STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265404	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 19016 Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form CMS-10055) for two sampled residents (Resident #8 and #31) out of three sampled residents who were discharged from Medicare part A services. The facility census was 44 residents. Review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C-09-20), dated 1/9/09, showed the following: -If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by the use of either the SNF ABN (form CMS-10055) or one of the five uniform denial letters. -The SNF ABN provides an estimated cost of items or services in case the beneficiary has to pay for them him/herself or through other insurance they may have. -If the SNF provides the beneficiary with either the SNF ABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met is obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination. Review of the facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notices policy, revised 9/2022 showed: -If the Director of Admissions or Benefits Coordinator believes upon admission or during the resident's stay that Medicare Part A will not pay for an otherwise covered skilled service the resident or representative is notified in writing why the service may not be covered and of the resident's potential liability for payment of the non-covered service. (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
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident or representative is informed they may choose to continue receiving skilled services that may not be paid for by Medicare and assume the financial responsibility. -If the facility expects Medicare will not continue to pay for items or services a physician has ordered, and the beneficiary would like to continue receiving the care, the SNF ABN is issued before such extended items or services are terminated. 1. Review of Resident #8's SNF Beneficiary Protection Notification Review showed: -A Notice of Medicare Provider Non-Coverage (NOMNC) (CMS 10123) form was provided to the resident showing skilled services would end on 5/8/24. The resident signed the form on 5/6/24. -The resident was not provided a SNF ABN/CMS-10055. 2. Review of Resident #31's SNF Beneficiary Protection Notification Review showed: -A NOMNC (CMS 10123) form was provided to the resident showing skilled services would end on 5/8/24. The resident signed the form on 5/6/24. -The resident was not provided a SNF ABN/CMS-10055. 3. During an interview on 7/16/24 at 11:30 A.M. the Social Services Director (SSD) said: -Since he/she had been at the facility, which was just over a month, the Bookkeeper had been issuing the residents' NOMNC and ABN forms, with the exception he/she had recently been asked to issue the forms for one resident. -He/She didn't know if the previous SSD or the Bookkeeper had issued Residents' #8 and #31's notices, but he/she was told he/she would be responsible for issuing the NOMNC and ABN forms to residents or their representatives in the near future. -It was his/her understanding the beneficiary forms were required. During an interview on 7/16/24 at 12:05 P.M. with the Regional Nurse and the Director of Nursing (DON), the Regional Nurse said: -The Bookkeeper had been responsible for making sure residents who remained in the facility received the SNF ABN when therapy services were expected to end and Medicare probably would no longer pay. -The SSD and Bookkeeper were both made aware three days before therapy services were expected to end so there was no reason why the residents shouldn't be given the SNF ABN forms as required.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on interview and record review, the facility failed to complete a quarterly assessment for two sampled residents (Resident #5 and #7) and to complete a significant change Minimum Data Set (MDS-a federally mandated assessment completed by facility staff) for one resident (Resident #7) out of 12 sampled residents. The facility census was 44 residents. Review of facility policy entitled Resident Assessment revised October 2023 showed: -A comprehensive assessment of each resident was completed at intervals designated by the Omnibus Budget Reconciliation Act (OBRA) regulations and Prospective Payment System (PPS) requirements. -Data from the Minimum Data Set (MDS) was submitted to the Internet Quality Improvement Evaluation System (iQIES). -OBRA-Required Assessments were federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. -OBRA assessments included: --Admission Assessment; --Quarterly Assessment; --Annual Assessment; --Significant Change in Status Assessment (SCSA); --Significant Correction to Prior Comprehensive Assessment (SCPA); --Significant Correction to Prior Quarterly Assessment (SCQA); --Discharge Assessment (return anticipated and return not anticipated). -Comprehensive MDS assessments included both the completion of the MDS as completion of the Care Area Assessment (CAA) process and care planning and included Admission, Annual, SCSA, and SCQA assessments. -Non-Comprehensive MDS assessments included a select number of item from the MDS used to track a resident's status between comprehensive assessments and ensured monitoring of critical indicators of the gradual onset of significant changes in resident status. -The resident assessment coordinator was responsible for ensuring that the interdisciplinary team conducted timely and appropriate assessments. 1. Review of Resident #5's Care plan dated 11/16/23 showed: (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was dependent on staff with mobility and needed assistance with staff with his/her wheelchair. -The resident wore glasses. -The resident had displayed attention seeking behavior by yelling out inappropriate comments while at the dining room table. Review of the resident's MDS assessments and tracking forms showed: -The resident had a quarterly MDS completed on 1/9/24. -There were no additional MDS's completed. During an interview on 7/15/24 11:15 A.M., the Administrator said: -The MDS Coordinators (MDS) left the position on 7/7/24. -He/She was currently trying to hire a person for the position. -He/She was having the corporate MDS person complete their MDS needs at that time. -No one was monitoring to ensure the MDS's were being completed for the residents. During an interview on 7/16/24 at 12:04 P.M., the Director of Nursing (DON) said: -The MDS Coordinators left the facility two weeks ago. -He/she was unaware of any MDS assessments not completed and submitted on time. -He/She had only been in the position for a week. -The MDS's should have been done as required and submitted on the correct timelines. -Usually the MDS Coordinator was responsible for the MDS. -The MDS should be completed upon admission, every 90 days there after, and when a significant change in the residents condition occurred. 51150 2. Review of Resident #7's MDS submissions showed: - A Quarterly assessment dated [DATE]. -There was no MDS submitted between 3/23-9/23. -A Quarterly assessment dated [DATE]. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's hospice (end of life care) admission sheet in his/her hospice communication book showed he/she was admitted to hospice services on 6/21/23. Review of the resident's quarterly MDS dated [DATE] showed the resident was not on hospice services. -NOTE: No documentation of a quarterly or significant change MDS was completed between March and September 2023. No documentation a significant change MDS was completed after the resident entered hospice services on 6/21/23. Review of the resident's Visit Note by the physician dated 2/01/24 showed the resident was on hospice. Review of the resident's Care Plan dated 3/11/24 showed the resident was on hospice for end stage stroke. Review of the resident's Physician's Order Sheet (POS) dated 3/2024 showed the following physician's orders to admit to hospice for end stage stroke. Review of the resident's Visit Note by the physician dated 4/03/24 showed the resident was on hospice. Review of the resident's Nurses Note dated 4/25/24 showed the resident was admitted to hospice services per physician order. Review of the resident's Visit Note by the Nurse Practitioner dated 5/01/24 showed the resident was on hospice. Review of the resident's Visit Note by the nurse practitioner dated 6/05/24 showed the resident was on hospice. Review of the resident's Nurses Note dated 6/28/24 showed the resident continued hospice services. During an interview on 7/16/24 at 8:42 A.M. the Assistant Director of Nursing (ADON) said: -He/She was working as a charge nurse on the floor. -He/She did not know how often the MDS's were updated. -He/She did not know who was responsible for updating the MDS's. During an interview on 7/16/24 at 12:04 P.M. the DON and the Regional Nurse said: -He/She did not have a MDS coordinator. -He/She had a candidate in mind for the MDS coordinator position and were planning to fill the position as soon as possible. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was unaware of any MDS assessments not completed and submitted on time. -He/She was aware that when a resident is admitted to hospice or has a change in condition, the MDS would need to be updated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on interview and record review, the facility failed to ensure resident falls were accurately reflected on their Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) for one sampled resident (Resident #4) out of 12 sampled residents. The facility census was 44 residents. Review of the facility's Resident Assessments policy, revised October, 2023 showed: -Federally mandated and required assessments must be performed for all residents of Medicare and Medicaid certified homes. -The resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments. -Any persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. -Information in the MDS will consistently reflect information in the progress notes, plans of care and resident observations and interviews. 