<br><br>-He/She would expect food to be free of foreign substances.<br><br>-All refrigerators should have thermometers in them.<br><br>Observations on 5/7/24 at 10:51 A.M. during another follow-up kitchen inspection showed the deep fryer oil had numerous crumbs floating on the top and was so black the bottom basket resting racks could not be seen. |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452<br><br>Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive, facility-specific infection prevention and control program designed to help prevent the development and transmission of water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease), and failed to provide documented assessments for such an outbreak with accepted response protocols, in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility, the facility failed to ensure proper hand hygiene was performed by staff during wound care for two sampled residents, (Resident #51 and Resident #35), failed to follow infection control practices to prevent potential cross-contamination during wound care for one sampled resident (Resident #35) and during suprapubic (s/p) catheter (a urinary bladder catheter inserted through the skin about one inch above the symphysis pubis) care, including ensuring the catheter drainage bag remained off the floor for one sampled resident (Resident #52), Additionally the facility failed to initiate and perform Enhanced Barrier Protection (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) for two sampled residents, (Resident #51 and #52), failed to ensure staff sanitized the rubber hub prior to accessing and administering (medication used to treat high blood sugars) for two residents (Residents #107 and #37), and the facility failed to implement appropriate infection control procedures to mitigate the communication of infectious diseases when staff failed to ensure all residents were screened for tuberculosis (TB), a potentially serious infectious bacterial disease affecting the lungs, and failed to ensure a two-step TB skin test (TST) or a chest x-ray (tests to determine if a person is infected with the TB bacteria) was completed and documented in accordance with the facility policy for four (residents #27, #61, #165, #166), out of 23 sampled residents. The facility census was 115 residents with a licensed capacity for 172 residents at the time of the survey.<br><br>1. Observations on 5/1/24 between 10:13 A.M. and 11:05 A.M. during the initial kitchen Life Safety Code (LSC) inspection showed a three-sink area, and an area with a low-heat, chemical dish-washing machine, a handwashing sink, and an ice machine.<br><br>Observations on 5/6/24 between 11:11 A.M. and 2:57 P.M. during the initial facility LSC room-to-room inspections with the Maintenance Supervisor (MS) and the Administrator showed the following:<br><br>-There was a facility-wide fire sprinkler system.<br><br>-There was a Laundry room with clothes washers next to the kitchen.<br><br>-There were rooms with hot water heaters/boilers, and six standard bathtubs.<br><br>-There were at least 85 resident rooms with sinks and bathrooms, two bathhouses, four clean/soiled utility rooms with sinks, and housekeeping closets with mop hopper sinks.<br><br>-There was a satellite dining room near the Rehab Gym with an ice machine.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the facility's 10-page water-borne pathogen prevention program entitled, Water Management Program, last revised on 4/1/24 and provided by the MS, showed the following:<br><br>-In Table 2., under the heading Inventory of System Components, some of the facility's plumbing components were mentioned, and Tables 3. and 4. had a list of Potential Hazardous Events and examples of Qualitative Measures of Likelihood, respectively, but there was no diagram or flowchart that identified and indicated specific potential risk areas of growth within the building with assessments of each area's individual potential risk level.<br><br>-There was no facility-specific risk assessment that considered the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188.<br><br>-There was no completed Centers for Disease Control (CDC) toolkit including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.<br><br>-Table 7. listed possible incidents with their response procedures, but there was no facility-specific infection prevention program or plan to deal with outbreaks of Legionella and/or other waterborne pathogens, including testing protocols and acceptable ranges for control measures with a method of monitoring them at this facility, with interventions or action plans for when control limits were not met.<br><br>-Tables 9. and 10. had 15 separate building descriptions and components to be completed, yet all were answered, 'No construction at this time.<br><br>-Table 12. contained 4 protocols for vacant rooms with suggested responses to each, but there was no documentation of any being performed and/or a site log book being maintained with any cleanings, sanitizings, descalings, and inspections mentioned.