STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview and record review, the facility failed to maintain the floors free from a heavy buildup of dust and debris in the following resident rooms 208, 207, 302, 300, 601, 510, 500 Hall shower room, 607, 405, 410, 409, 407, 401; failed to maintain the fans free of a heavy buildup of dust in the following resident rooms 302, 301; and failed to maintain ceiling vents free of a heavy buildup of dust in the following resident rooms 405 and the 500 Hall shower room . This practice potentially affected at least 30 residents who resided in or used those areas. The facility census was 88 residents. 1. Review of the undated Housekeeping Route sheet (a sheet which showed the steps to clean the resident rooms), showed: 7-Step room cleaning: 1. Pull Trash. 2. Dust horizontal surfaces. 3. Sanitize high traffic areas. 4. Spot clean walls. 5. Sweep floors under and behind furniture and beds. 6. Damp mop floors under and behind furniture and beds. 7. Wipe down beds. 8. Sanitize high touch areas such as call lights, bed remotes light switches etcetera (etc.) 2. Observations with the Maintenance Director (MD) and the Regional Maintenance Person on 5/21/24, showed: - At 10:15 A.M., there was a heavy buildup of dust on the floor of resident room [ROOM NUMBER]. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 10:17 A.M., there was a heavy buildup of dust on the floor of resident room [ROOM NUMBER]. - At 10:37 A.M., there was a crack in the shower chair in the 200 Hall shower room. - At 10:51 A.M., there was a buildup of debris on the floor and the there was a buildup of dust on the fan blades in resident room [ROOM NUMBER]. - At 10:52 A.M. there was a buildup of grime on the floor in resident room [ROOM NUMBER]. - At 10:53 A.M., there was a buildup of grime on the floors in resident room [ROOM NUMBER]. - At 11:00 A.M., there was a buildup of dust and hair between the bed and the wall in resident room [ROOM NUMBER]. - At 11:05 A.M., there was a buildup of dust on the fan in resident room [ROOM NUMBER]. - At 12:44 P.M., there was a buildup of grime on the floor next to the bed in resident room [ROOM NUMBER]. - At 1:05 P.M., there was a buildup of debris on the floor behind the nightstand in resident room [ROOM NUMBER]. - At 1:09 P.M., there were many sugar packets, food crumbs and empty coffee creamer containers on the floor behind the 600 Hall nurse's station. - At 1:18 P.M., there was a buildup of crumbs on the floor in resident room [ROOM NUMBER]. - At 1:37 P.M., there was a buildup of dust on the ceiling vent in the restroom of Resident room [ROOM NUMBER]. - At 1:39 P.M., there was a buildup of grime and debris in under the bed and next to the bed in resident room [ROOM NUMBER]. - At 1:42 P.M., there was a buildup of grime between the bed and wall in resident room [ROOM NUMBER]. - At 1:51 P.M., there was a buildup of food debris under the bed in resident room [ROOM NUMBER]. - At 1:53 P.M., there was a layer of dust between the bed and the wall in resident room [ROOM NUMBER]. - At 1:56 P.M., there was a buildup of dust ad debris on the floor in resident room [ROOM NUMBER]. 3. Review of Resident #47's quarterly Minimum Date Set (MDS-a federally mandated assessment tool completed by the facility for care planning) dated 3/22/24, showed the resident was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/24 at 11:02 A.M., the resident said the housekeepers do not get behind his/her bed as he/she noticed a lot of debris between his/her bed and the wall in his/her room. 4. Review of Resident #5's quarterly MDS dated [DATE], identified the resident as cognitively intact. During an interview on 5/21/24 at 1:54 P.M., the resident said the housekeeping department did not have enough staff to clean his/her room regularly. 5. Observation on 5/22/24 at 12:37 P.M., with the Housekeeping Supervisor showed a buildup of grime and hair along the wall in room [ROOM NUMBER]. During an interview on 5/21/24 at 12:47 P.M., the Housekeeping Supervisor said there were only three housekeepers at that time and the housekeepers felt rushed to get to every room. During an interview on 5/21/24 at 1:10 P.M., Certified Medication Technician (CMT) B said the housekeepers do not get a chance to clean behind the nurse's station very often. During an interview on 5/22/24 at 12:39 P.M. the Housekeeping Supervisor said the dust and debris were present on the floor of resident room [ROOM NUMBER], because there were only three housekeepers on staff and they feel rushed to get to every room and may not do as thorough as a job in cleaning each room. During an interview on 5/23/24 at 1:04 P.M., Housekeeper A said: - He/she did not have enough time to clean the resident rooms because they were short staffed. - The housekeepers do their best to clean all the rooms. - He/she did not have enough time to move the beds and he/she can get under the beds as best he/she can, when the residents do not have a lot of stuff under the beds. 6. Observations with the MD and the corporate Maintenance Person on 5/21/24, showed: -At 1:34 P.M., there was a buildup of dust on the ceiling vent in the 500 Hall shower room. -At 1:37 P.M., there was a buildup of dust on the ceiling vent in the restroom of Resident room [ROOM NUMBER]. During an interview on 5/21/24 at 1:35 P.M., the MD said he/she did not know how long the ceiling vent in the shower room had dust inside of it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on observation, interview and record review, the facility failed to ensure a system in place for monitoring shower/bathing related to Activities of Daily Living (ADL's- grooming, bathing, hygiene), and to ensure baths or showers were provided at as scheduled for five sampled residents (Resident #6, #32, #58, #76, and #85) out of 18 sampled residents. The facility census was 88 residents. Review of undated facility policy entitled Bath, Shower/tub showed: -The purpose was to promote cleanliness, provide comfort to the resident and observe the condition of the resident's skin. -Complete bathing per residence preference (shower or bath). -Document the time the shower/tub bath was performed. -Document the name and title of the individual(s) who assisted the resident with shower/tub bath. -Document all assessment data. -Document how the resident tolerated the shower /tub bath. -Document if the resident refused shower/tub bath, the reason(s) why and the interventions taken. -Document the signature and title of the person who recorded the data. -Notify the supervisor if the resident refused the shower/tub bath. -Report other information in accordance with facility policy and professional standards of practice. 1. Review of Resident #32's Admission record showed the resident was admitted to the facility on [DATE] with a diagnosis of Cerebral Palsy (a congenital disorder of movement, muscle tone, or posture). Review of the resident's bathing documentation from the Electronic Medical Record (EMR) dated 3/2024 showed: -The resident received a shower on 3/8/24, 3/11/24 and 3/12/24 and was totally dependent on staff. -The resident received a bed/towel bath on 3/21/24 and was totally dependent on staff. -The resident was scheduled for a shower/bath twice a week and received four baths out of eight opportunities. Review of the resident's bathing documentation from the EMR dated 4/2024 showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident received a shower on 4/2/24, 4/12/24, 4/18/24 and was totally dependent. -The resident was scheduled for a shower/bath twice a week and received three shower/baths out of nine opportunities. Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 4/20/24 showed the resident: -Had severe cognitive impairment. -Required staff to perform all the activities for bathing and showering. Review of the resident's bathing documentation from the EMR from 5/1/24 through 5/21/24 showed: -The resident received a shower on 5/14/24 and was totally dependent. -The resident was scheduled for a shower/bath twice a week and received one shower/bath out of six opportunities. Review of the resident's Skin Monitoring Comprehensive Shower Review sheets 5/1/24-5/21/24 showed: -A signed shower sheet for 5/14/24 and 5/17/24 that did not show if a bath or shower was given was not signed by the Certified Nurse's Aide (CNA) just signed by the charge nurse. -A signed shower sheet for 5/21/24 that does not show if a bath or shower was given and was signed by the CNA, but not signed by the charge nurse. -The resident was scheduled for a shower/bath twice a week and received three shower/baths out of five opportunities. -No other shower sheets were received. Review of the resident's care plan revised on 5/2/24 showed the resident required total assistance for bathing/showering. Observation on 5/20/24 at 10:18 A.M. showed the resident had greasy hair that was combed. 