1. Review of resident #4's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Muscle wasting and atrophy. -Vascular dementia (brain damage caused by a stroke or lack of blood flow to the brain) with agitation and behavioral disturbance. Review of the resident's Nurse's note dated 4/10/24 showed: -At 5:15 P.M. the Nurse Assistant (NA) went in the resident's room to get him/her for supper. -The resident was sitting on floor in his/her bathroom. Noted his/her walker was by his/her bed and he/she had shoes on the wrong feet. -After neuro checks (neurological checkpoints to monitor level of consciousness, ability to move extremities, eye responses and change in pupils and vital signs) and checking for injuries they assisted the resident off floor. The resident unable to ambulate at all. -The resident denied pain. Pupils equal and reactive to light. Hand grips strong. The resident following commands. Alert and oriented to self, location, and situation which is normal baseline. -Noted a large hematoma (a collection of blood that forms outside a blood vessel) to left side of his/her forehead. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notified Nurse Practitioner (NP) and family of fall and hematoma. -Resident taken to hospital by private vehicle. Hospital notified. NP notified family was taking resident to hospital. Review of the resident's Hospital Discharge Summary, dated 4/10/24 showed: -The resident presented to emergency room (ER) after ground-level fall. -Computerized Tomography (CT) scan of head and cervical spine. CT scan did not show any traumatic injuries with exception of forehead hematoma. Review of the resident's Nurse's note, dated 5/11/24 showed: -At approximately 5:20 P.M. the resident was observed sitting on the floor near the end of the bed. -Unwitnessed fall. -Family member and on-call Physician aware. -No new orders. -Neuro checks and vital signs started. -Using wheelchair for mobility due to resident's unsteadiness. -Report to Night shift nurse and instructed Certified Nurse Assistant (CNA) to keep close eye on resident due to poor safety awareness. -No redness, bruising or injury noted. Will continue to monitor. Review of the resident's Nurse's note, dated 5/25/24 showed: -At approximately 11:10 A.M. the resident was observed sitting next to his/her bed. -The resident stated he/she sat down. -No redness, bruising or injury noted. -Family member, on-call physician, and hospice notified. -Neuro checks and vital signs being done. -The resident stable and able to move all extremities well. Denies pain. -The resident assisted to wheelchair and brought to dining room for increased observation. Review of the resident's Significant Change MDS, dated [DATE] showed the resident: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was severely cognitively impaired with continuous disorganized thinking. -Had only one fall since the prior assessment (quarterly assessment completed on 3/17/24). -Had zero non-injury falls. -Had zero non-major injury falls. During an interview on 7/16/24 at 12:05 P.M. the Director of Nursing (DON) and Regional Nurse Manager, the Regional Nurse Manager said: -The MDS Coordinator position has been empty for a couple of weeks and the facility was looking to fill it. -Information related to falls, was discussed daily in clinical meetings. -The MDS information should be accurate at the time it is submitted. -He/She expected the MDS guidelines to be followed. -If the guidelines showed a hematoma was a non-major injury and a subdural hematoma as a major injury then the MDS should show the resident's injury.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51150 Based on observation, interview, and record review, the facility failed to follow physician's orders for wound care on a surgical wound for one sampled resident (Resident #7) out of 12 sampled residents. The facility census was 44 residents. A policy for following physicians orders was requested and not received from the facility. 1. Review of Resident #7's annual Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 12/14/23 showed the resident: -Was severely cognitively impaired. -Had a surgical wound. Review of the resident's Care Plan dated 3/11/24 showed: -The resident had a healing surgical wound. -The wound was related to a right above the knee amputation. Review of the resident's Physician's Order Sheet (POS) dated 6/2024 showed the following physician's order to treat the right distal stump (surgical removal site of an above knee amputation) with wound cleanser or normal saline, apply skin prep (topical barrier between skin and air) daily and leave open to air. Review of the resident's Treatment Administration Record (TAR) dated 6/2024 showed: -Right distal stump: Clean with wound cleanser or normal saline, apply skin prep daily and leave open to air. -No documentation the treatment was completed by facility staff 12 out of 30 opportunities. Review of the resident's (TAR) dated 7/2024 showed: -Right distal stump: Clean with wound cleanser or normal saline, apply skin prep daily and leave open to air. -No documentation the treatment was completed by facility staff 15 out of 15 opportunities. Observation on 7/15/24 at 11:01 A.M. showed the resident had no open areas of skin on the his/her right above the knee amputation stump. During an interview on 7/16/24 at 8:42 A.M. the Assistant Director of Nursing (ADON) said: -He/She was working as a charge nurse on the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When wound care was completed the charge nurse was responsible for documenting this on the resident's TAR. -If the wound care was not documented as completed on the TAR, he/she would assume that the wound care was not completed. During an interview on 7/16/24 at 12:04 P.M. the Director of Nursing (DON) said: -When wound care was completed the charge nurse was responsible for documenting this on the resident's TAR. -If the wound care was refused by the resident, the charge nurse was responsible for documenting refusal on the resident's TAR. -If the wound care was not documented as completed on the TAR, he/she would assume that the wound care was not completed. -The charge nurse should be auditing to ensure the treatments are being documented on the TAR.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on interview and record review, the facility failed to complete a thorough investigation to determine the root cause of a resident's fall, to document monitoring and neurological assessments after a resident reported an unwitnessed fall, and to update the resident's care plan with appropriate interventions and monitor the effectiveness of interventions to prevent additional falls for one sampled resident (Resident #29) out of 12 sampled residents. The facility census was 44 residents. Review of facility policy entitled Accidents and Incidents-Investigating and Reporting revised July 2017 showed: -All accidents or incidents that involved residents that occurred on our premises would be investigated and reported to the administrator. -The nurse supervisor/charge nurse and/or the department director or supervisor would have promptly initiated and documented investigation of the accident or incident. -The following data, as applicable would have been included on the Report of Incident/Accident form: --The date and time the accident or incident took place. --The nature of the injury/illness (e.g. bruise, fall, nausea, etc. --The circumstances surrounding the accident or incident. --Where the accident or incident took place. --The name(s) of witnesses and their accounts of the accident or incident. --The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions. --The date/time the injured person's family was notified and by whom. --The condition of the person, including his/her vital signs. --The disposition of the injured person. --Any corrective action that was taken. --Follow-up information. --Other pertinent data as necessary or required. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--The signature and title of the person that completed the report. -The nurse supervisor/charge nurse and/or the department-director or supervisor shall complete a Report of Incident/Accident form for each occurrence. -The director of nursing services shall ensure that the administrator received a copy of the Report of Incident/Accident form for each occurrence. 1. Review of Resident #29's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Legal Blindness. -Complete traumatic amputation (the action of surgically cutting off a limb) at level between knee and ankle, right lower leg. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning) dated 5/18/24 showed the resident: -Was cognitively intact; -Required set-up staff assistance for bed mobility, transfers, locomotion, dressing, personal hygiene, eating, and toileting; -Had no falls since admission up to the time of the assessment. Review of the resident's Fall Care Plan dated 5/19/24 showed: -The resident was at risk for falls due to right above the knee amputation, non-ambulatory, poor vision, unsteady balance, and history of prior falls. -Refer the resident for physical therapy. -Monitor for changes in condition that might have warranted increased supervision/assistance and to have notified the physician. -Wheelchair was the residents primary form of locomotion. Review of Therapy Services Referral/Screening dated 6/17/24 showed the resident stated that he/she had fallen out of bed when he/she was sitting on the edge of the bed and reached for his/her meal tray. Saff were educated on placing food tray on bedside closer to the resident. Review of the resident's Nurse's Notes dated 6/27/24 at 2:45 showed: -Resident reported complaining of a headache. -The resident said he/she hit his/her head on the floor when he/she fell about a week ago. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident requested to go to the hospital and was sent. -Doctor and responsible party was notified. Review of Therapy Services Referral/Screening dated 7/1/24 showed the resident reported that he/she had falls in the past but had not reported the falls to any staff. The resident was educated on reporting any fall he/she had to staff immediately. A fall investigation was not provided by the facility upon request for any fall the resident had. During an interview on 7/9/24 at 11:57 A.M. the resident said he/she had fallen a couple of weeks ago, but he/she was ok. -He/She did not tell staff because he/she was ok, but he/she did tell staff about a week later of the fall. He/She was just sent to the hospital because he/she was complaining of a headache. The facility did not do anything else as far as he/she knew. During an interview on 7/16/24 at 9:48 A.M., Certified Nurses Aide (CNA) B said: -Anytime a resident was found on the floor or a resident told him/her of a fall the charge nurse was notified immediately. -Usually when a resident told him/her of a fall that had happened it was treated as an unwitnessed fall. -With an unwitnessed fall there would be a sheet were he/she would document vital signs taken at prescribed intervals like every 15 minutes, then every half hour and so on. -The nurse on duty would also be assessing the resident. During an interview on 7/16/24 at 9:51 A.M., the Assistant Director of Nursing (ADON) said: -He/She just started as ADON last week. -He/She was the charge nurse that day for the hall. -When any resident reported that he/she had a fall it should be investigated as a fall and the following should have been done: --Doctor and responsible party should have been notified. --Investigation should have been started. --Since the fall being reported was unwitnessed, then the unwitnessed falls protocol should have been done to include neurological checks. --The resident should have been assessed for an injury and assessment should have been documented. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Maywood Terrace Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 East Truman Rd Independence, MO 64052	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Interviews conducted to see if any staff or resident knew of the fall. --Root cause analysis completed for the reported fall. --Care plan would have been updated with the findings from the investigation. During an interview on 7/16/24 at 12:04 P.M., Director of Nursing (DON) said: -He/She just started at the facility last week. -It was his/her expectation that when a resident fell or reported a fall that a complete investigation would have been performed. -The investigation would have a included: --Assessment of the resident for injuries. --Statements from witnesses. --Root cause analysis of fall. --Other assessments depending on what is needed such as neurological checks for an unwitnessed fall. --Updated care plan on the findings of the investigation. --Documentation on the investigation. -It was his/her expectation that when a resident reported a fall that the staff would treat the fall as an unwitnessed fall. -It was his expectation that when a resident reported to staff that a fall occurred week ago then a fall investigation would have been started. MO00238230

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 19016 Based on observation, interview and record review, the facility failed to ensure sanitizing of the indwelling catheter (tubing inserted in the bladder to drain urine) drainage port and hand hygiene during catheter tubing and drainage bag change and failed to have complete physician's orders for the size of the catheter for one sampled resident (Resident #21) out of 12 sampled residents. The facility census was 44 residents. Review of the facility's Catheter Care, Urinary Care policy, revised 8/2022 showed: -The policy goal was to prevent urinary-associated complications including Urinary tract infections. -Use aseptic technique when handling or manipulating the drainage system. -Keep catheter tubing and drainage bags off the floor. -Empty collection bag every eight hours using a separate clean collection container for each resident. Avoid splashing and prevent contact of drainage spigot with nonsterile container. Review of the facility Handwashing/Hand Hygiene policy revised October 2023 showed: -Hand hygiene is indicated immediately before touching a resident, before moving from a soiled site and immediately after glove removal. -Use an alcohol-based hand rub for most clinical situations. 1. Review of the Resident #21's Face Sheet, dated 1/3/24 showed the resident had a diagnosis upon admission that included urinary tract infection (UTI). Review of the resident's Indwelling Catheter Care Plan, initiated 1/3/24 showed: -The resident had an indwelling catheter (a tube passed through the urethra into the bladder to drain urine) due to urine retention. -The goal was for the resident to be free of infection related to catheter use. -Staff to complete catheter care each shift. Review of the the resident's quarterly Minimum Data Sheet (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 4/7/24 showed the resident: -Was severely cognitively impaired. -Had a catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician Orders Sheet (POS) dated 06/2024 showed: -Foley (a type of indwelling catheter) catheter care every shift start date 2/27/24. -Replace foley catheter monthly on the 15th starting 3/13/24. -Irrigate foley catheter with 30 milliliter (ml) sterile water as needed for blockage start date 2/27/24. -Ciprofloxacin 500 milligrams (mg) twice daily for five days starting on 5/28/24 for UTI. Note: There was no order showing the size of the catheter. Observation on 7/10/24 at 12:08 P.M. showed: -The resident was lying in his/her bed. -His/her catheter tubing (the clear tubing that drains urine from the catheter to the urine collection bag) had sediment and a pink/reddish discoloration. -Certified Nursing Assistant (CNA) A changed the resident's catheter tubing and urine collection bag. -CNA A removed the tubing from the resident's catheter, did not cleanse the end of the catheter with an alcohol pad, removed his/her gloves, did not sanitize his/her hands before putting on clean gloves and attached the new catheter tubing to the resident's catheter. -Upon connection of the new catheter tubing, clear yellow urine flowed into the catheter tubing. During an interview on 7/20/24 at 12:12 P.M. CNA A said: -After removing the resident's existing catheter tubing, he/she removed his/her gloves and did not sanitize or wash his/her hands before putting on clean gloves. -He/she should have sanitized or washed his/her hands before putting on clean gloves and attaching the resident's new catheter tubing. -He/she usually did wash or sanitize his/her hands each time he removed his/her gloves before putting on clean gloves. -He/she did not cleanse the resident's catheter drainage port before attaching the new catheter tubing; he/she should have wiped the resident's catheter drainage port with an alcohol wipe before connecting the new tubing; alcohol wipes were kept locked up; he /she could have gotten an alcohol wipe from the charge nurse before changing the resident's catheter tubing. -After changing the resident's catheter tubing, the urine in his/her catheter tubing was a little cloudy, yellow and had no red or orange color. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 12:05 P.M. the Director of Nursing (DON) said: -All residents with indwelling catheters should have a physician order indicating the size of the resident's catheter. -Staff should cleanse the catheter port with an alcohol wipe before attaching new catheter tubing. -Hand hygiene was to be completed before starting resident care, with all glove changes and after finishing resident care. -When changing catheter tubing, gloves were to be removed, hand hygiene performed, and clean gloves put on before attaching new catheter tubing to catheters.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 43345 Based on interview and record review, the facility failed to identify, assess and provide supportive interventions for one sampled resident (Resident #35), with a diagnosis of Post-Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), out of 12 sampled residents. The facility census was 44 residents. Review of Trauma-Informed Care Implementation Center (https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/) copyright 2021 showed: -Trauma-informed care shifts the focus from What's wrong with you? to What happened to you? -A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation - past and present - in order to provide effective health care services with a healing orientation. -Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors. -Trauma-informed care seeks to: --Realize the widespread impact of trauma and understand paths for recovery. --Recognize the signs and symptoms of trauma in patients, families, and staff. --Integrate knowledge about trauma into policies, procedures, and practices. --Actively avoid re-traumatization. Review of facility policy entitled Trauma-Informed and Culturally Competent Care' revised August 2022 showed: -To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. -Trauma resulted from an event, series of events, or set of circumstances that was experienced by an individual as physically or emotionally harmful or life threatening, and that has lasting adverse effects on the individuals functioning and mental, physical, social, emotional, or spiritual well-being. -Trauma-informed care was an approach to delivering care that involved understanding, recognizing, and responding to the effects of trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A trauma-informed approach to care delivery recognized the widespread impact and signs and symptoms of trauma in residents, and incorporated knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. -Trigger was a psychological stimulus that prompted recall of a previous traumatic event, even if the stimulus itself was not traumatic or frightening. -Developed individualized care plans that addressed past trauma in collaboration with the resident and family, as appropriate. -Identified and decreased exposure to triggers that might re-traumatize the resident. -Recognized the relationship between past trauma and current health concerns. 