<br><br>-Table 14. showed the quantities of several points of their water system throughout the building, but there was no written explanation of the water flow throughout the facility, with a schematic, diagram, or flowchart of the facility's complete water system.<br><br>During an interview on 5/9/24 at 12:31 P.M., the MS said the following:<br><br>-He/She had viewed educational materials on Legionella on the computer, but it really was not specific on program requirements.<br><br>-He/She conducted an in-service for staff once and explained to them what Legionella was.<br><br>Review of the in-service sign in sheets provided by the MS showed they were dated 3/31/23, 7/26/23, 8/31/23, 10/5/23, and 11/29/23, and consisted of the signature pages only, with no educational materials attached.<br><br>During an interview on 5/9/24 at 2:32 P.M., the Administrator said that he/she had been educated on Legionella program requirements through viewing a recent PowerPoint training.<br><br>39469<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 2. Review of the facility's policy, Hand Hygiene, dated 6/13/23 showed:<br><br>-Associates perform hand hygiene (even if gloves were used) in the following situations:<br><br>--Before and after contact with the resident.<br><br>--After contact with blood, body fluids, or visibly contaminated surfaces.<br><br>--Before performing a procedure such as dressing care.<br><br>-Ensure that supplies necessary for adherence to hand hygiene were readily accessible in all areas where patient care was being delivered.<br><br>Review of the facility's Insulin policy, dated 8/30/23 did not include directions for the staff to sanitize the hub before applying the needle.<br><br>Review of the facility's Policy, Enhanced Barrier Precaution, dated 3/21/24 showed:<br><br>-EBP is indicated for residents with wounds and/or indwelling devices even if the resident is not known to be infected or colonized with a multidrug-resistant organism (MDRO).<br><br>-EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities which would include wound care.<br><br>-The facility may choose to post signage on the door or wall outside of the resident room indicating the resident was on EBP.<br><br>-Examples of high-contact resident care activities requiring gown and gloves include device care of use, including urinary catheters, and wound care for any skin opening requiring a dressing.<br><br>Review of the Mayo Clinic instructional guide, How to use an Insulin Pen, on the Mayo Clinic Website, dated 6/13/14 showed:<br><br>-Remove the cap from the insulin pen.<br><br>-Wipe the rubber membrane with an alcohol wipe.<br><br>-Apply needle.<br><br>3. Review of Resident # 51's face sheet showed he/she was admitted on [DATE] with a diagnosis of Malignant Melanoma of the skin (a type of skin cancer - when the cells that give the skin its color grow out of control).<br><br>Review of the resident's Annual Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated 3/14/24 showed:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -The resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating he/she was cognitively intact.<br><br>-He/She had a medically complex condition.<br><br>-He/She had a skin tear, abrasion (a scraping or wearing away), or laceration (a deep cut or tear in the skin or flesh).<br><br>-He/She had ointment or medications applied to (places) other than the feet.<br><br>Review of the resident's 3/14/24 care plan showed:<br><br>-He/She had excoriation ( a conscious repetitive picking of the skin that leads to skin lesion)/Yeast (a skin condition on the skin that creates a raised, red itchy bumps on the skin) on bilateral rear thighs upon admission.<br><br>-He/She was witnessed on several occasions scratching and picking at areas.<br><br>-Staff was to administer treatments as ordered.<br><br>-The care plan did not address placing the resident on EBP related to his/her open wounds.<br><br>Review of the resident's May 2024 Physician's Order Sheet (POS) showed the following order:<br><br>-Apply antifungal cream to bilateral posterior thigh every day and evening shift for dry skin and itching, dated 2/10/22.<br><br>Review of the resident's Weekly Skin Integrity Data Collection sheet dated 5/1/24 showed the following alterations in skin:<br><br>-The resident had friction (the resistance that one surface encounters when moving over another) or shearing (a force acting in a direction that's parallel to a surface causing pressure).<br><br>Observation and interview on 5/03/24 at 11:12 A.M. during wound care with Licensed Practical Nurse (LPN) C/Wound Care Nurse showed:<br><br>-The resident did not need to be on EBP as the wound was not open.<br><br>-The resident would often scratch his/her thighs until he/she would bleed.<br><br>-The wound would heal and then open up again.<br><br>-There was no EBP sign on the door.