2. Review of Resident #58's Admission record showed the resident was admitted to the facility on [DATE] with a diagnosis of quadriplegia (paralysis of all four limbs). Review of the resident's bathing documentation from the EMR dated 3/2024 showed: -The resident received a shower on 3/7/24, 3/14/24, 3/18/24, 3/21/24, and 3/25/24 and was totally dependent on staff. -The resident was scheduled for a shower/bath twice a week and received five shower/baths out of eight opportunities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's bathing documentation from the EMR dated 4/2024 showed: -The resident received a shower on 4/11/24, 4/15/24, and 4/22/24 and was totally dependent. -The resident was scheduled for a shower/bath twice a week and received three shower/baths out of nine opportunities. Record review of the resident's quarterly MDS dated [DATE] showed the resident: -Was severely cognitively impaired. -Required staff to perform all the activities for bathing and showering. Review of the resident's care plan revised on 4/16/24 showed: -The resident required total assistance for bathing/showering. -The resident's family preferred to do to the resident bed baths. -The care plan did not state when staff were supposed to give baths. Review of bathing documentation from the EMR from 5/1/24 through 5/21/24 showed no baths/showers were given. Review of the resident's Skin Monitoring Comprehensive Shower Review sheets dated 5/2024 showed: -The resident's family member gave the resident a bath on 5/11/24 and 5/20/24 signed by the charge nurse. -The resident was scheduled for a shower/bath twice a week and received two shower/baths out of six opportunities. During and interview on 5/20/24 at 9:30 A.M., the resident's family member said: -He/She preferred the resident to have a bed bath instead of a shower. -He/She preferred to do the bathing, but expected the facility to do the bathing when he/she could not. 3. Review of Resident #76's Admission record showed the resident was admitted to the facility on [DATE] with a diagnosis of quadriplegia. Review of the resident's admission MDS dated [DATE] showed the resident: -Was cognitively intact. -Required staff to perform all the activities for bathing and showering. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's bathing documentation from the EMR dated 4/2024 showed: -The resident received a shower on 4/22/24 and was totally dependent on staff. -The resident was scheduled for a shower/bath twice a week and received one shower/baths out of five opportunities. Review of the resident's Skin Monitoring Comprehensive Shower Review sheet for 4/2024 showed: -The resident received a bath/shower on 4/23/24 signed by the CNA, but the form did not show if the resident received a shower or bath and was not signed by the charge nurse. -This was the only shower sheet provided by the facility. Review of the resident's care plan dated 5/1/24 showed the resident was totally dependent on staff to provide a bed bath/shower twice weekly and as necessary. Review of bathing documentation from the EMR from 5/1/24 through 5/21/24 showed: -The resident received a shower on 5/2/24 and was totally dependent. -The resident was scheduled for a shower/bath twice a week and received one shower/baths out of five opportunities. During an interview on 5/19/24 at 12:08 P.M. the resident said that no baths had be given to him/her in over 20 days. Review of the resident's Skin Monitoring Comprehensive Shower Review sheet for 5/2024 showed: -The resident received a bath/shower on 5/21/24 signed by the CNA, but the form did not show if the resident received a shower or bath and was not signed by the charge nurse. -This was the only shower sheet provided by the facility. 19016 4. Review of Resident #85's Admission Face Sheet showed the resident was admitted to the facility on [DATE] with diagnosis of traumatic brain injury (TBI - damage to the brain resulting from external mechanical force). Review of the resident's ADL Care Plan dated 12/21/23 showed the resident required extensive assistance by one staff with showering twice weekly as necessary. Review of the resident's Quarterly MDS dated [DATE] showed the resident: -Was severely cognitively impaired. -Required substantial/maximal assistance of facility staff for bathing and showers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Was frequently incontinent of urine and occasionally incontinent of bowel. Review of the resident's undated shower schedule showed the resident was scheduled for showers on Tuesdays and Fridays. Review of the resident's electronic CNA Bathing Task dated 3/2024 showed: -The resident received showers on 3/1/24, 3/15/24, 3/21/24 and 3/26/24. -On 3/5/24, 3/12/24, and 3/29/24 the resident did not receive a shower or bath. There was no documentation why these showers were missed. -The resident received four out of nine showers. Review of the resident's electronic CNA Bathing Task dated 4/2024 showed: -The resident showered on 4/2/24, 4/5/24 and 4/17/24. -There was no shower as scheduled on 4/9/24, 4/12/24, 4/19/24, and 4/30/24. There was no documentation why he/she did not receive a shower. -The resident received five out of nine showers. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review Sheets for 4/2024 showed: -He/she showered on 4/22/24, and 4/25/24. He/She refused a shower on 4/29/24, but there was no documentation why or if the resident had an opportunity to make up the shower. The resident did not sign the shower sheet acknowledging he/she refused the shower. -The resident received five out of nine showers. Review of the resident's Skin Monitoring Comprehensive CNA Shower Review sheets for 5/1/24 through 5/21/24 showed: -The resident had a shower on 5/9/24. No other showers were given. -The resident received one out of six showers scheduled for the three week period. During an interview on 5/20/24 at 12:22 P.M., the resident said: -He/She was not getting showers twice weekly as scheduled and had gone as long as two or three weeks before getting them. -He/She had accidents and sometimes urinated before staff could get him/her to the toilet. The accidents made him/her smell. -He/She needed help getting onto a shower chair and taking a shower. It was hard to get staff help for showers and staff never offered him/her a shower for any that were missed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 10:10 A.M. the resident's responsible party said: -The resident sometimes urinated on himself/herself. -The resident required staff assistance with ADLs. During an interview on 5/22/24 at 11:08 A.M. Certified Medication Technician (CMT) A said the resident was incontinent every day. The resident just couldn't hold his/her urine and staff couldn't always toilet him/her in time. During an interview on 5/23/24 at 3:16 P.M. CMT C said: -All residents were scheduled to be showered twice weekly. The shower schedule was located at the nurses' desk and was available to all nursing staff. -If a resident refused his/her shower staff were supposed to tell the charge nurse and the Director of Nursing (DON). -The resident was partly incontinent, so showers for him/her were important. -Staff used to document showers on the residents' electronic CNA Bathing Task form, but some staff weren't filling it out like they were supposed to. -Staff were recently asked to do shower documentation on the shower (Skin Monitoring: Comprehensive CNA Shower Review) sheets. -Shower sheets should be completed for every shower given or refused. -Showers should be given as scheduled. -The resident sometimes refused to shower and staff had to sweet talk him/her into taking a shower. -He/She didn't know why there was missing documentation of all the resident's scheduled showers, but there should be documentation showing all the resident's showers. 33409 6. Review of Resident #6's Admission Face Sheet showed the resident admitted to the facility with diagnosis of quadriplegia. Review of the resident's Care Plan 6/29/21 showed: -The resident has an ADL self-care performance deficit related to quadriplegia. -During resident showers/bathing care staff were to check nail length, trim and clean on bath day and as necessary. Report any changes to the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident requires total assistance from care staff for bathing/showers. Review of the resident's Quarterly MDS dated [DATE] showed: -The resident was cognitively intact. -Required total assistance of facility staff for bathing and showers. -He/she had impairment of both upper and lower extremities. Review of the resident's electronic CNA Bathing Task dated 4/2024 showed the resident had documentation that he/she was given a shower 7 out 10 opportunities. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review sheet for 4/1/24 to 4/30/24 showed. -Had no documentation of nail care was provided. -The resident had documented on shower sheet showed he/she was given eight showers out of 10 opportunities. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review sheet for 5/1/24 to 5/23/24 showed: -Had documentation of a shower given on 5/1/24. -Had no written Skin Monitoring: CNA shower sheet were completed from 5/8/24 to 5/20/24. -The resident had documented on a shower sheet showed he/she was given one shower out seven opportunities. Review of the resident's electronic CNA task report for 5/2024 showed the resident: -Documented had been given a shower on 5/13/24 and 5/15/24. -The resident had bathing documented showed he/she was given a shower two out seven opportunities. Observation and interview on 5/19/24 at 11:30 A.M., the resident said: -The CNAs were not clipping the resident's fingernails and toe nails. -Observation of the resident's fingernails were slightly long. During an interview on 5/20/24 at 10:45 A.M. the resident said: -He/she was supposed get showers on Monday and Thursday and was not receiving showers. -He/she had not received a shower that morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she had refused a shower one time when care staff came in at 6:00 A.M. to take him/her to shower room. -He/she washed his/her own hair in the morning at his/her bedside. During an interview on 5/20/24 at 10:54 A.M., CNA D said: -He/she was only working until 2:30 P.M. that day. -He/she was not sure what residents were scheduled for shower/baths that day. -Observation showed the CNA D went into the shower room and obtain the resident's shower schedule. -Resident #6 was listed under Monday and Thursday as his/her shower days. During interview 5/22/24 at 5:28 A.M., CNA E said: -Resident # 6 requires total assistance with cares from facility staff. -The resident had made complaints to staff related not getting baths as schedule. -He/she had seen the resident not well groomed upon coming on for shift. -The resident would request bucket of water to be able to wash his/her hair while in bed. The CNA would assist the resident at that time. -He/she had notified the day shift care staff that the resident was requesting a shower. During an interview on 5/22/24 at 6:50 A.M., CNA B said: -He/she would complete a Skin Monitoring Comprehensive CNA Shower sheet for resident had received a shower and if refused would write resident refused and number of times offered shower that day. -He/she would document on CNA shower sheet care provided to include hair washed and nails clipped. -The electronic record under Task the CNA would document bath given or refused. -He/she would normally complete the Skin Monitoring: shower sheet form, which would include skin monitoring section. -If resident refused a shower, he/she would document on shower sheet and have the resident signed the shower sheet form. During an interview on 5/22/24 at 7:07 A.M., with CNA F said: -Each CNA for that hall would complete the resident's shower assigned to the CNA that day. -He/she would complete the skin/shower sheet and give to the nurse for review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she would notify the nurse if resident the refused showers or if found any skin issue during showers. -He/she would have the resident sign shower sheet showing the resident had refused the shower. -He/she would inform the charge nurse of resident refusal of care or new skin issue. -The DON would review the resident shower sheets. During an interview on 5/22/24 at 10:47 A.M., CNA D said: -He/she would complete handwritten shower sheets and document the shower in the resident's EMR. -He/she was not aware of any resident left alone shower room. -Staff were stay with the resident while in shower for safety issue. During an interview on 5/23/24 at 12:13 P.M., Registered Nurse (RN) A said: -CNA would verbally inform him/her any skin changes or if resident had refused a shower or care. -He/she was not aware who assigned the resident shower or were CNA were to document showers given. -He/she had not received or reviewed resident shower sheets. -He/she not aware of Resident #6 complaint of not getting showers. 7. During an interview on 5/23/24 at 9:23 A.M., CNA A said: -Residents were supposed to get showers/baths two times a week. -Realistically the residents rarely get bathed twice a week. -Residents would hopefully get a shower/bath at least every two weeks to a month. -The lack of showers was due to lack of staff. There were only two CNAs assigned for the three halls. -When a resident refused a shower or bath, he/she would tell the charge nurse after trying to reeducate the resident on the importance of the shower/bath if the resident still refused. -The bathing charting used to be done on the computer, but now on shower sheets were started about two weeks ago. During an interview on 5/23/24 at 9:28 A.M., CNA B said: -When a resident refused showers/baths he/she would try to reeducate the resident on the importance and chart the refusal in the computer or on a shower sheet and inform the charge nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents were supposed to get a shower/bath twice a week, but it would usually be one bath every two to three weeks for the residents. -There was usually not enough staff to do showers twice a week in his/her opinion. -There was usually only two CNA's for the three halls no bath aide. During an interview on 5/23/24 on 9:34 A.M., CNA C said: -Residents would get showered/bathed depending on the staffing schedule. - Residents were showered/bathed at least once every week to every two weeks. -The facility had no shower/bath aid full time. -Two CNAs cannot work the hall provide cares, answer call lights and give baths. -The shower/bath charting used to be done in the EMR but now was done on paper charting. -When a resident refused a shower/bath he/she would inform the charge nurse. During an interview on 5/23/24 at 9:40 A.M., RN A said: -Residents were to be shower/bathed two to three times a week. -Residents were being showered/bathed maybe once a week. -He/she was unsure why, but felt it was because the facility did not have a full time bath aide. -When a resident refused a shower/bath and was told this by the CNA he/she would find out why and the reason and then educate. - When resident still refused a shower/bath he/she would chart the refusal and education that was given in the chart. -He/She might not chart first refusal but defiantly the second and consecutive refusals. -When the resident's preferences were identified he/she would put this information in the residents care plan. -The shower/bath charting was done in the EMR as a task but now it was done on paper. During an interview on 5/23/24 at 2:50 P.M., Assistant Director of Nursing (ADON) said: -Shower/Bathing was discovered to be an problem and a performance improvement plan (PIP) was started in March. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Documentation for shower and baths was done in the computer, but there was an issue with the computer, so it was changed to a paper process then. -The charge nurse was to ensure the bathing sheets were being done. -The charge nurse reviewed bath sheets and then signed them. -The charge nurses would give the signed shower sheets to the ADON who reviewed them for skin issues. -When a resident refused a shower. A shower sheet was still filled out with refusal written on it. -The resident was supposed to sign the refusal shower/bath sheet if the resident was able. -When a resident had multiple refusals the ADON would talk with resident and find out why and see if a compromise could made to make the resident willing to get the shower/bath. -It was easier to track refusals and when multiple refusals happen with the shower/bath sheets versus the computer. -Prior to the PIP there was no system in place to track showers/baths. -The expectation was for residents to get showers/baths was minimal shower/bath twice a week. -He/she felt that if had been more than three weeks since a resident had a shower/bath it was an issue. -The computer charting system did not flag if showers/baths were not done there was no report the system could generate. -This was why it was decided to go back to the shower/bath sheets so the showers/baths would be tracked. -The process for a refusal was when a resident refused a bath/shower the CNA reported this to the charge nurse then the charge nurse would approach and try to reschedule the shower/bath. -The charge nurse would then sign the shower sheet and follow up on the bath/shower. -There had been a lot of change in staff so tracking of the showers/baths had not been consistent. -The facility had a bath aide and he/she used to track and reschedule residents for showers/baths he/she was then making up for missed showers/baths. -He/She had left the facility about a month ago and the facility has not been able to hire a new bath aide. -When a shower/bath was missed it should be charted in the progress notes and the reason why it was and the education provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents should have received showers/baths at least twice weekly. MO00236026, MO00235049 and MO00236223