1. Review of Resident #35's Level One Pre-Admissions Screening and Resident Review (PASRR) (federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in Medicaid Certified beds in a nursing facility regardless of the source of payment) dated 11/9/23 showed: -The resident had a diagnosis of PTSD. -The resident had a car accident in 2022 that caused trauma and the PTSD diagnosis with chronic symptoms. -The residents needs could be provided by the nursing facility and required: --Behavioral support plan. --Structured environment. --Personal support network. --Medication therapy. --Activities of Daily Living (ADL activities of daily living is a term used in healthcare to refer to an individual's daily self-care activities) program. Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 1/9/24 showed: -The resident was cognitively intact. -Had PTSD. Review of the Physician Orders dated 6/5/24 showed the following physician's orders showed: -No diagnosis of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Divalproex Sodium (calms overstimulated nerves and soothes and calms the brain, and has been successful in treating patients suffering from panic) take 250 milligrams (mg) take by mouth twice a day for anxiety and/or depression. -Klonipin (produces a calming effect on the brain and nerves, which helps to reduce anxiety, prevent seizures, and promote relaxation) give 0.25 mg three times a day for depression. -Sertraline (a type of antidepressant drug used to relieve depression) medication give 25 mg by mouth at daily for Depression (is a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world). Review of the resident's care plan revised 6/17/24 showed: -PTSD was not addressed in the care plan. -The resident's triggers were not addressed. -The resident's interventions were not addressed. -The resident was on an antidepressant medication for PTSD. During an interview on 7/12/24 at 8:12 A.M. the resident said: -He/she was unsure if he/she had a diagnosis of PTSD. -He/She was anxious around loud sounds and large crowds. -He/She stayed at the same table with the same people at meals, and mostly in his/her room due to this. During an interview on 7/16/24 9:48 A.M., Certified Nurses Aide (CNA) B said: -He/She was unsure if the resident had PTSD. -He/She was unsure what his/her triggers are, or his/her inventions were. -The resident did not have any behaviors. -He/She would look on the care plan for the triggers and interventions. During an interview on 7/16/24 9:51 A.M., Assistant Director Of Nursing (ADON) said: -He/She just started as ADON last week. -He/She was the charge nurse that day for the hall. -The MDS Coordinator was responsible for care plan development. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not know if the resident had a diagnosis of PTSD. -He/She did not know the resident's triggers or interventions. -The information of the resident's triggers and interventions should have been in the care plan. -It was his/her experience that the nurse that did the admission assessment and the MDS Coordinator would have assessed the resident for PTSD. During an interview on 7/15/24 11:15 A.M., the Administrator said: -He/She had only been at the facility about a month. -The MDS Coordinator left the position on 7/7/24. -He/She was currently trying to hire a person for the position. -The MDS Coordinator was responsible for care plan development. -The care plan should accurately reflect the resident's condition at the time it was developed along with diagnosis. -The care plan should have the triggers and the interventions for PTSD. -The staff should have been made aware of the resident's triggers and interventions. During an interview on 7/16/24 at 12:40 P.M., Director of Nursing (DON) said: -He/She had just started at the facility the past week. -It was his/her expectation that the MDS Coordinator would be responsible for the care plans. -It was his/her expectation that if the resident had a diagnosis of PTSD, it would be addressed in the care plan to include triggers and interventions. -The MDS Coordinator would be responsible for the information for the PTSD care plan. -The care plan would have addressed the triggers and the interventions. -It was his/her expectation that the nurses and CNAs would know a resident's triggers and interventions. -The Inter-disciplinary Care Team (IDT) audited the care plans. -He/She was ultimately responsible to ensure the care plan were correct for the residents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure nursing staff were available at all times for two sampled residents (Resident #4 and #21) who reside on the dementia (a slowly progressive disease of the brain characterized by impairment of memory and reasoning) Special Care Unit (SCU). The facility census was 44 residents. 1. Review of the facility census for 7/2/24 showed sixteen residents lived on the SCU. Review of the facility's staffing sheets for 7/9/24 showed a Licensed Practical Nurse (LPN) and two Certified Nurse Assistants (CNAs) were scheduled to be on the SCU from 7:00 A.M. to 7:00 P.M. Observation on 7/9/24 at 11:55 A.M. showed: -Several residents from the SCU were in the main common area at tables listening to music with multiple staff with them. -At 12:00 P.M. it was noted Residents #21 and #4 were both in their respective beds on the SCU and the other SCU residents were off the unit. -No nursing staff was on the unit. -A staff person with linens said he/she worked in the laundry department and hadn't seen any nursing staff. -At 12:18 P.M. the laundry staff left the unit. -At 12:31 P.M. a housekeeper with housekeeping supplies came onto the unit. -At 12:33 P.M. Certified Medication Technician (CMT) B came onto the unit. Note: Residents were left without nursing staff for 33 minutes from 12:00 P.M. to 12:33 P.M. 2. Review of Resident #4's Face Sheet showed he/she was admitted to the facility on [DATE] with diagnoses that included: -Muscle wasting and atrophy. -Vascular dementia (brain damage caused by a stroke or lack of blood flow to the brain) with agitation and behavioral disturbance). Review of the resident's Significant Change Minimum Data Set (MDS-xxx dated 5/30/24 showed the resident: -Was severely cognitively impaired with continuous disorganized thinking. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required supervision for transfers. -Had fallen, including a fall with injury, since the previous MDS. -Received hospice care (end of life care). -Required maximal assistance to propel his/her wheelchair. The resident's care plan, updated 5/30/24 showed: -The resident was at risk for falls related to psychotropic medications, unsteady gait and balance, shuffling feet, placing shoes on the wrong feet, having shoes untied, poor safety awareness related to dementia, and resistance to others keeping his/her room tidy. -Interventions included: --Stand by assist of one staff while ambulating. --Assist with footwear to ensure shoes are on the right feet and tied. -The resident required assistance to safely complete Activities of Daily Living (ADLs-bathing, dressing, walking). Review of the resident's Fall Risk Evaluation dated 6/27/24 showed: -The resident was at high risk for falls due to unsteady gait, shuffling feet, and cognitive impairment. -His/Her fall risk score was 22. Residents with a fall risk score of 10 or more required a fall risk care plan. During an interview on 7/16/24 at 9:46 A.M. Hospitality Aide (HA) A said: -The resident had fallen multiple times since 4/2024. -The resident tried to get out of bed on his/her own when staff weren't around and required one-person assistance every time he/she gets up and for assistance in the bathroom. -The resident wouldn't be safe if left alone on the unit because of his/her risk for falls and has other safety needs related to dementia. -The resident was severely cognitively impaired. -The resident should never be left without staff. During an interview on 7/16/24 at 10:23 A.M. Certified Nurse Aide (CNA) A said: -The resident would try to get out of bed on his/her own when staff are busy elsewhere. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was on a one-person transfer status due to weakness in his/her legs. -It wouldn't be OK to leave the resident by himself/herself on the unit because of his/her risk for falls as well as his/her poor safety awareness in general. -The resident had dementia and didn't know his/her physical limitations. 3. Review of Resident #21's Face Sheet showed he/she was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance. Review of the resident's comprehensive care plan, dated 1/3/24, showed the resident: -Was at risk for falls. -Had safety awareness problems. -Was dependent upon staff for ADLs. -Was unable to walk. Review of the resident's quarterly MDS, dated [DATE] showed the resident: -Was severely cognitively impaired. -Had upper extremity impairments on one side and lower extremity impairments on both sides. -Was dependent upon staff for ADLs. During an interview on 7/2/24 at 11:55 A.M. RN A said the resident required staff assistance for all ADLs. During an interview on 7/16/24 at 9:27 A.M. Hospitality Aide A said the resident shouldn't be left alone on the unit because he/she needed total care from staff. During an interview on 7/16/24 at 10:11 A.M. CNA A said: -It would never be OK to leave the resident without staff on the unit because he/she received total care for feeding and to make sure beverages were within reach. -The resident had to be checked on often and can become emotional. It would make the resident feel anxious if he/she was left alone on the unit. 4. During an interview on 7/16/24 at 12:05 P.M. with the Director of Nursing (DON) and Corporate Nurse Manager, the DON said: -He/She would expect nursing staff to always be on the memory care unit and available if any residents were on the unit. It would not be safe for staff not to be available. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It was not safe for Resident #4 with his/her recent fall history or for either resident with their care needs to be left without nursing staff. -It was not enough to just have housekeeping or laundry staff on the unit. -If there were two nursing staff on the unit and one left for a break the other nursing staff was expected to stay on the unit and to know to do so.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 43345 Based on observation, interview and record review, the facility failed to post staffing information in a location that was easily accessible to residents on the Long Term Care (LTC) and Rehabilitation units of the facility and to ensure staffing data was posted for visitors including the facility name, daily census, and the actual hours worked per shift for each of the three categories of nursing employees: Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs)/Certified Medication Technicians (CMTs) directly responsible for resident care. The facility census was 44 residents. Review of the facility's Nurse Staffing Posting Information, revised August 2022 showed: -The facility would have posted on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible that provided direct care to residents. -Within two hour of the beginning of each shift, the number of licensed nurses RNs, LPNs, and CNAs directly responsible for resident care was posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. -The information recorded on the form would include the following: --The name of the facility name. --The current date. --The resident census at the beginning of the shift for which the information was posted. --Twenty-four-hour shift schedule operated by the facility. -Type (RN, LPN, or CNA) and category of nursing staff that worked during that shift who were paid by the facility (including contract staff). -The actual time worked during that shift for each category and type of nursing staff. -Total number of licensed and non-licensed nursing staff working for the posted shift. 1. Observation on 7/9/24 at 3:09 P.M. showed the daily staffing with required information including staff titles and total hours worked was not posted in the facility where it was easily observable to all residents and visitors. Observation on 7/10/24 at 9:46 A.M. showed the daily staffing with required information including staff titles and total hours worked was not posted in the facility where it was easily observable to all residents and visitors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/12/24 at 9:46 A.M. showed the daily staffing with required information including staff titles and total hours worked was not posted in the facility where it was easily observable to all residents and visitors. During an interview on 7/16/24 at 11:05 A.M., the Administrator said: -He/She was currently responsible for posting staffing. -He/She did not currently have a staffing coordinator. -He/She was trying to hire a staffing coordinator. -He/She was in charge of making up the schedule and had it posted by the time clock. -The document should contain the facility name, number or residents, number of hours worked for each RN, LPN, and CNA. -It should have been posted where all residents could see it. During an interview on 7/16/24 at 12:04 P.M., the (Director of Nursing) DON said: -He/she did not do the daily staffing. -He/she did not verify this was completed daily. -It was his/her expectation the staffing would be posted daily with the required information. -It was his/her expectation the daily staffing with the required information would be accessible to all residents and visitors. -He/She had just started at the facility and was unsure who was posting the staffing.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on interview and record review, the facility failed to follow through on the pharmacy consultant identified irregularities in the resident's medication orders without an appropriate diagnosis or indication for use during the pharmacists monthly Drug Regimen Review (DRR) for one sampled resident (Residents #29) out of 12 sampled residents. The facility census was 44 residents. Review of facility policy entitled Medication Regimen Reviews (MRR) revised May 2010 showed: -The consultant pharmacist reviewed the medication regimen of each resident at least monthly. -The consultant pharmacist performed a MRR for every resident in the facility that received medications. -The MRR involved a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors, and other irregularities. -Within 24 hours of the MRR, the consultant pharmacist provided a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contained: --The resident's name. --The name of the medication. --The identified irregularity. --The pharmacist's recommendations. -If the physician did not provide a timely or adequate response, or the consultant pharmacist identified that no action had been taken, he/she contacted the medical director or (if the medical director was the physician of record) the administrator. -The attending physician documented in the medical record that the irregularity had been reviewed and what (if any) action was taken. -The consultant pharmacist provided the director of nursing services and medical director with a written, and signed and dated copy of medication regimen reports. -Copies the medication review reports, including physician responses, were maintained as part of the permanent record. 1. Review of Resident #29's Face Sheet showed he/she was admitted to the facility on [DATE]. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Monthly Medication Record Review (MRR) dated 4/29/24 showed the pharmacy consultant identified medication orders without a diagnosis or indication for use. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning) dated 5/18/24 showed the resident: -Was cognitively intact; -The resident used the following medications: --Anticoagulants (an anticoagulant, commonly known as a blood thinner, is a chemical substance that prevents or reduces the coagulation of blood, prolonging the clotting time). --Diuretics (A diuretic is any substance that promotes diuresis, the increased production of urine). --Antiplatelets (An antiplatelet drug, also known as a platelet agglutination inhibitor or platelet aggregation inhibitor, is a member of a class of pharmaceuticals that decrease platelet aggregation and inhibit thrombus (clot) formation). --Hypoglycemic's (Drugs used in diabetes treat diabetes mellitus by decreasing glucose levels in the blood). Review of the resident's care plan dated 5/19/24 showed the resident had Type II Diabetes Mellitus (DM-the pancreas doesn't make enough insulin. Insulin is a hormone that lets sugar into cells to fuel muscles and other tissues. With this disease, cells also respond poorly to insulin and take in less sugar). Review of the resident's July 2024 Physician's Order Sheet (POS) showed: -Lantus (a medication used for DM) 20 units at bedtime. The order did not include a diagnosis or indication for use. -Amlodipine (used to treat high blood pressure and chest pain) 10 milligram (mg) 1 tablet daily. The order did not include a diagnosis or indication for use. -Aspirin (a synthetic compound used medicinally to relieve mild or chronic pain and to reduce fever and inflammation) 81 mg take daily, and the order did not include a diagnosis or indication for use. -Plavix (used to prevent stroke, heart attack, and other heart problems) 75 mg daily. The order did not include a diagnosis or indication for use. -Vitamin B12 (is a water-soluble vitamin involved in metabolism) 500 mg daily. The order did not include a diagnosis or indication for use. -Polyethylene Glycol (used to promote bowel movements) 1 packet mixed with water daily. The order did not include a diagnosis or indication for use. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Vesicare (used to treat symptoms of an overactive bladder) 10 mg daily. The order did not include a diagnosis or indication for use. -Flomax (used to treat an enlarged prostate (benign prostatic hyperplasia)) 0.4 mg daily. The order did not include a diagnosis or indication for use. -Torsemide (diuretic (causing increased passing of urine)medication used to treat fluid overload due to heart failure, kidney disease, and liver disease) 20 mg daily. The order did not include a diagnosis or indication for use. - Myrbetriq (used to treat overactive bladder) 25 mg daily. The order did not include a diagnosis or indication for use. -Protonix (used to treat heartburn) 40 mg twice a day. The order did not include a diagnosis or indication for use. -Lyrica (used to treat nerve pain) 150 mg daily. The order did not include a diagnosis or indication for use. 3. During an interview on 7/16/24 at 9:37 A.M., Certified Medication Technician (CMT) A said: -All medication orders should have a diagnosis or indication for use. -A pharmacy consultant comes to the the facility every month. He/She thought the pharmacy consultant checked for diagnosis on the POS. -If a medication does not include a diagnosis or indication for use, he/she would clarify the order with the charge nurse. During an interview on 7/16/24 9:51 A.M., Assistant Director Of Nursing (ADON) said: -He/She just started as ADON last week. -He/She was the charge nurse that day for the hall. -All medications should have a diagnosis or indication for use. -If a medication does not have a diagnosis or indication for use, the order should be clarified with the resident's physician. -The nurse checking the POS during monthly change-over should have noticed the medications did not have a diagnosis or indication for use. -He/She thought when the pharmacy consultant checked the residents' charts each month, medication diagnosis was one of the components being checked. During an interview on 7/16/24 at 12:40 P.M., Director of Nursing (DON) said: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had just started at the facility the past week. -He/She expected staff to clarify medication orders that did not include a diagnosis or indication for use. -He/She would have expected either the facility nurse completing the change-over chart checks or the facility pharmacy consultant to identify and clarify medication orders without a diagnosis or indication for use. -All medication should have included a diagnosis or indication for use.