<br><br>-There was no isolation supplies in the resident's room.<br><br>-The nurse entered the resident's room without a gown or gloves on.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -The nurse was stopped to put on isolation Personal Protective Equipment (PPE - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses).<br><br>-The resident had a large open area on his/her inner right thigh 8 x 3 inches with bloody meaty looking opened area.<br><br>-The resident had a large open area on his/her left inner thigh 8 x 2 inches with red raw looking area.<br><br>-The nurse cleansed the wounds per the physician's order.<br><br>-He/She took off his/her gloves cleansed his/her hands and reapplied gloves.<br><br>-He/She opened two packets of antifungal (medication used to treat skin infections) cream and squirted both packets of the cream into his/her right gloved hand.<br><br>-He/She applied the cream to the residents right wound.<br><br>-He/She applied the cream to the resident's left side wound without changing gloves or cleansing his/her hands.<br><br>-The resident had the wound when he/she came into the facility a couple of years ago.<br><br>-The resident went to the dermatologist (a physician who specialized in conditions that affect the skin) twice in the last couple of months.<br><br>-The dermatologist said the resident had Dermatitis (An inflammation of the skin).<br><br>-He/She maybe should not have applied the medicated cream to both wounds without changing gloves.<br><br>-They just started EBP at the facility in April.<br><br>-The resident should have had a EBP sign on his/her door stating they had to wear PPE.<br><br>-He/She did the wound care on the resident daily.<br><br>-The resident scratches the areas and then the area would open up again.<br><br>-He/She should have worn a gown and gloves to treat the wound per the EBP protocol.<br><br>-Any time there was a opening in the resident staff should have used EBP protocol.<br><br>During an interview on 5/3/24 at 11:45 A.M. the resident said:<br><br>-The areas on his/her thighs often itched.<br><br>-He/She had scratch his/her thighs until they bleed.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -The Wound Care Nurse puts medication on his/her thighs just like he/she did today.<br><br>-Staff had not been wearing a gown only gloves when doing wound cares.<br><br>During an interview on 5/7/24 at 9:30 A.M. Certified Nursing Assistant (CNA) E said:<br><br>-The facility had provided education on EBP more than two weeks ago.<br><br>-If there were any open wounds the resident would have been on EBP.<br><br>-There should have been a sign on the resident's door which showed they were on EBP.<br><br>-There should have been PPE at the resident's door.<br><br>-The nurse was responsible for ensuring there was a sign on the resident's door and PPE available.<br><br>During an interview on 5/7/24 at 10:00 A.M. Certified Medication Technician (CMT) B said:<br><br>-The facility had provided education on EBP maybe three weeks ago.<br><br>-The staff was expected to wear a gown and gloves when doing cares with the resident if they had an open wound.<br><br>-There should have been a EBP sign on the resident's door.<br><br>-There should have been an isolation cart with PPE at the resident's door.<br><br>-The nurse should have been responsible for ensuring it was done.<br><br>During an interview on 5/7/24 at 10:52 A.M. Registered Nurse (RN) C said:<br><br>-The facility had recently provided education on EBP.<br><br>-If a resident had a wound, open area, or tube the resident should have had a sign on their door stating EBP precautions were in place.<br><br>-That resident should have had EBP precautions in place.<br><br>-There should have been a EBP sign on the door and PPE at the door.<br><br>-The nurse or charge nurse should have ensured EBP precautions were in place.<br><br>-The nurse should have changed gloves and cleansed hands before applying medication to the second wound because it would spread infection from one wound to the other.<br><br>During an interview on 5/7/24 at 12:25 P.M. the Director of Nursing (DON) said:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -According to the Centers for Disease Control (CDC), any direct patient care when they have a wound should have EBP in place.<br><br>-The facility has provided education on what was expected for EBP.<br><br>-There should have been a EBP sign on that resident's door.<br><br>-There should have been PPE at the resident's door.<br><br>-The nurse should have used EBP because the resident had an open wound.<br><br>-Any nurse could have initiated the EBP.<br><br>-The nurse should have changed gloves and cleansed his/her hands before applying medication to the second wound because it would have spread germs from one wound to the other.<br><br>4. Observation on 5/3/24 at 7:50 A.M. during a medication pass with LPN B showed:<br><br>-He/She took out Resident #107's Novolog (a rapid acting insulin used to control high blood sugars) insulin pen.