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on observation, interview, and record review, the facility failed to obtain a physician order for the setting of the low air loss mattress (LAL - a mattress designed to distribute weight over a broad surface and help prevent skin breakdown. It has continuous air flow through tiny holes on the mattress surface) for one sampled resident (Resident #77) who had developed a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister) out of 18 sampled residents. The facility resident census was 88 residents. Review of the facility's Pressure Ulcer (PU)/Skin Breakdown - Clinical Protocol policy, revised April, 2018 showed the physician will order pertinent treatments, including pressure reduction surfaces and identify medical interventions related to wound management. 1. Review of Resident #77's Admission Record showed the resident was readmitted to the facility on [DATE] with diagnoses that included dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). Review of the physician's Orders Summary Report (OSR) showed LAL mattress on at all times. Settings at resident's comfort. Check comfort level and functioning status every shift and as needed for skin integrity, starting 3/4/24. Review of the resident's current Skin Integrity Care Plan, initiated 9/15/23 and showed: -LAL mattress as ordered, initiated 3/4/24. -An opened area was classified as pressure on 5/17/24. -There was no information on how the resident's LAL mattress was to be set. Review of the resident's Electronic Medical Record (EMR) showed the resident's most recent weight was 130.8 pounds on 5/3/24. Review of the resident's Weekly Wound Assessment, dated 5/17/24 showed: -A Stage II PU was identified on 5/17/24 on the resident's coccyx (small triangular bone at the base of the spine) measuring 1.8 centimeters (cm) long, 0.7 cm wide and 0.2 cm deep, red in color with no drainage or odors. -Turn resident every two hours, continue LAL mattress as ordered, cushion in resident's chair while up, vitamins and wound care as ordered. Physician notified. -No LAL mattress setting was specified. Review of the physician's OSR on 5/21/24 showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LAL mattress on at all times. Settings at resident's comfort. Check comfort level and functioning status every shift and as needed for skin integrity, starting 3/4/24. -The order had not been changed once the resident developed a PU to specify a LAL mattress setting. Review of the resident's Significant Change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 5/20/24 showed the resident: -Was severely cognitively impaired. -Was receiving hospice services (medical care focused on comfort and quality of life for a person approaching end of life). -Was at risk for PUs. -Had one Stage II PU. -Had a pressure reducing device for his/her bed and wheelchair. Observation on 5/19/24 at 11:35 A.M. showed: -The resident was lying on his/her right side in bed. -The resident appeared thin and frail. -The resident's LAL mattress was set to 200 pounds. -The LAL adjustment device had 130 pounds as one possible setting. Observation on 5/20/24 at 10:33 A.M. showed: -The resident was lying in bed. -The resident's LAL mattress was set at 200 pounds. During an interview on 5/22/24 at 11:12 A.M. Certified Medication Technician (CMT) A said: -The resident had a PU for about three weeks. He/She had a LAL mattress before acquiring the PU. -Direct care staff were responsible for repositioning the resident every two hours. -The CMTs and Certified Nurse Assistants (CNAs) didn't touch the LAL settings and he/she hadn't been trained on appropriate settings. Observation on 5/23/24 at 9:30 A.M. showed: -The resident was lying in bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's LAL mattress was set at 200 pounds. During an interview on 5/23/24 at 11:20 A.M. the Wound Nurse said: -The physician and his/her Nurse Practitioner (NP) assessed the resident's PU and he/she did the resident's wound treatments. -He/She monitored LAL mattress settings for all residents when doing wound treatments, but he/she didn't document anywhere when settings were checked. -He/She wasn't sure if hospice checked the resident's LAL mattress settings when they visited. -The resident's physician's orders show his/her LAL mattress should be set for comfort. Once the resident developed a PU the mattress should have been set according to his/her weight. During an interview on 5/23/24 at 12:37 P.M. the Assistant Director of Nursing (ADON) said: -If a PU develops or gets worse the LAL mattress could be too hard or too soft. The LAL mattresses should be at the setting closest to the resident's weight. If a resident's weight is half-way between two settings the LAL mattress can be set up or down. -The CMT should check the settings every shift. The LAL mattress settings should be on the physician's orders and there should be an order to check the resident's LAL mattress. CMTs wouldn't necessarily know they should check the settings by weight if the order doesn't show it should be set according to weight. -The CMTs don't adjust the settings, but they should tell the charge nurse or the wound nurse when the mattress isn't set according to weight. -The resident was unable to communicate, except by grimacing, if the LAL mattress was comfortable. -The mattress should be set as close as possible to 130 pounds for the resident. During an interview on 5/23/24 at 1:01 P.M. LPN B said: - If an order showed a LAL mattress was to be set for comfort the residents could tell staff how they wanted it set. He/She asked residents if they want the mattress alternating or static. He/She had been taught if a resident had a PU staff were to set it alternating and not on static. -He/She hadn't received any training at the facility on setting LAL mattresses. -The nurse had to document on the Treatment Administration Record (TAR) that they checked the mattress. -He/She wasn't sure how staff knew how to set the LAL mattresses if the order showed it was to be set according to comfort. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the resident weighed half-way between two weight settings staff could set the mattress to the setting up or down from their weight. Any resident who had a PU should have the LAL mattress set according to their weight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409 Based on observation, interview and record review, the facility failed to ensure accurate documentation of refusal of enteral feeding via feeding tube called Percutaneous endoscopic gastrostomy (is a surgery to place a feeding tube also called a PEG or G-tube) and physician order for total amount caloric formula to be given in a 24 hour period, for one sampled resident (Resident #4) who's at risk for weight loss due to decline health, refusal of treatment and cares out of 18 sampled residents. The facility resident census of 88 residents. Review of the facility Policy for Medication Orders revised on 11/2014 showed: -Enteral feedings orders: when recording orders for enteral tube feedings, specify the type of feeding, amount, frequencies of the feeding and rationale if as needed. -The order should always specify the amount of flushing following the feeding. Review of the facility Enteral Tube feeding via a Pump revised on 11/2018 showed: -Document the average fluid intake per day. -If the resident refused procedure or enteral feeding document the reason why and intervention taken. -Report to supervisor if the resident refuses procedures. 1. Review of Resident #4's Admission Face Sheet showed the resident had diagnosis of: -Gastrostomy (is a surgical procedure used to insert a tube, often referred to as a G-tube, through the abdomen and into the stomach.) -Protein-Calorie Malnutrition (is the state of inadequate intake of food). -Dysphagia (difficult to swallowing). -Adult Failure to thrive (is a decline in older adults that manifests as a downward spiral of health and ability). Review of the resident's Nutrition Assessment Note dated 2/13/24 showed: -Had recent new diagnosis of Protein-Calorie Malnutrition, G-tube, Dysphagia, Diabetes Mellitus, Failure to thrive. -Readmission noted, resident back on enteral feedings as he/she used to be. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oral diet advanced to pureed but resident was not eating well and has a history of refusing pureed food. -Therapy orders noted, including speech therapy for Dysphagia. Weight down 4.8 pounds in one month, 15.5 pounds in six months, within ideal body weight. Recent weekly weights reviewed. -Blood Sugar are generally less than 200 on return. -Would change enteral regimen to Glucerna 1.2 at 80 milliliters (ml) per hour(hr) times 20 hr per day with no change to water flushes. -Will monitor weight/intake/enteral tolerance moving forward. ` Review of the resident's Care plan initiated on 2/20/24 showed: -The resident required tube feeding related to Dysphagia, failure to thrive and poor intake. -Discuss with resident/family/care givers any concerns about tube feeding. Review of the resident Quarterly MDS dated [DATE] showed: -Was severely cognitive impairment. -Required tube feeding and altered mechanical diet while a resident at the facility. -His/her weight at time of assessment was 155 pounds. -Was dependent on facility staff for all cares. Review of the resident's Nutrition Task (amount eaten) from 5/1/24 to 5/21/24 showed: -The resident had meal intake of 37 out 63 opportunities documented at 0-25% of meal eaten. -The resident had meal intake of 7 out 63 opportunities documented at 26%-50% of meal eaten. -The resident had meal intake of 3 out 63 opportunities documented at 51%-75% of meal eaten. -He/she had refused meal 13 out of 63 opportunity. Review of the resident's nursing note dated 5/16/24 at 7:36 A.M. showed: -A late entry note: dated 5/15/24 at 5:00 P.M., the resident hollering in his/her room, demanded to be unhooked from his/her PEG tube feeding stating I don't want this, get this off of me while pulling at his/her PEG tube in distress. -Resident was assisted out of bed to dining room at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notified social services of his/her distress and verbalization of not wanting his/her feeding per tube. Review of the resident's nursing note dated 5/16/24 at 12:53 P.M. showed the nurse