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on interview and record review, the facility failed to ensure the resident's physician reviewed the pharmacist's recommendations for a Gradual Dose Reduction (GDR) of the resident's psychotropic medications (drugs which affect psychic function, behavior, or experience) on the Drug Regimen Review (DRR) for one sampled resident (Resident #7) and failed to failed to follow through on the pharmacy consultant identified irregularities in the resident'psychotropic medication orders without an appropriate diagnosis or indication for use during the pharmacists monthly DRR for one sampled resident (Resident #26) out of 12 sampled residents. The facility census was 44 residents. Review of the facility's Medication Regimen Review (MRR) policy dated 5/2019 showed: -The attending physician would document in the medical record that the irregularity (the use of medication that is inconsistent with accepted pharmaceutical services standards of practice) had been reviewed and what (if any) action was taken to address it. 1. Review of Resident #7's annual Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 12/14/23 showed the resident: -Was severely cognitively impaired. -Was taking an antipsychotic medication (a group of psychoactive drugs (pertaining to a drug or other agent that affects such normal mental functioning as mood, behavior, or thinking processes) commonly but not exclusively used to treat psychosis) -Was taking an antianxiety medication. -Was taking an antidepressant medication. -GDR has not been attempted. Review of the resident's Physician's Order Sheet (POS) dated 3/24 showed the following physician's orders: -Seroquel (antipsychotic) 150 milligrams (mg) 1 tablet by mouth daily for psychosis (a mental state involving loss of contact with reality and causing deterioration of normal social functioning)/bipolar (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs) ordered 3/30/23. -Seroquel 50 mg 1 tablet by mouth daily for psychosis/bipolar ordered 3/30/23. -Lorazepam (antianxiety) Intensol 2mg/milliliters (ml) 0.5 ml sublingual twice a day for anxiety ordered 9/12/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Depakote (anti-convulsant and mood stabilizer) 125 mg 2 tablets by mouth three times a day for bipolar/mood ordered 3/11/23. -Seroquel 300 mg 2 tablets by mouth at bedtime for psychosis/bipolar ordered 3/30/23. -Remeron (antidepressant) 45 mg 1 tablet by mouth at bedtime for appetite ordered on 9/13/23. Review of the resident's Care Plan dated 3/11/24 showed: -The resident was at high risk for side effects from psychotropic medications. - A GDR as indicated. Review of the resident's Consulting Services from Pharmacist dated 3/19/24 showed a GDR for Mirtazapine. Review of the resident's Visit Note by the physician dated 4/03/24 showed: -Medications reviewed and continued. -No documentation the pharmacy recommendation was reviewed and/or addressed. Review of the resident's Consulting Services from Pharmacist dated 4/29/24 showed a GDR due written for above recommendation 3/19/24. Review of the resident's Visit Note by the Nurse Practitioner dated 5/01/24 showed: -Medications reviewed and continued. -No documentation the pharmacy recommendations were reviewed and/or addressed. Review of the resident's Consulting Services from Pharmacist dated 5/27/24 showed a GDR for Seroquel, Ativan, and DVPK (Depakote). Review of the resident's Visit Note by the Nurse Practitioner dated 6/05/24 showed no documentation the pharmacy recommendations were reviewed and/or addressed. Review of the resident's Consulting Services from Pharmacist dated 6/19/24 showed: -Written for above recommendation dated 5/27/24. Please add what the pharmacist was requesting and why? Needs more record review. Was this signed by the physician or anything documented by the physician on the form? Review of the resident's POS dated 7/24 showed the following physician's orders: -Seroquel 150 mg 1 tablet by mouth daily for psychosis/bipolar ordered 3/30/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Seroquel 50 mg 1 tablet by mouth daily for psychosis/bipolar ordered 3/30/23. -Lorazepam Intensol 2mg/ml 0.5 ml sublingual twice a day for anxiety ordered 9/12/23. -Depakote 125 mg 2 tablets by mouth three times a day for bipolar/mood ordered 3/11/23. -Seroquel 300 mg 2 tablets by mouth at bedtime for psychosis/bipolar ordered 3/30/23. -Remeron 45 mg 1 tablet by mouth at bedtime for appetite ordered on 9/13/23. During an interview on 7/16/24 at 8:42 A.M. the Assistant Director of Nursing (ADON) said: -He/She was working as a charge nurse on the floor. -He/She did not know who was responsible for taking care of pharmacy recommendations and/or reviews. During an interview on 7/16/24 at 12:04 P.M. the Director of Nursing (DON) and the Regional Nurse said: -He/She would expect that a pharmacy recommendation would be taken care of within two weeks. -MRR's come to facility electronically to Director of Nursing (DON) and administrator. -This is a separate sheet from the Consulting Services from Pharmacist document that is in the resident's paper medical record. -MRR's sent to physician to review and sign. -The facility could not locate any physician responses to the pharmacy recommendations for Resident #7. 43345 2. Review of Resident #26's Face Sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of major depressive disorder (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts). Review of the resident's MRR dated 4/29/24 showed the pharmacy consultant identified medication orders without a diagnosis or indication for use. Review of the resident's quarterly MDS dated [DATE] showed the resident: -Was cognitively intact; -The resident took: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-- Antidepressants (Antidepressants are a class of medications used to treat major depressive disorder, anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus) disorders, and addiction). Review of the resident's care plan dated 5/19/24 showed the resident was at risk for side effects from antidepressant medication use for depression. Review of the resident's July 2024 POS and showed a physican order for Zoloft (a medication used to treat depression) 50 milligrams (mg) take at bedtime. The order did not include a diagnosis or indication for use. During an interview on 7/16/24 at 9:37 A.M., Certified Medication Technician (CMT) A said: -All medication orders should have a diagnosis or indication for use. -A pharmacy consultant comes to the the facility every month. He/She thought the pharmacy consultant checked for diagnosis on the POS. -If a medication does not include a diagnosis or indication for use, he/she would clarify the order with the charge nurse. During an interview on 7/16/24 9:51 A.M., ADON said: -He/She just started as ADON last week. -He/She was the charge nurse that day for the hall. -All medications should have a diagnosis or indication for use. -If a medication does not have a diagnosis or indication for use, the order should be clarified with the resident's physician. -The nurse checking the POS during monthly change-over should have noticed the medications did not have a diagnosis or indication for use. -He/She thought when the pharmacy consultant checked the residents' charts each month, medication diagnosis was one of the components being checked. During an interview on 7/16/24 at 12:40 P.M., DON said: -He/She had just started at the facility the past week. -He/She expected staff to clarify medication orders that did not include a diagnosis or indication for use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She would have expected either the facility nurse completing the change-over chart checks or the facility pharmacy consultant to identify and clarify medication orders without a diagnosis or indication for use. -All medication should have included a diagnosis or indication for use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46890 Based on observation, interview and record review, the facility failed to ensure medication were stored, labeled and dated correctly in medication room and two sampled medication carts out of three medication carts. The facility census was 44 residents. Review of the facility Medication and Storage Policy revised 2/2023 showed: -The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. -The nursing staff is responsible for maintaining medication storage and preparation areas in clean, safe, and sanitary method. -Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. -Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments. 1. Observation on 7/10/24 at 9:30 A.M., showed: -North medication cart was unlocked and unattended. -Three staff members walked by the cart. Observation on 7/12/24 at 7:15 A.M. thru 7:45 A.M., showed: -North treatment cart had been left unlocked and unattended. -Three undated cups of unknown medication had been left unattended in the top drawer of the cart. -Seven staff members had walked by the cart without locking. Observation on 7/12/24 at 12.13 P.M., of the North Medication Room showed: -The refrigerator controlled substances (Scheduled II-V) lock box was unlocked. -One opened vial of tuberculin PPD (an injection test to check if the person has tuberculosis) with no open date on the vial. -Six bottles of over the counter calcium tablets expired 6/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 7/16/24 at 9:06 A.M., Certified Nursing Assistant (CNA) A said the Medication carts should always be locked. During an interview on 7/16/24 at 9:16 A.M., the Assistant Director of Nursing (ADON) said: -Medication carts should be locked when unattended. -The refrigerator lock box should be locked. -There should be no expired medication in the medication room. -There should be no cups of unmarked medication in the treatment cart. -It would be the nursing staff who was responsible to make sure carts art locked. -Medication rooms should be audited weekly for expired medications. During an interview on 7/16/24 at 9:51 A.M., Licensed Practical Nurse (LPN) B said: -Medication carts and refrigerator lock boxes should be locked at all times when not attended. -Nursing staff was responsible to make sure medication was not expired in medication rooms and carts. -The Director of Nursing (DON) and ADON was responsible for auditing medication carts and medication rooms. During an interview on 7/16/24 at 12:02 P.M., the Director of Nursing (DON) said: -He/She was responsible to make sure medication rooms and medication carts are audited monthly. -He/She would expect medication carts are locked when unattended. -He/She would expect controlled substances are double locked when unattended. -He/She would not expect medication cups with unmarked medications be left in the treatment cart unlocked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation, interview, and record review, the facility failed to keep the Dry Storage (DS) room clean; failed to ensure food preparation items/equipment were kept in a sanitary condition; failed to keep trash dumpsters lidded; and failed to maintain plastic cutting boards in good order to avoid food safety hazards (cross-contamination), in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 44 residents with a licensed capacity for 86 residents at the time of the survey. 