<br><br>-He/She did not clean the rubber hub before applying the needle and administering the insulin to the resident.<br><br>Observation on 5/3/24 at 7:55 A.M. during a medication pass with LPN B showed:<br><br>-He/She took out Resident #37's Lantus (a long acting insulin used to control high blood sugars) insulin pen.<br><br>-He/She did not clean the rubber hub before applying the needle and administering the insulin to the resident.<br><br>During an interview on 5/3/24 at 8:00 A.M. LPN B said:<br><br>-He/She did not clean the rubber hub on the insulin pens because he/she forgot to.<br><br>-The facility had provided education on using the insulin pens.<br><br>During an interview on 5/7/24 at 10:52 A.M. Registered Nurse (RN) C said:<br><br>-They have had education on using Insulin pens.<br><br>-The nurse should have cleaned the rubber hub with an alcohol wipe before attaching the needle and administering the insulin to the resident.<br><br>-The charge nurse or DON should have been responsible for ensuring the nursing staff were giving the residents insulin correctly.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 5/7/24 at 12:25 P.M. the DON said:<br><br>-The staff has had education on how to use insulin pens.<br><br>-The nurse should have cleaned the rubber hub with alcohol before attaching the needle to administer insulin to the resident.<br><br>33409<br><br>5. Review of Resident #35's Admission Face Sheet showed the following diagnoses:<br><br>-Pressure Ulcer (is 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) of his/her left hip Stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling).<br><br>-Pressure Ulcer of Sacral (sacrum, is a large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity) Area Stage IV.<br><br>Review of the resident's Admission MDS dated [DATE] showed:<br><br>-The resident had a BIMS score of 15 out of 15 indicating he/she was cognitively intact.<br><br>-He/She had a two wounds upon admission and Moisture-associated skin damage (MASD, is the general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture).<br><br>-Required total staff assistance with all cares.<br><br>Review of the resident's Skin Care Plan dated 3/7/24 showed he/she had break in skin integrity, Pressure Ulcer Coccyx/Sacrum and to Left Ischium (the lower and back part of the hip).<br><br>Review of the resident's Physician order Sheet May 2024 showed:<br><br>-Cleanse Coccyx/Sacrum and wound with Normal Saline (NS), Apply Skin Prep (a topical barrier between skin and adhesives) to surrounding edges, then apply Collagen Prisma Wound Dressing (It is a freeze-dried product designed to kick start the healing process while providing protection from infection) and apply Aquacel AG (a surgical Hydro fiber cover dressing with Ionic Silver for your wound care needs. Is suitable for a wide range of acute and chronic wounds) then cover with bordered foam dressing (convenient adhesive border helps secure the dressing in place and provides a barrier to outside contaminants) every dayshift on Monday, Wednesday and Fridays. As needed for if soiled or dressing removed. (Ordered on 4/12/24).<br><br>-Cleanse Left Ischium with Normal Saline (NS), Apply Skin Prep to surrounding edges, then apply Collagen Prisma and apply Aquacel AG, then cover with bordered foam. Change dressing every dayshift on Monday, Wednesday, Friday and as needed for if soiled or dressing removed. (Ordered on 4/11/24).<br><br>Observation of the resident on 5/3/24 at 8:00 A.M., showed:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -The resident was on Enhanced Barrier Precautions.<br><br>-Had signage posted due to wounds and other health factors.<br><br>Observation on 5/3/24 at 9:00 A.M., of the resident's wound care showed:<br><br>-Wound Nurse and unknown CNA entered the resident room and washed their hands with soap water, then applied protective gown and gloves on hands.<br><br>-With gloves hands the Wound Nurse had removed the three old wound dressings dated 5/1/24.<br><br>-The old dressings had soiled brown substance and slight wound odor noted.<br><br>-Wound nurse removed his/her gloves and without washing or sanitizing his/her hands, donned clean gloves.<br><br>-He/She then cleaned the resident's coccyx wound, sacral wound, and left ischium wound with the same gloved hands without changing gloves or sanitizing his/her hands between each wound.<br><br>-Wound nurse removed gloves and without washing or sanitizing his/her hands, donned clean gloves.<br><br>-He/She then then Apply Skin Prep to surrounding wound edges for each of the three wounds with same the gloved hands.<br><br>-Without changing his/her gloves, he/she then applied the wound treatments to each wound. He/she did not change his/her gloves or sanitize hand between each wound dressing.<br><br>-Wound nurse removed soiled gloves and then sanitized his/her hands to assisted in replacement of a draw sheet under the resident.