had notified the resident's nurse practitioner, about the resident's ongoing refusal at time for tube feeding and/or medications/general decline and routine refusal to eat pureed food. Order received for hospice (end of life) to consult/notified social services. Review of the resident's nursing note dated 5/17/24 at 3:06 P.M. showed: The resident continued to refuse tube feeding to be re-administered. -He/she said, no and repeatedly says don't put nothing in there referring to his/her peg tube. -Was unable to even flush the peg tube due to resident's agitation when he/she even touched the resident's peg tube. -The resident also refused both breakfast and lunch, he/she would attempt to have the resident to eat dinner. -Was told in change of shift report the doctor was already aware and a hospice care consult was pending. Review of the resident's nursing note dated 5/18/24 at 3:09 P.M. showed: - An enteral feed order every shift for hydration and to flush the peg tube with 250 cubic centimeters (cc) water every four hours. -The resident was refusing anything to be put into peg tube including just water. Review of the resident's Treatment Administration (TAR) dated from 5/1/24 to 5/31/24, showed: -Enteral Feed every shift for nutrition Glucerna 1.2 to run at 85 ml/hr continuous time 20 hours off tube feeding from 10:00 A.M. to 2:00 P.M. (initial order was dated 4/18/24). -Enteral feed every shift for hydration, Flush tube with 250 cc's water every four hours (order dated 2/7/24). -Had documented on 5/16/24 at 6:30 A.M. code 9 and nursing initial, which meant to see progress note for tube feeding and water flushes. -Had documented 5/16/24 at 6:30 P.M. had code 2 which meant resident refused tube feeding and water flushes. -Had documented on 5/17/24, 5/18/24, had code 2 and nursing initial. Resident refused tube feeding and water flushed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had documented on 5/19/24 and 5/20/24 a check mark and nursing initials of the tube feeding and water flushed were given. Review of the resident's Orders - Administration Note dated 5/19/24 at 11:21 A.M. showed: -Order to shut tube feeding off one time a day for overload. -The resident was not allowing tube feeding to be infused at this time and stated don't put anything in that tube. Observation and interview on 5/20/24 at 11:00 A.M., the resident showed: -His/Her enteral feeding pump in the resident room was not running or connected to the resident. -Had no formula bottle or bag hung on tube feeding pole/pump. -The resident said he/she not getting tube feeding at this time. Review of the resident's Orders - Administration Note dated 5/20/24 at 1:39 P.M. showed: -A physician's order to shut the tube feeding off one time a day for overload. -The resident continued to refuse his/her tube feed. Review of the resident's Physician Order Sheet (POS) dated 5/21/24 showed: -Enteral Feed every shift for hydration, Flush tube with 250 cc's water every four hours (order dated 2/7/24). -On 5/21/24 an order for Enteral Feeding be placed on hold. --Enteral Feed every shift for nutrition Glucerna 1.2 to run at 85 ml/hr continuous time 20 hours. The tube feeding turned off from 10:00 A.M. to 2:00 P.M. (initial order was dated 4/18/24). -New order dated 5/21/24, nursing staff were to check feeding tube placement prior to administering medications or feeding. --1. Current measurement for resident feeding tube was one centimeter (cm) between skin & bumper. If area between skin & bumper was more than finger width wide or two inches, notify physician. --2. Residual (amount of formula left in the tube) check if 250 ml-500 ml, take measures to reduce risk of aspiration. If more than 500 ml, notify physician. Monitor residual every shift. -NOTE: There were no physician's order's for recommended amount of tube feeding formula intake in a 24 hour and order for monitoring/documentation of caloric intake. Review of resident nurse's note dated 5/21/24 at 12:40 P.M. showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's tube feeding was placed on hold until further notice due to refusals. -Hospice was to consult. -Nursing staff will continue with meals by mouth although intake was declining. -The resident family member aware of the resident refusal. Review of the resident's Order-Administration Note dated 5/21/24 at 11:31 A.M. showed: -An order to shut off tube feeding one time a day for overload. -The resident was refusing tube feeding states If you put that in, I will pull it out. I do not want it. Review of the resident's Care plan revision on 5/21/24 showed the resident refusing to eat and refusing to allow tube feeding. Observation and interview on 5/21/24 at 1:11 P.M. showed: -The resident was in a low bed in his/her room. -No meal tray in room. -Had tube feeding pole and pump at bedside. Did not have tube feeding bottle hung or running. During an interview on 5/21/24 at 1:12 P.M., Certified Nursing Assistant (CNA) G said: -The resident was only staying up in his/her wheelchair for 30 minutes at a time. -He/she not aware if the tube feeding was running at this time. -The resident was declining in his/her health. -He/she had a meal tray for the resident, but he/she did not want to eat. -The meal tray was taken away. Observation of the resident at 05/22/24 at 8:20 A.M., showed: -The resident was in a low bed. -The tube feeding pump not running, and no formula was hung at that time. Observation and interview on 5/22/24 at 10:00 A.M., of the resident tube feeding and site showed: -Registered Nurse (RN) A enter the resident room washed hand soap and water. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had agreed to have PEG tube site checked and to provide water flush through the feeding tube. -RN A check PEG tube for residual, obtained a clear thick creamy substance from tube. -He/she flushed the feeding tube with water. -The resident said he/she would agree to have formula via pump connected. -RN A said he/she needed to verify order, since tube feeding was placed on hold at that time. -The resident was able to make his/her needs and wishes known, but difficulty understand him/her at times. -RN A cleaned PEG site with Normal saline, then dried with gauze pad, then applied clean split 4 x 4. -Resident denied any pain at this time. During an interview on 5/23/24 at 9:49 A.M., with the resident said: -He/she ate breakfast that morning and was up in wheelchair in dining area. -He/she did have tube feeding per pump yesterday afternoon. 3. During an interview on 5/21/24 at 1:15 P.M., Licensed Practical Nurse (LPN) A said: -The resident had a hospice evaluation and waiting on family response for approval of services. -He/she was refusing his/her tube feeding and meals at times. -The resident had a declined in health, with a short life expected. -The resident's family members were aware of the resident's declining health, refusal of cares and meals. During an interview on 5/22/24 at 8:00 A.M., Assistant Director of Nursing (ADON) said: -Review of the resident TAR with ADON. -When the resident had refusal of tube feeding and water flushes, he/she would expect nursing staff to code as refusal and document in the resident's nursing note. -A check mark on TAR would indicate as treatment or medication were given as ordered or treatment completed. -He/she had received an order to place tube feeding on hold 5/21/24, due to the resident's refusal of tube feeding and water flushes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On the TAR, if a check marked and nursing initial then would have meant tube feeding was given, but the resident had been refusing tube feedings and flushes. He/she and other nursing staff should had coded the resident refusal of tube feeding on the TAR and include a nursing note. -He/she would expect nursing staff to documented refusal of tube feeding accurately and correctly. -Nursing staff should report to the physician the resident refusal of tube feeding and document notification in the resident's nursing notes. -The resident's family member was aware of his/her refusal of cares, tube feeding and medication. -The facility recently obtained a physician order for hospice evaluation and care. -The facility does not document or monitor the total amount of formula that was administered each shift. During an interview on 5/22/24 at 9:42 A.M., RN A said: -The resident had been refusing tube feedings. -The resident had really did not want tube feeding since beginning, the family requested the resident be on tube feedings. -The water flushing had also been refused by the resident. During an interview on 5/23/24 at 12:13 P.M., RN A said he/she would document in the TAR if feedings were completed and if refused coded as refusal and complete a progress note for refusal and any action taken. During an interview on 5/23/24 at 2:48 P.M., Regional Nurse and ADON said: -The acting DON was out of facility for part of the survey. -He/she would expect a physician order to include recommended intake amount and recorded per shift and would expect nursing staff to document the amount formula received each shift. -He/she would expect to have accurate documentation and coding for administered and refusal for treatment/feeding in the resident TAR and progress notes. -He/she would expect nursing staff to notify the resident physician of the resident refusal tube feeding and cares, and complete progress notes of the of the notification. -He/she would expect the CNA to document in the resident oral meal intake or refusal of meals under the CNA Meal Task section.