1. During an interview on 7/9/24 at 9:33 A.M. the Administrator said the facility did not currently have a Dietary Manager (DM). Observation on 7/9/24 between 10:06 A.M. and 10:48 A.M. during the initial kitchen inspection with the facility's Dietician present showed the following: -The reach-in refrigerator at east end of the kitchen had half of the right door's gasket dislodged and hanging off. -There were various food splatters on the 6-burner stove and adjacent flat-top grill. -A meat [NAME] in a wall-mounted knife box next to the pegboard over a food preparation table was heavily streaked with residue on one side. -There was a scoop sitting inside on the bottom of a sugar bin. -Large and small ladles hanging on a pegboard hook had food residue in their bowls. -The green cutting board was excessively scored to the point of plastic bits flaking off. -On a large can dispensing rack in the DS room was a 6 pound (lb.) 10 ounce (oz.) can of creamed corn deeply dented on one side towards its bottom. Observation on 7/9/24 between 11:33 A.M. and 12:14 P.M. during the initial facility Life Safety Code (LSC) outer perimeter inspection with the Director of Maintenance (DOM) showed the westernmost dumpster of two had its west lid pushed in down past the sides of the waste container. Observation on 7/9/24 at 3:21 P.M. during a follow-up kitchen inspection showed a four-slice toaster had its left crumb tray full and the right one missing. Review of the local health department's Food Inspection Report, dated 7/9/24 and provided by the Administrator, showed under Non-Critical Items, it read Clean items found stored in soiled containers. Observation 7/10/24 between 9:10 A.M. and 9:27 A.M. during a follow-up kitchen inspection showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There were various food splatters on the 6-burner stove and adjacent flat-top grill. -A meat [NAME] in a wall-mounted knife box next to the pegboard over a food preparation table was heavily streaked with residue on one side. -There was a scoop sitting inside on the bottom of a sugar bin. -Large and small ladles hanging on a pegboard hook had food residue in their bowls. -The green cutting board was excessively scored to the point of plastic bits flaking off. -On a large can dispensing rack in the DS room was a 6 pound (lb.) 10 ounce (oz.) can of creamed corn deeply dented on one side towards its bottom and there was litter, trash, plastic utensils, and Styrofoam cups on the floor. -The west dumpster had its west lid pushed down below the dumpster 's sides. During an interview on 7/10/24 at 9:14 A.M. the DOM said: -All the employees in the kitchen were new. -The previous dietary staff quit about a week ago. Observation on 7/12/24 at 11:03 A.M. during a follow-up outer perimeter inspection showed the west lid of the west dumpster was pushed down past the sides of the container itself. During an interview on 7/15/24 at 10:27 A.M. the new DM said: -They were hired on 7/12/24. -The day-cook and the dishwasher would be responsible for cleaning the kitchen and DS floors. -Damaged food items would be sent back to the food vendor for a refund. -Damaged food preparation items should be reported and replaced as soon as they were found. -Dumpster lids should close tightly to reduce the presence of pests. -He/She would expect food to be free of foreign substances. -Food preparation items should be cleaned daily. Observation on 7/16/24 at 11:29 A.M. during a follow-up outer perimeter inspection showed the west lid of the west dumpster was pushed down past the sides of the container itself, completely flat against the back of the inside.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46890 Based on observation, interview and record review, the facility failed to complete a Facility Assessment timely to determine resources necessary to meet the needs of the residents, such as assessments of the resident population, staff competencies needed to provide resident care, physical plant requirements, services needed, technology resources and facility and community based risk assessment. A total of 12 residents were sampled. The facility census was 44 residents. Review of the facility policy titled Facility Assessment Tool, dated 8/8/17 showed: -Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and resources the facility needs to care for their residents. 1. Review of the Facility assessment dated [DATE] revised 10/26/22 showed: -Two residents on dialysis (a procedure that removes waste and excess fluid from the blood when kidneys are not working properly). -Four residents physically restrained (the use of manual hold to restrict freedom of movement of all or part of a person's body, or restrict normal access to the person's body). Review of the facility's Resident Census and Condition dated 7/9/24 showed the following resident demographics in the building: -Four resident's with indwelling catheters (a tube with a retaining balloon passed through the urethra into the bladder to drain urine). -Two resident's nutrition from a tube feeding (a medical device used to provide nutrition to patients who cannot obtain nutrition by swallowing). -Six resident's with pressure ulcers (localized injury to the skin and/or underlying tissue over a boney prominence, as a result of pressure, or pressure in combination with shear and/or friction). -34 resident's diagnosed with 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, judgement and impulses) -Ten resident's with infections. -Four resident's with significant weight loss. -35 resident's with falls. During observation and record review on 7/9/24 thru 7/16/24 the facility showed: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Having a specialized memory care unit (a type of long-term care geared toward those living with Alzheimer's Disease or another form of progressive-degenerative dementia). -Resident's with wounds. -Resident's with falls. -Resident's with enteral feedings (a medical device used to provide nutrition to patients who cannot obtain nutrition by swallowing). -Resident's with behaviors. -Residents receiving hospice care (a special kind of care that focuses on quality of life for people who are experiencing an advanced, life limiting illness). -Resident's receiving oxygen. During an Interview 7/16/24 at 9:00 A.M., the Administrator said: -The Facility Assessment should be completed annually and with any changes in facility status. -He/She has not had a chance to update the facility assessment since starting approximately three months ago. -He/She was responsible to ensure The Facility Assessment was up to date and completed.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 09895 Based on interview and record review, the facility failed to employ an Infection Preventionist (IP) on at least a part-time basis. The facility census was 44 residents. Review of the facility Infection Preventionist policy, revised September 2022 showed: -The infection preventionist was employed on site and at least part time. -The infection preventionist was scheduled with enough time to properly assess, develop, implement, monitor and manage the Infection Prevention and Control Program (IPCP). 1. During an interview on 7/16/24 at 10:50 A.M. the Administrator said: -He/she had worked at the facility for one month. -He/she was the IP. -He/she had worked on IP activities about three and one half hours per week. -Prior to him/her working at the facility, the previous Administrator was the IP. During an interview on 07/16/24 12:05 PM facility Corporate Nurse said: -The previous Administrator had been at the facility for about one year and may have been the IP during that time. -Given the requirement that the IP work at least part time on infection control and antibiotic stewardship activities, it was not practicable for the Administrator to be the facility IP. -Going forward the facility would assign IP duties to the Assistant Director of Nursing (ADON).