<br><br>-Wound nurse and CNA removed gloves and gown, washed hands with soap and water prior to exiting the resident room.<br><br>During an interview on 5/7/24 10:20 A.M., CNA C said:<br><br>-Hand hygiene should be done between dirty to clean areas and with every glove change to prevent cross contamination.<br><br>-The facility had just started Enhanced Barrier Precaution for those resident with catheters, wounds, other medical condition that would be potential for cross-contamination during care.<br><br>During an interview on 5/7/24 at 10:32 A.M., the Wound Nurse said:<br><br>-He/She would wash his/her hands upon enter of the resident room prior to wound care.<br><br>-He/She should sanitize or wash his/her hand between each glove change, when soiled, and from a dirty to clean process.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -For residents on EBP, hands-on care staff should wear gloves and gowns, wash their hands upon entering the room, between glove changes, and from a dirty to clean process.<br><br>-He/She said thought had he/she had sanitized his/her hands between each glove change by using the hand sanitizer that was in his/her scrub top pocket.<br><br>-He/she should have completed each wound care separately to include hand hygiene and glove change between each wound care treatment to prevent cross-contamination during wound care and to reduce the risk of the resident getting wound infections.<br><br>During an interview on 5/7/24 at 12:23 P.M., DON, Regional Director Services, Assistant Director of Nursing (ADON) said:<br><br>-He/She would expect care staff to perform hand washing or sanitize hands between each glove change and between each wound care process.<br><br>-He/she would expect wound care nurse and nursing staff to complete each wound care process separately, to change gloves and perform hand hygiene prior the start on the next wound to prevent cross-contamination.<br><br>-He/She would expect glove changes and hand hygiene when hands or gloves were soiled or contact body fluid and from a dirty to clean process.<br><br>-If wounds were open area, staff should change gloves between each wound process.<br><br>6. Review of Resident #52's Admission Face sheet showed the following diagnoses:<br><br>-History of urinary tract infection.<br><br>-Neurogenic bladder (a disorder of urinary bladder control due to damage to the spinal cord or to the nerves supplying the bladder).<br><br>Review of the resident's Quarterly MDS dated [DATE] showed:<br><br>-The resident had a BIMS score of 15 out of 15 indicating he/she was cognitively intact.<br><br>-He/She had a diagnosis of Neurogenic Bladder.<br><br>-Required a indwelling catheter.<br><br>-History of antibiotic use during look back period.<br><br>Review of the resident's Care Plan revised on 4/12/24 showed:<br><br>-The resident had a Suprapubic Catheter (S/P) related to Neurogenic bladder.<br><br>-Position catheter bag and tubing below the level of the bladder.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265355 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/09/2024 |
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| NAME OF PROVIDER OR SUPPLIER Life Care Center of Grandview | | STREET ADDRESS, CITY, STATE, ZIP CODE 6301 East 125th St Grandview, MO 64030 | |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -Catheter care every shift.<br><br>Review of the resident's POS 5/2024 showed:<br><br>-He/She had physician order for a Suprapubic Catheter related to Neuromuscular Dysfunction of bladder, ordered on 8/28/23.<br><br>-Suprapubic catheter to be irrigated with Acetic Acid Irrigation Solution 0.25 % (Acetic Acid, irrigation solution is used to prevent infection due to placement of a catheter into the bladder), use 50 centimeters (cc) via irrigation one time a day, related to his/her personal history of UTI. Plug catheter for 30 minute then unplug, (ordered on 11/7/23).<br><br>-Cleanse suprapubic site with warm soap and water and replace split sponge daily every night shift. (Ordered on 9/20/22).<br><br>-Catheter care every shift with warm soap and water every shift, keep catheter bag placed below the level of the bladder at all times. (Ordered on 9/8/22).<br><br>Observation on 5/1/24 at 1:59 P.M. and 3:30 P.M., showed the resident's bed was in lowest position to ground, and the catheter drainage bag laid on ground without a protective barrier.<br><br>Observation on 5/2/24 at 8:58 A.M., showed:<br><br>-The resident bed was in low position.<br><br>-His/Her catheter drainage bag hung on bed rail touching the ground without a protective barrier for the drainage bag.<br><br>Observation 5/3/24 at 7:18 A.M., showed the resident's bed in the lowest position with the catheter drainage bag touching the ground.<br><br>Observation on 5/3/24 at 8:38 A.M., showed the resident's bed was in lowest position to ground, with catheter drainage bag touching the floor with no barrier under the bag.