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on interview and record review, the facility failed to ensure sufficient staffing numbers to consistently provide timely Activities of Daily Living (ADL - dressing, grooming, bathing, eating, and toileting) assistance for two sampled residents (Resident #77 and Resident #69) out of 18 sampled residents and ADL-dependent residents on the [NAME] Side of the building and to ensure adequate weekend staffing as reflected on the Payroll Based Journal data (PBJ- a report that provides staffing dataset information submitted by nursing homes on a quarterly basis) for the fourth quarter of 2023 (July 1 - September 30, 2023) and first quarter of 2024 (October 1 - December 31, 2023) which had the potential to affect all residents. The census was 88 residents. Review of the facility's Staffing policy, revised October, 2017 showed: -The facility provided sufficient numbers of staff with the skills and competencies necessary to provide care and services for all residents according to identified resident care needs and facility assessments. -Daily direct care staffing information was submitted to the Centers for Medicare and Medicaid Services (CMS) PBJ system on the schedule specified by CMS but no less than quarterly. -Concerns relative to facility staffing should be directed to the Administrator or his/her designee. Review of the facility's Hospitality Assistant (HA) Job Description, undated showed: -The HA was responsible for providing non-nursing, non-direct care, and ancillary services under the direction of the nurse supervisor. -Has assisted nursing staff by making beds, passing ice and water, passing linens, answering call lights, passing meal trays, distributing laundry, cleaning and organizing equipment, reporting resident and family concerns to the supervisor, stocking rooms with health care items, and non-hands-on care to residents. 1. Review of the facility's PBJ Staffing Data Report for Fiscal Year (FY) Quarter Four 2023 (July 1 - September 30, 2023) showed excessively low weekend staffing for the quarter. Review of the facility's PBJ Staffing Data Report for FY Quarter One 2024 (October 1 - December 31, 2023) showed excessively low weekend staffing for the quarter. 2. Review of the Facility Assessment Tool, dated 5/2/24, showed: -An average daily census of 95 residents. -Seventy residents required some to total assistance from staff for dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Seventy residents required some to total assistance from staff for bathing. -Seventy residents required some to total assistance from staff for toileting. -Seventy residents required some to total assistance from staff for transferring. -Sixty residents required some to total assistance from staff for eating. 3. Review of the working staff schedules, dated 5/15/24 through 5/21/24 showed: -The facility had three distinct staffing areas. The [NAME] Side consisted of three halls. The East Side consisted of two halls and there was a Special Care Unit (SCU - locked unit for residents with cognitive impairments who were at risk for wandering and/or needed dementia-specific cares). -There were twelve, eight, and four-hour shifts shown on the schedule. -The following nurse aide staffing was documented on the [NAME] Side: --On 5/15/24 two Certified Nurse Assistants (CNAs) worked four hours each covering one Night shift from 10:30 P.M. to 6:30 A.M. Two HAs, were scheduled four hours each to cover the Night shift, but could not provide resident cares. There was not a second CNA scheduled for the Night shift. --On 5/16/24 one CNA worked from 10:30 P.M. to 6:30 A.M. An HA was scheduled, but could not provide resident cares. There was not a second CNA scheduled for the Night shift hours. --On 5/17/24 there was not a third CNA scheduled for the Day Shift. No staff was assigned bathing/showering responsibilities. On the Evening shift from 4:30 P.M. to 6:30 P.M. there was only one CNA scheduled. --On 5/18/24 there was not a third CNA scheduled for the Day shift. --On 5/19/24 there was not a third CNA scheduled for the Day shift. --On 5/21/24 there was only one CNA scheduled from 7:30 P.M. to 10:30 P.M. Two other CNAs left at 7:30 P. M. An HA was scheduled from 6:30 P.M. to 10:30 P.M., but could not provide resident cares. 4. Review of Resident #77's Significant Change Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 5/20/24, showed the resident was: -diagnosed with Alzheimer's disease (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception). -Severely cognitively impaired. -Dependent upon staff for eating, toilet hygiene, bathing, dressing, and transfers. Observation on the SCU on 5/19/24 starting at 9:46 A.M. showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Three residents were sitting in the common area/dining room. There was no staff in the area. -A few minutes later Certified Medication Technician (CMT) A came out of a resident's room. -At 9:55 A.M. Resident #77 was observed lying in bed. During an interview on 5/19/24 at 10:15 A.M. CMT A said: -He/She had been the only staff on the SCU since 7:00 A.M. -The East Side nurse could help as needed for medical cares. -There should always be two people on the SCU on the Day shift, but someone called in and he/she was by himself/herself. -He/She thought an HA was coming in. The HA could help pass trays and restock linens and gloves, but couldn't do hands on cares with residents like feeding, transferring, or changing anyone who was incontinent, so he/she would need to do all the resident cares. -There were 17 residents on the unit. Seven were incontinent and also needed help getting dressed. Two residents required cuing to toilet and two others required one-person staff assistance for transfers. -Resident #77 transferred with a two-person mechanical lift. The resident hadn't gotten out of bed since there was nobody on the unit to help get him/her up. The resident also needed help repositioning in bed. -Resident #77 needed to be fed so he/she raised the head of the bed to feed him/her breakfast. Two other residents needed cueing during meals, so he/she had to feed Resident #77 at a separate time. Observation on 5/19/24 starting at 11:16 A.M. showed the Marketing Director entered the unit. During an interview on 5/19/24 at 11:20 A.M. the Marketing Coordinator said: -He/She came in on a Sunday because there was a new admission. -He/She had current nurse aide certification and would be assisting on the SCU for as long as was needed. Observation on 5/19/24 starting at 11:46 A.M. showed: -CMT A and the Marketing Coordinator went into Resident #77's room. -They were observed using the mechanical lift to get the resident out of bed. Note: Review of the working staff scheduled showed a Certified Medication Technicians (CMT) and a CNA were scheduled to work the entire 6:30 A.M. to 2:30 P.M. shift. The schedule was not adjusted to show only one staff had provided resident cares from 7:00 A.M. to 11:15 A.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Review of Resident #69's quarterly MDS, dated [DATE], showed the resident: -Had previously had a stroke. -Had an upper body impairment on one side. -Was cognitively intact. -Required maximal assistance (staff does over half the effort) for showering and required moderate assistance to transferring into the shower or tub. -Required cueing and/or steadying for toilet transfers. During an interview on 5/20/24 at 9:44 A.M. Resident # 69 said: -He/She needed help with transfers on and off the toilet. -He/She had been left on the toilet for 25 minutes during the night shift. -There wasn't any staff responding to the bathroom call light. 6. During an interview on 5/22/24 at 5:20 A.M. CMT D said: -On the SCU a CMT and either an HA or CNA was usually scheduled during the Evening shift and a CMT or CNA was scheduled on the Night shift. -An HA was sometimes left with the residents when he/she took a break. When residents got up during the night the HA was unable to toilet them or change them. If anyone needed any resident cares while the HA was alone on the SCU the East Side nurse had to leave that area unattended and provide the cares because the nurse was the only staff person scheduled on the East Side at night. During an interview on 5/22/24 at 6:10 A.M. CNA H said: -Several times there had just been a nurse, himself/herself, and one HA working the three [NAME] Side halls at night. The nurse had to pass medications as needed during the night. The HA wasn't supposed to help with incontinent cares, transfers, and dressing. There were times only he/she and a nurse worked the three halls. -The 300 hall had 10 incontinent residents and another resident needed to be taken to the toilet during the night. -Nine residents on the 200 hall were incontinent and one had to be taken to the toilet. -On the 100 hall there were two incontinent residents. -When he/she was the only CNA working he/she was unable to keep up with all the cares the residents needed during the night. He/She just did the best he/she could. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/22/24 at 6:33 A.M. CNA B said: -He/She sometimes worked the 6:30 P.M. to 11:00 P.M. hours if the facility was short staffed. There were times between those hours that he/she and the nurse were the only two staff. -Thirteen residents on the 300 hall were sometimes or always incontinent and one resident needed to be taken to the toilet. -Three residents on the 200 hall were always incontinent and one needed to be taken to the toilet. -Two residents on the 100 hall were incontinent and one needed help getting off the toilet. -Many times he/she had worked the 6:30 A.M. to 6:30 P.M. hours with only a nurse and two CMTs. -Before meals the nurse was always busy getting the diabetics' blood sugar levels and giving insulin and the two CMTs were busy passing medications. -The facility needed at least three CNAs on the [NAME] Side to do the three halls. It was too much for one CNA to get residents out of bed, changed if wet, and dressed for breakfast. The [NAME] Side was busy before the lunch and supper meal as well with only one CNA. During an interview on 5/22/24 at 6:56 A.M. CNA D said: -He/She did the [NAME] Side halls by himself/herself the previous night from 6:30 P.M. to 11:00 P.M. A nurse was also on the unit but had to pass medications leaving just him/her to do the cares part of the time. -Some of the 100 hall residents could put on their call lights to let him/her know if they were wet. -There were at least five residents on the 100 hall and at least five on the 200 hall who were incontinent and couldn't use their call lights or tell him/her if they were wet, so he/she had to check on them frequently. During an interview on 5/23/24 at 9:23 A.M., CNA A said: -Residents were supposed to gets showers or baths two times a week. -Realistically the residents rarely got them twice a week. -Residents would hopefully get a shower or bath at least every two weeks to a month. -The lack of showers was due to a lack of staff. Often there were only two CNAs assigned for the three [NAME] Side halls. During an interview on 5/23/24 at 9:28 A.M., CNA B said: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Residents were supposed to get two showers/baths twice a week, but it would usually be two to three weeks with no baths for the residents. -There was usually not enough staff to do showers twice a week. During an interview on 5/23/24 on 9:34 A.M., CNA C said: -Residents would get showered/bathed depending on staffing coverage. -Residents were showered/bathed at least once every week to two weeks. -The facility had no shower/bath aide full time. -Two CNAs couldn't provide cares, answer call lights, and give baths on the three [NAME] Side halls. During an interview on 5/23/24 at 9:40 A.M., Registered Nurse (RN) A said: -Residents were to be showered/bathed two-three times a week. -He/She was unsure how often residents were showered/bathed, but thought it was maybe once a week. During an interview on 5/23/24 at 10:30 A.M. the Assistant Director of Nursing (ADON) said: -He/She was responsible for the staffing assignment sheets which should accurately reflect the various nursing staff working on any given shift. -Shifts were 6:30 A.M. to 2:30 P.M., 2:30 P.M. to 10:30 P.M. and 10:30 P.M. to 6:30 A.M. -Minimum staffing on the [NAME] Side was: --On the Day shift there should be one nurse, two Certified Medication Technicians (CMTs), and at least three Certified Nurse Assistants (CNAs), one of which was responsible for resident showers and the other two CNAs were responsible for care on the three resident halls. --On the Evening shift there should be at least one nurse, two CMTs and two CNAs. --On the Night shift there should be at least one nurse and two CNAs. -Staffing on the two East Side halls should be: --At least one nurse and one CMT or CNA on the Day shift. --One nurse and one CMT on the Evening shift. --One nurse on the Night shift. -Minimal staffing on the SCU was: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--One nurse and two CNAs on the Day shift. --One nurse or CMT and a CNA on the Evening shift. --One CMT or CNA on the Night shift. If a CNA was working the hall the nurse from the East Side would assist with medications and medical needs. -Weekends should be staffed the same as the weekdays on all shifts and all living areas, and as far as he/she knew they were. -HAs were not allowed to do any resident cares such as transfers, incontinence cares, or feeding. They could make beds, keep the linen cart tidy, answer call lights and relay messages to the nurse or CNA, get ice for residents, wash wheelchairs and wipe trash bins. During an interview on 5/28/24 at 3:56 P.M., the Administrator said: -He/she was not aware that the facility triggered for low weekend staffing on the PBJ Staffing Data Report for two quarters. -The facility used a third-party vendor for payroll who sent a summation with hours worked for each nursing category which was used for submitting PBJ data. -He/She and the DON and ADON were responsible for addressing any known low nursing staff numbers. MO00236223

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview and record review, the facility failed to cook broccoli florets so they would not be mushy; failed to follow the recipe for pureed (cooked food, that has been ground, pressed, blended or sieved to the consistency of a creamy paste or liquid) broccoli, so the broccoli would be palatable; and failed to maintain room trays at the 600 Hall and the 300 Hall at or close to 120 F (degrees Fahrenheit) at the time of service. This practice potentially affected at least 13 residents. The facility census was 88 residents. 1. Review of the recipe for pureed broccoli florets, dated 9/1/15, showed: - Steam broccoli 15-25 minutes until tender. - Drain broccoli, in large mixing bowl, and toss broccoli with margarine and season with salt and pepper. - Transfer to service pans and hold at a temperature of 135 F or greater. - Puree step: Remove desired number of servings and add nutritive liquid such as milk or broth. Blend until desired consistency. - Add approved thickener to achieve desired consistency if needed. Observation during a taste test on 5/19/24 at 10:33 A.M., showed the broccoli had a mushy and overcooked texture. Observation on 5/19/24 at 12:00 P.M., showed the following: - Dietary [NAME] (DC) A made pureed broccoli. - DC A added water to the mixture. - DC A had no recipe book open. During a taste test on 5/19/24 at 12:05 P.M., the pureed broccoli tasted bland. During an interview on 5/19/24 at 12:07 P.M., DC A said the pureed broccoli was more bland, after he/she tasted the pureed broccoli. Review of the recipe with DC A showed that he/she should have added broth to the pureed mixture instead of just water. During an interview on 5/19/24 at 2:33 P.M., the Dietary Director (DD) said: -DC A had been training for only a couple of weeks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she expected the dietary staff to taste the pureed food for temperature and taste. -He/she expected facility staff to use the recipe book when making pureed recipes. During an interview on 5/19/24 at 2:36 P.M., DC A said: - He/she thought he/she was trained. - The other cook (DC B) he/she did not tell him/her about using the broth instead of water for the pureed broccoli. 2. Observation on 5/19/24 from 1:05 P.M. through 1:34 P.M., showed the following: - At 1:05 P.M., the food cart arrived at the 600 Hall. - There were 12 residents in the 600 Hall dining room. - None of the food trays inside the cart, had covers on them. - Certified Medication technician (CMT A) and the Marketing director started serving the residents. - With 5 more trays in the cart, the state surveyor checked the temperature of the test tray and the following temperatures were recorded: -Sliced turkey was 95.2 F, the mashed sweet potatoes were 93.3 F and the broccoli was 93.7 F. During an interview on 5/19/24 at 1:34 P.M., CMT A said no one from the dietary department had come to the 600 Hall to check temperatures of the room trays. 3. Observation on 5/19/24 at 2:19 P.M. showed the following temperatures of a tray that was served on the 300 Hall with two residents left to serve showed the following temperatures: Sliced turkey was 93.9 F, the mashed sweet potatoes were 97.4 F and the broccoli was 95.5 F. Record review of Resident #39's annual Minimum Date Set (MDS-a federally mandated assessment tool completed by the facility for care planning) dated 5/12//24 showed the resident was cognitively intact. During an interview on 5/22/24 at 12:51 P.M., Resident #39 said: - At almost every meal, the food was cold. - About two out of every three days, the meals were cold. - People who eat in the dining room get their meals delivered to them hot. - It makes him feel like less of a person because the residents who ate in the dining room get hot food. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's significant change MDS dated ,d+[DATE]//24, identified the resident as cognitively intact. During an interview on 5/22/24 at 12:56 P.M, Resident #3 said: - The food was cold at times when it was delivered to his/her room. - Turkey was offered on one day and the flavor was OK, but the food temperature was cold, so he/she did not like it. Record review of Resident #83's quarterly MDS dated [DATE], identified the resident as cognitively intact. During an interview on 5/22/224 at 1:03 P.M., Resident #83 said: -The room trays were cold every day said the room trays are cold every day. -On 5/22/24, the food was served warm, but usually it was cold. - During breakfast meals, the eggs were usually cold. - He/she has received warm milk in the past if the food the food was late. During a phone interview on 5/28/24 at 2:11 P.M., the Dietary Director said: - He/she was working on temperature logs. - He/she liked the facility staff to measure the temperatures of the foods when they cook the foods, again about halfway through the service and close to the end of service. - He/she did not have any processes for checking temperatures of meals when those meals got to a resident or a certain hall. - He/she only knew of a few complaints from residents about the food being cold.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview and record review, the facility failed to puree (to make food into a paste or a thick liquid suspension which is made from finely ground cooked food) turkey into a smooth texture that was not stringy. This practice potentially affected three residents with pureed diets. The facility census was 88 residents. 1. Review of the recipe for pureed turkey showed: - Place turkey roasts in oven at a temperature of 375 F (degrees Fahrenheit) and roast for 3-4 hours. [NAME] until an internal temperature of 165 F was reached. - Remove from oven and allow turkey breast to rest for 15 minutes prior to carving. - Hold at 135 F or greater, for service. - For pureed step do the following: Remove the desired number of servings and add nutritive liquid such as milk, broth etc. Blend until desired consistency. Add approved thickener to achieve desired consistency if needed. Observation on 5/19/24 from 12:57 P.M. through 1:00 P.M., showed the following: - DC A did not have the recipe book open. - Dietary [NAME] (DC) A placed 3 servings of (3-4 ounces per serving) into the food processor and added broth and he/she pureed the turkey servings and the broth together. - After pureeing the turkey servings with the broth, DC A placed the mixture into a pan and placed that pan on the steam table without tasting the mixture for texture. Observation on 5/19/24 at 1:00 P.M., during a taste test of the pureed turkey the texture of the pureed turkey did not have a smooth texture and consistency. During an interview on 5/19/24 at 1:58 P.M., the Dietary Director (DD) tasted the pureed turkey and said the pureed turkey was a bit stringy. During an interview on 5/19/24 at 2:01 P.M., the DD said he/she required the cooks to taste the pureed foods. During a phone interview on 5/29/24 at 10:58 A.M., the Consultant Registered Dietitian (RD) said: -He/she has been the Consultant RD to that facility for at least [AGE] years. -He/she expected the cooks for that meal to taste the puree food (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected the cook that day to taste the pureed food 100 %. He/she usually planned in-services for the dietary staff at least quarterly, but those do not always occur, due to dietary staff turnover and scheduling issues. Realistically, in-services happen at least twice per year.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 19916 Based on observation and interview, the facility failed to maintain the floor under the refrigerator in the storage room, free of heavy dust buildup; failed maintain the sprinkler heads over the handwashing sink and the food preparation, free of dust buildup on the sprinkler heads; failed to remove a buildup of grime from under the deep fat fryer; failed to maintain the gaskets (a mechanical seal which fills the space between two or more mating surfaces, generally to prevent leakage from or into the joined objects) of the walk-in freezer and the reach-in refrigerator across from the food preparation table in good repair; failed to maintain the ceiling vents in the kitchen free of a heavy buildup of dust; failed to maintain the handles of the food spatula in good repair; failed to maintain the nozzle of the upper spray wand of the dishwasher; failed to have a trash container dietary staff did not have to use their hands to open the lid every time they placed trash in the trash container; failed to maintain the bottled milk in the dining room at or close to a temperature of 41 F (degrees Fahrenheit); and failed to have enough spatulas available for use. This practice potentially affected 87 residents who ate food from the kitchen. The facility census was 88 residents. 1. Observations on 5/19/24 from 9:49 A.M. through 1:40 P.M., during the lunch meal preparation, showed: - A buildup of dust and debris under the refrigerator in the storage room. - The presence of dust on the sprinkler heads over the handwashing station and the food preparation table. - A buildup of greasy grime under the deep fat fryer. - A 24.5-inch (in.) section of the gasket of the reach-in refrigerator next to the food preparation table was held to the refrigerator door frame with black tape. - A buildup of dust on the ceiling vent over the clean side of the automated dishwasher. - A buildup of dust on the sprinkler head between the food preparation table and handwashing sink. -A buildup of grime under the deep fat fryer. The presence of food debris on the blade of the tabletop can opener. - The handle of a spatula with melted areas which were not easily cleanable. - An 18.5 in. section of gasket of the walk-in freezer was in disrepair. - The presence of debris in the nozzle of the upper spray wand. - Dietary staff had to use their hands to lift the lid of trash container and wash their hands every single time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Dietary [NAME] (DC) A pulled two hamburgers from a frying pan and placed into a pan to place on the steam table without checking the temperature of the burgers. - The DD said the kitchen ran out of spatulas while he/she looked for a spatula to use when another one was being used for another process. - A temperature check was conducted of the milk that served in the dining room by pouring a sample of milk into a glass and the temperature of the milk was 50 F. During interviews on 5/19/24, the Dietary Director (DD) said the following: - At 10:59 A.M., he/she said the gasket of the refrigerator across from the food preparation table was held together tape before he/she started employment in 11/2023. - At 11:01 A.M., he/she said the freezer did not close properly because of the damaged gasket and the lever at the top did not operate the way it should. - At 1:46 P.M., the DD said he/she had not checked the temperature of the milk in the bins in the different dining rooms and may have to use a different method keeping the milk at a cool temperature. - At 2:24 P.M., the DD said he/she expected facility staff to sweep under the refrigerator in the storage room nightly. - At 2:26 P.M. he/she expected dietary staff to scrub clean under the deep fat fryer weekly and to sweep and mop nightly. - At 2:29 P.M., DD said it was his/her job to check on the spatula handles to ensure they were easily cleanable. He/she knew about the white handled one but not the black handled spatula. - At 2:36 P.M., the DM said the dietary staff needed another trash container with a foot operated lid. During an interview on 5/22/24 at 1:20 P.M., the DM said he/she expected the dietary cooks to check temps of potentially hazardous foods.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation and interview, the facility failed to ensure there was negative airflow in the restrooms of the following resident rooms: 106, 102, 210, 209, 206/204, 205, 311/309, and 302/304. This practice potentially affected at least 20 residents who resided in those rooms. The facility census was 88 residents. **Note: Air flow was tested by holding one piece of tissue paper to the ceiling vent. If the paper was drawn up then negative air flow was present; if the paper was not drawn to the ceiling vent, then negative airflow was absent. 1. Observations with the Maintenance Director and the Regional Maintenance Person on 5/21/24, showed: -At 9:52 A.M., there was not any negative airflow from the restroom vent of resident room [ROOM NUMBER]. -At 9:57 A.M., there was not any negative airflow from the restroom vent of resident room [ROOM NUMBER]. -At 10:04 A.M., there was not any negative airflow from the restroom of resident room [ROOM NUMBER]. -At 10:11 A.M., there was not any negative airflow from the restroom of resident room [ROOM NUMBER]. -At 10:18 A.M., there was not any negative airflow from the shared restroom of resident rooms 206/204. -At 10:21 A.M., there was not any negative airflow from the shared restroom of resident rooms 205. -At 10:39 A.M., there was not any negative airflow from the shared restroom of resident rooms 311/309. and -At 10:51 A.M., there was not any negative airflow from the shared restroom of resident rooms 302/304. During a telephone interview on 5/29/24 at 5:08 P.M., the Maintenance Director said: -When he/she investigated the issue regarding the ventilation he/she was not sure if it was something related to electrical wiring. -Some fans needed a bigger motor. -The issues which affected the fans not providing negative airflow, was a little different for each hall.