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09895 Based on interview and record review, the facility failed to ensure residents influenza (a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs and can cause mild to severe illness) and/or pneumococcal (a serious wide ranging bacterial infection that can cause severe illness) vaccination status was verified as having been administered or refused and that risks and benefits of vaccination were presented residents or their representatives for four sampled residents (Resident #22, #25, #40, #42) out of 12 sampled residents. The facility census was 44 residents. Review of the facility Influenza Vaccine policy, revised March 2023 showed: -All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza: -The facility shall provide pertinent information about the significant risks and benefits of vaccines to residents (or residents' legal representatives). -Between October 1st and March 31 each year, the influenza vaccine shall be offered to residents, unless the vaccine is medically contraindicated. -Prior to the vaccination, the resident (or the resident's legal representative) will be provided information and education regarding the benefit and potential side effects of the influenza vaccine; provision of such education shall be documented in the resident's medical record. -A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. Review of the facility Pneumococcal Vaccine policy, revised October 2023 showed: -Residents are assessed for eligibility to receive pneumococcal vaccine and when indicated, are offered the vaccine within thirty days of admission to the facility unless medically contraindicated or the resident has completed vaccination. -Assessment of pneumococcal vaccination status is conducted within five working days of the resident's admission. -Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine; provision of such education is documented in the resident's medical record. -Pneumococcal vaccines are administered to residents (unless contraindicated, already given or refused). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident's/representatives have the right to refuse vaccination; if refused appropriate information is documented in the resident's medical record indicating the date of the refusal. -For each resident who receives the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record. 1. Review of Resident #22's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning), dated 5/10/24 showed: -He/she was admitted to the facility on [DATE]. -He/she was severely cognitively impaired. -He/she had not received the influenza vaccine during this year's influenza season. -He/she had not been offered the influenza vaccine. Review of the resident's medical record on 7/16/24 showed no record of the resident being offered or having received the influenza vaccine during the 2023-2024 influenza season. 2. Review of Resident #25's Quarterly MDS dated [DATE] showed: -He/she was admitted to the facility on [DATE]. -He/she was severely cognitively impaired. -His/her pneumococcal vaccination was not up to date. -He/she had not been offered the pneumococcal vaccine. Review of the resident's medical record on 7/16/24 showed no record of the resident being offered or having received pneumococcal vaccine. 3. Review of Resident #40's Quarterly MDS, dated [DATE] showed: -He/she was admitted to the facility on [DATE]. -He/she was severely cognitively impaired. -He/she had not received the influenza vaccine for the current year's influenza season. -He/she had not been offered the influenza vaccine. -His/her pneumococcal vaccine was not up to date. -He/she had not been offered the pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record on 7/16/24 showed no record of the resident being offered or having received pneumococcal vaccine. 4. Review of Resident #42's Quarterly MDS, dated [DATE] showed: -He/she was admitted to the facility on [DATE]. -He/she was moderately cognitively impaired. -His/her pneumococcal vaccine was not up to date. -He/she had not been offered the pneumococcal vaccine. Review of the resident's medical record on 7/16/24 showed no record of the resident being offered or having received pneumococcal vaccine. 5. During an interview on 7/16/24 at 10:40 A.M. Licensed Practical Nurse (LPN) B said: -Each resident should have information showing when they had their influenza and pneumococcal vaccines or information the vaccines were refused. -The information for each resident's vaccination information should be in their medical record under the vaccine tab. During an interview on 7/16/24 the Director of Nursing (DON) said: -Each resident should be offered influenza and pneumococcal vaccines. -The resident or their decision maker should be given information regarding the benefits and risks of the vaccines and be given an opportunity to consent or refuse the vaccines. -The information about when the vaccines were administered or refused should be in the resident's medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09895 Based on interview and record review, the facility failed to ensure four residents (Residents #25, #35, #40, and #42) were offered COVID-19 (an infectious disease caused by the SARS-CoV 2 virus) vaccination, that education was provided regarding the benefits and risks of the COVID-19 vaccine and signed consent, or refusal obtained from the resident or the resident's representative, for four out of 12 sampled residents. The facility census was 44 residents. Review of the facility Coronavirus Disease (COVID-19) Vaccination of Residents policy, revised May 2023 showed: -Each resident is offered the COVID-19 vaccination unless the immunization is medically contraindicated, or the resident is fully vaccinated. -The resident (or resident representative) has the opportunity to accept or refuse a COVID-19 vaccine, and to change his/her decision. -Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. -Residents must sign a consent to vaccinate form prior to receiving the vaccine. 1. Review of Resident #25's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning), dated 5/12/24 showed: -He/she was admitted to the facility on [DATE]. -He/she was severely cognitively impaired. Review of the resident's medical record on 7/16/24 showed: -No record of the resident being offered or having received the COVID-19 vaccine or having declined the vaccine and that the resident was educated regarding the risks and benefits of COVID-19 vaccination. 2. Review of Resident #35's Quarterly MDS, dated [DATE] showed: -He/she was admitted to the facility on [DATE]. -He/she was cognitively intact. Review of the resident's medical record on 7/16/24 showed: (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No record of the resident being offered or having received the COVID-19 vaccine or having declined the vaccine and that the resident was educated regarding the risks and benefits of COVID-19 vaccination. 3. Review of Resident #40's Quarterly MDS, dated [DATE] showed: -He/she was admitted to the facility on [DATE]. -He/she was severely cognitively impaired. Review of the resident's medical record on 7/16/24 showed: -No record of the resident being offered or having received the COVID-19 vaccine or having declined the vaccine and that the resident was educated regarding the risks and benefits of COVID-19 vaccination. 4. Review of Resident #42's Quarterly MDS, dated [DATE] showed: -He/she was admitted to the facility on [DATE]. -He/she was moderately cognitively impaired. Review of the resident's medical record on 7/16/24 showed: -No record of the resident being offered or having received the COVID-19 vaccine or having declined the vaccine and that the resident was educated regarding the risks and benefits of COVID-19 vaccination. 5. During an interview on 7/16/24 at 10:40 A.M. Licensed Practical Nurse (LPN) B said: -Each resident should have information showing when they had their COVID-19 vaccines or information the vaccines were refused. -The information for each resident's COVID-19 vaccination should be in their medical record under the vaccine tab. During an interview on 7/16/24 at 12:02 P.M. the Director of Nursing (DON) said: -Each resident should be offered COVID-19 vaccines. -The resident or their decision maker should be given information regarding the benefits and risks of the vaccines and be given an opportunity to consent or refuse the vaccines. -The information about when the vaccines were administered or refused should be in the resident's medical record.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation, interview, and record review, the facility failed to be adequately equipped with a complete, functioning call light system throughout the facility, specifically with audible notification, to ensure the ability to meet the residents' needs in a timely manner. This deficient practice had the potential to affect all residents who resided in the facility. The facility census was 44 residents with a licensed capacity for 86 residents at the time of the survey. 1. Observation on 7/9/24 at 9:58 A.M. during the facility resident room inspections showed resident room [ROOM NUMBER] had its hallway ceiling call light lit along with the corresponding call light board at the nursing station, with no audible notification heard there or at the room. Observation on 7/9/24 at 1:55 P.M. in resident room [ROOM NUMBER] at bed A, showed the call light button was not within reach for the resident while lying in a horizontal position. Observation on 7/10/24 at 9:32 A.M. during a follow-up resident room inspection showed resident rooms #16 and 24 had their hallway ceiling call lights lit for at least five minutes, with no visual notification on the call light board at the nursing station or audible notification heard. Review on 7/15/24 of the facility's undated Emergency Preparedness plan in a binder obtained from the Administrator and currently being updated, at Section J with the heading Emergency Power Supply/Water Main Break and Utility Outages and Locations, showed there was no policy or procedural plan for an alternate method (for example, bells, whistles, or flashlights) for residents to contact staff to have their needs met in the event of a power outage to the building. Observation on 7/16/24 at 1:03 P.M. during a follow-up resident room inspection showed a resident in room [ROOM NUMBER] had their hallway ceiling call light lit along with the call light board at the nursing station, with no audible notification heard. During an interview on 7/16/24 at 12:08 P.M. the Director of Maintenance (DOM) said that he/she was not aware the call light systems' audible notification was having trouble and they would look into it. During an interview on 7/16/24 at 12:44 P.M. the Administrator said that he/she did not know the call light system's audible function was inoperable and they thought they had heard it at times.