<br><br>Observation on 5/3/24 at 9:45 A.M., showed:<br><br>-Upon enter of the resident room noted a EBP signage posted on the open door.<br><br>-LPN B was going to flush the resident's suprapubic (SP) catheter.<br><br>-He/She the entered the resident room and washed his/her hands. Placed gloves on his/her hands.<br><br>-He/She did not don a protective gown prior to flushing the Foley catheter<br><br>-He/she removed soiled gloves and washed his/her hands with soap and water.<br><br>During an interview on 5/6/24 at 1:25 P.M., CMT A said:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -SP catheters drainage bag should be keep below the bladder at all times.<br><br>-When resident laid in bed with bed in lowest position, he/she would place on drainage back on bed frame ensuring catheter drainage bag does not touch ground to prevention infection.<br><br>Observation on 05/07/24 at 9:15 A.M. the resident Foley catheter bag on touching ground no barrier, bed in lowest position.<br><br>During an interview on 5/7/24 at 10:20 A.M., CNA C said:<br><br>-If resident's bed low position the catheter drainage bag should be placed in a dignity bag and never touch ground. If found on ground should notify nurse and replace the catheter drainage bag.<br><br>-The catheter drainage bag and tubing should not touch round due to possible pull catheter out and the possibility of cross contamination and infections.<br><br>-Hand hygiene should wash your hand or sanitize your hands between a dirty to clean process and between each glove changes to prevent cross contamination.<br><br>-Enhanced barrier precaution was new at the facility.<br><br>-He/she should wear gown and gloves when provided direct resident care for those resident on EBP.<br><br>During an interview on 5/7/24 at 10:56 A.M., LPN B said:<br><br>-He/She had recent training related to EBP, a new process the facility putting in place.<br><br>-If catheter care or wound care need to be completed, he/she would expect care staff to don a gown and gloves during those care to prevent cross contamination.<br><br>-He/She did not wear a gown during catheter irrigation and SP site care, he/she did not see the EBP signage posted.<br><br>During interview on 5/7/24 at 12:23 P.M., DON, Regional Director Services, and the ADON said:<br><br>-If the resident was in bed, the catheter drainage bag should not be touching the floor or laid on ground.<br><br>-He/She would expect a barrier for the catheter drainage bag if bed lowest position and not laid on floor/ground without a barrier, to prevent the potential for infection and cross contamination.<br><br>-The facility had recent training for all staff related to EBP.<br><br>-The facility would determine by facility EBP policy and per CDC standard of care, that any resident with open wounds, indwelling catheter, supra pubic would be placed on EBP. This would require any direct care for the wear a gown, gloves and possible mask.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -He/She would expect nursing staff to have worn a gown and gloves to prevent cross contamination from potential splatters or spills when doing a catheter flush/irrigation.<br><br>50579<br><br>7. A facility policy on resident TB screening, testing and mitigation was requested but not provided.<br><br>Review of the facility Long-term Care - TB Risk Assessment, dated 2/6/24, showed:<br><br>-The facility was a low-risk setting for the transmission of TB.<br><br>-A two-step TST (where one antigen skin test is administered and observed for a reaction 48-72 hours later. Then, a second skin test is administered one to three weeks later and observed 48-72 hours after administration to determine if a person has antibodies for the TB bacteria) should have been completed upon resident admission.<br><br>-A medical evaluation would be completed, including symptom assessment and chest x-ray is TST is positive.<br><br>Review of Resident #27's medical record showed:<br><br>- An admitted [DATE].<br><br>-No administration of a two-step TST upon admission.<br><br>-No screening or evaluation of TB symptoms.<br><br>-No documentation of a chest x-ray to rule out active TB infection.<br><br>Review of Resident #61's medical record showed:<br><br>-Administration of one step of a two-step TST (administered 1/18/24, evaluated 1/20/24).<br><br>-No administration of a second step of the two-step TST.<br><br>-No screening or evaluation of TB symptoms.<br><br>-No documentation of a chest x-ray to rule out active TB infection.<br><br>Review of Resident #165's medical record showed:<br><br>-Administration of a two-step TST (3/11/21 and 3/21/21).<br><br>-No annual screening or evaluation of TB symptoms.<br><br>Review of Resident #166's medical record showed:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265355 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/09/2024 |
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| NAME OF PROVIDER OR SUPPLIER Life Care Center of Grandview | | STREET ADDRESS, CITY, STATE, ZIP CODE 6301 East 125th St Grandview, MO 64030 | |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -An admitted [DATE].<br><br>-No administration of a two-step TST upon admission.<br><br>-No screening or evaluation of TB symptoms.<br><br>-No documentation of a chest x-ray to rule out active TB infection.<br><br>During interview on 5/07/24 at 9:22 A.M., the Assistant Director of Nursing (ADON) said Resident #166 is unable to receive a TST because they come back positive. However, the facility did not have a chest x-ray, other proof the resident did not have an active TB infection, or documentation to support inability to have a TST due to a previous positive.<br><br>During interview on 5/07/24 at 9:40 A.M., the ADON said:<br><br>- He/she was responsible for ensuring the completion of TB screening and skin tests.<br><br>-He/She would put the orders in for resident's two-step TSTs on admission and the nurses were responsible for administering and evaluating the TST.<br><br>-The nurses didn't always get the order completed or put the information into the resident's immunization record.<br><br>-The residents should have an annual screening for TB in addition to their admission TST.<br><br>-Any positives would need further evaluation to determine why the TST was positive.<br><br>During interview on 5/7/24 at 12:24 P.M., the Director of Nursing (DON) said:<br><br>- The ADON was tasked with ensuring TB screening and skin testing was completed, but the DON was ultimately responsible.<br><br>-New admissions needed a two-step TST or chest x-ray on admission.<br><br>-An annual evaluation needed to be completed to screen for TB.<br><br>-Any readmission would need another TST if they were in the community for over 30 days.<br><br>-The nurses were responsible for administering and documenting results of TSTs. |

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|---|---|---|---|
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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579<br><br>Based on interview and record review, the facility failed to provide education to the resident or the resident's representative and obtain signed consent or refusal of the pneumococcal (any infection caused by the bacteria Streptococcus pneumoniae) vaccine, for two residents (Residents #48 and #166), failed to obtain signed refusal the pneumococcal vaccine for one resident (Resident #165) and failed to administer a consented pneumococcal vaccine to one resident (Resident # 61) out of five sampled residents. The facility census was 115 residents.<br><br>Review of a facility policy titled Influenza and Pneumococcal Vaccine Policy for Residents, dated 7/30/2019, showed:<br><br>-The facility was to offer each resident the pneumococcal vaccine unless medically contraindicated or the resident has already been immunized.<br><br>-There should have been documentation in the medical record if there was reason to believe the resident was previously given the pneumococcal vaccine.<br><br>-Refusals should have been documented in the medical record and re-addressed each year.<br><br>-Education should have been provided in the form of a vaccine information statement (VIS) and a consent or refusal should have been signed.<br><br>1. Review of Resident #48's medical record showed:<br><br>-An admitted [DATE].<br><br>-No pneumococcal vaccination history.<br><br>-No evidence of a pneumococcal vaccine being offered or administered by the facility.<br><br>-No signed consent or refusal for the pneumococcal vaccine.<br><br>-No evidence of pneumococcal vaccine education provided to the resident or resident's representative.<br><br>2. Review of Resident #166's medical record showed:<br><br>-An admitted [DATE].<br><br>-No pneumococcal vaccination history.<br><br>-No evidence of a pneumococcal vaccine being offered or administered by the facility.<br><br>-No signed consent or refusal for the pneumococcal vaccine.<br><br>(continued on next page) |

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|---|---|---|---|
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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -No evidence of pneumococcal vaccine education provided to the resident or resident's representative.<br><br>3. Review of Resident #165's medical record showed:<br><br>-A current admitted [DATE], with an initial admitted [DATE].<br><br>-No pneumococcal vaccination history.<br><br>-A status of Consent Refused for the pneumococcal vaccine under facility immunization tracking.<br><br>-No signed refusal for the pneumococcal vaccine.<br><br>4. Review of Resident #61's medical record showed:<br><br>-An admitted [DATE].<br><br>-No pneumococcal vaccination history.<br><br>-A Informed Consent for Pneumococcal Vaccine verbally consented by resident's medical representative dated 9/7/23.<br><br>-No evidence of pneumococcal vaccine education provided to the resident or resident's representative.<br><br>-No evidence of administration of the pneumococcal vaccination.<br><br>During interview on 5/07/24 at 9:40 A.M., the Assistant Director of Nursing (ADON) said:<br><br>-He/She was responsible for ensuring the completion of pneumococcal vaccinations for residents.<br><br>-Vaccine history was reviewed on admission, including the state vaccine registry.<br><br>-The facility would offer the vaccine to residents able to consent and send letters to the medical representatives of those who were not.<br><br>-The residents should have signed a form indicating a consent or refusal for the pneumococcal vaccine.<br><br>-The pneumococcal vaccine administration or refusal should have been documented in the resident's medical record.<br><br>During interview on 5/7/24 at 12:24 P.M., the Director of Nursing (DON) said:<br><br>-The ADON was tasked with infection control, including ensuring the completion of the pneumococcal vaccinations of residents.<br><br>(continued on next page) |

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

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The DON was ultimately responsible for ensuring the resident's received education, the facility obtained a signed consent/refusal, administered the pneumococcal vaccine as appropriate and documented the resident's pneumococcal vaccination status in the medical record.<br><br>-He/she would expect education, signed consents/refusals, vaccination administration information and the offering of the pneumococcal vaccination as appropriate to be done and documented by the facility. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579<br><br>Based on interview and record review, the facility failed to provide education to the resident or the resident's representative and obtain signed consent or refusal of the Coronavirus Disease 2019 (COVID-19), for three residents (Residents #48, #61, and #166) out of five sampled residents. The facility census was 115 residents.<br><br>Review of a facility policy titled COVID-19 Vaccination Program Policy for Residents, dated 1/3/22, showed:<br><br>-The vaccine should have been offered to each resident and staff member unless the immunization was medically contraindicated or the resident or staff member had already been immunized.<br><br>-Education should have been provided to the resident or resident representative before being offered the COVID-19 vaccination.<br><br>-There should have been documentation in the medical record of the education provided, each dose of the COVID-19 vaccine that was administered, and any contraindications or vaccine refusals.<br><br>1. Review of Resident #48's medical record showed:<br><br>-An admitted [DATE].<br><br>-No COVID-19 vaccination history.<br><br>-No evidence of a COVID-19 vaccine being offered or administered by the facility.<br><br>-No signed consent or refusal for the COVID-19 vaccine.<br><br>-No evidence of COVID-19 vaccine education provided to the resident or resident ' s representative.<br><br>2. Review of Resident #166's medical record showed:<br><br>-An admitted [DATE].<br><br>-No COVID-19 vaccination history.<br><br>-No evidence of a COVID-19 vaccine being offered or administered by the facility.<br><br>-No signed consent or refusal for the COVID-19 vaccine.<br><br>-No evidence of COVID-19 vaccine education provided to the resident or resident ' s representative.<br><br>3. Review of Resident #61's medical record showed:<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -An admitted [DATE].<br><br>-No COVID-19 vaccination history.<br><br>-No evidence of a COVID-19 vaccine being offered or administered by the facility.<br><br>-No signed consent or refusal for the COVID-19 vaccine.<br><br>-No evidence of COVID-19 vaccine education provided to the resident or resident ' s representative.<br><br>During interview on 5/07/24 at 9:40 A.M., the Assistant Director of Nursing (ADON) said:<br><br>-He/She was responsible for ensuring the completion of COVID-19 vaccinations for residents.<br><br>-Vaccine history was reviewed on admission, including the state vaccine registry.<br><br>-The facility would offer the vaccine to residents able to consent and send letters to the medical representatives of those who were not.<br><br>-The facility did not have a form for residents to sign that indicated a consent or refusal to accept the COVID-19 vaccine.<br><br>During interview on 5/7/24 at 12:24 P.M., the Director of Nursing (DON) said:<br><br>-The ADON was tasked with infection control, including ensuring the completion of the COVID-19 vaccinations of residents.<br><br>-The DON was ultimately responsible for ensuring the resident's received education, the facility obtained a signed consent, administered the COVID-19 vaccine as appropriate and documented the resident's COVID-19 vaccination status in the medical record.<br><br>-He/She would expect education, signed consents, vaccination administration information and the offering of the COVID-19 vaccination as appropriate to be completed and documented by the facility. |