

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024
NAME OF PROVIDER OR SUPPLIER Avalon View Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 West College Street Liberty, MO 64068	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect, when staff failed to cover up a resident (Resident #71) who was walking down the hallway in a white pull-up brief, without pants, and failed to assist a resident into his/her personal clothes when requested by the resident (Resident # 74). The facility also failed to provide a resident with clean bed pads and sheets so he/she could return to bed after an incontinent episode (Resident #49). This affected two of 21 sampled residents. The facility census was 104.</p> <p>The facility did not provide a policy on resident dignity.</p> <p>Review of nursing home Resident's Rights, showed:</p> <p>-Residents had a right to be treated with consideration, respect, dignity, and recognizing each resident's individuality.</p> <p>-Equal access to quality of care;</p> <p>-Quality of life is maintained or improved.</p> <p>1. Review of Resident #71's significant change Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 7/29/24, showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She required substantial/maximal assistance with his/her personal hygiene and lower body dressing;</p> <p>-He/She required supervision or touching assistance with transfers from chair to bed, mobility from sitting to lying;</p> <p>-He/She was dependent on a wheelchair;</p> <p>-He/She did not attempt walking 10 feet due to medical condition or safety concerns;</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included: Arthritis, schizophrenia (a mental illness that affects a person's thoughts, feelings, and behaviors), anxiety disorder (a condition that causes excessive worry and fear that can affect a person's daily life), bipolar disease (a mental illness that causes extreme mood swings, or shifts in energy, activity levels, and concentration), depression (a mental health condition that can cause a persistent low mood or loss of interest in activities), need for assistance with personal care, generalized muscle weakness, difficulty walking, tendency to fall, and bone infection of left ankle and foot.</p> <p>Review of the resident's care plan, revised 8/2/24, showed:</p> <ul style="list-style-type: none"> -Receive adequate and appropriate care; -Resident has a right to privacy and confidentiality; -Resident had an activities of daily living self-care performance deficit. -Resident was able to walk independent 10 feet, 50 feet with 2 turns and 150 feet; -Resident required staff assistance to extent needed to accomplish task. -Resident was an elopement risk/wanderer. <p>Observation on 9/18/24 at 9:59 A.M. showed the resident walking up Maple hall wearing no pants and only a white pull up brief. He/She walked pass the nurses station, passed Registered Nurse (RN) A, and continued down the hallway. He/She was met by a therapy staff member who offered to take the resident to the therapy room. The resident was then walked past the [NAME] nurses station, rooms B20, B19, B9, B10, B18, and into therapy with no pants on. Multiple residents, staff, and family members observed witnessing the resident.</p> <p>2. Review of Resident #49's Quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -He/She had clear speech, and was able to make self-understood and understand others; -He/She felt down, depressed or hopeless half or more days; -He/She had no behavioral symptoms or rejection of care; -He/She had impairment on one side of upper and lower extremities; -He/She was dependent on walker and wheelchair; -He/She required substantial/maximal assistance with bathing -He/She was frequently incontinent; <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included: Stroke (condition causing damage to the brain from an interruption of its blood supply), hemiplegia (condition causing weakness on one side of the body), heart failure, high blood pressure, diabetes (too much sugar in the blood), depression, post traumatic stress disorder (PTSD) (a mental health condition that can develop after a person experiences a traumatic event), unsteadiness on feet, lack of coordination, pain in left shoulder, need for assistance with personal care, osteoarthritis of the right shoulder (a chronic joint disease that causes the cartilage in one or more joints to break down over time).</p> <p>Review of resident's care plan, revised 7/30/24, showed:</p> <ul style="list-style-type: none"> -He/She had an ADL self-care performance deficit due to hemiplegia; -He/She required extensive assistance with one person assist for shower twice weekly and as necessary; -He/She required assistance washing under his/her arm, abdominal folds, and lower body; -He/She had a rash under breast and pannus due to moisture; -Preventive skin care as ordered, keep area under breast and pannus clean and dry. <p>During an interview on 9/16/24 at 6:32 P.M., the resident said:</p> <ul style="list-style-type: none"> -He/She felt staff were degrading at times and treated him/her like he/she was a kid and could not think for him/herself; -He/She had staff tell him/her that he/she needed to go to the bathroom; -Staff wake him/her up at 4:00 A.M. to go to the bathroom; -Staff will wake him/her up to go to the bathroom and then not have clean sheets to put back on his/her bed; -He/She is forced to sit up and not able to go back to sleep; -He/She was a night owl and it is difficult for him/her not to be able to go back to bed after being awakened. <p>During an interview on 9/16/24 at 12:11 P.M., Certified Nurse Aide (CNA) A said:</p> <ul style="list-style-type: none"> -The laundry staff do not restock linens; -He/She had to go to laundry room to locate bed pads and sheets; -It took him/her away from patient care when he/she had to go down and try and locate clean sheets and bed pads. <p>During an interview on 9/17/24 at 5:18 A.M., Licensed Practical Nurse (LPN) A said:</p> <p>(continued on next page)</p>

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on interviews, the facility staff failed to ensure residents had access to their personal funds after business hours and on the weekends. This impacted three of 21 sampled residents (Resident #83, #28, and #5). The facility census was 104.</p> <p>The facility did not provide a policy regarding access to resident funds.</p> <p>1. Review of Resident #83's Significant change minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 7/26/24, showed:</p> <ul style="list-style-type: none"> -He/She had moderately impaired cognition; -He/She had clear speech, was able to make self-understood and understand others; -Diagnoses included depression, cancer of the colon, high blood pressure, and diabetes (too much sugar in the blood). <p>During an interview on 9/16/24 at 12:20 P.M., the resident said:</p> <ul style="list-style-type: none"> -He/She does not always have access to his/her money; -The facility said that they had not gone to the bank, so they did not have money to give him/her. <p>2. Review of Resident #28's Admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -He/She had moderately impaired cognition; -He/She had clear speech, and was able to make self-understood and understand others; -He/She had diagnoses of chronic obstructive pulmonary disease (a condition making it difficult to breath), alcohol dependence, high blood pressure, and dementia (condition causing a decline in mental function such as thinking, remembering, and reasoning, that interferes with daily life). <p>During an interview on 9/16/24 at 7:30 P.M., the resident said:</p> <ul style="list-style-type: none"> -He/She did not have full access to his/her money. <p>3. Review of Resident #5's Quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -He/She had clear speech, and was able to make self-understood and understand others; -He/She had diagnoses of anxiety (feeling of fear, dread, or uneasiness that can be a normal reaction to stress), wound infection, and high blood pressure. <p>(continued on next page)</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/16/24 at 1:14 P.M., Resident #5 said:</p> <ul style="list-style-type: none"> -He/She had asked for money, but had been denied money when the facility stated they had not gone to the bank. <p>During an interview on 9/19/24 at 3:35 P.M., the Business Office Manager (BOM), said:</p> <ul style="list-style-type: none"> -Receptionist A distributes resident funds; -When residents want money they go up to the front desk and make a request with receptionist A; -Residents come and request money daily; -Resident cash turn around request time is one day; -If it is a holiday the facility does not disburse any cash; -He/She did not know if the weekend receptionist had access to cash; -He/She had not had residents ask for cash on weekends; -On Fridays residents usually take out extra money to get them through the weekend; -Receptionist A and B have access to cash box; -Total amount available in facility cash had been increased due to running out of cash on hand to meet resident requests; -He/She could cut checks for petty cash; -Facility administrator has to go and cash all facility petty cash checks and ensure facility had cash in house; -He/She is in the building until 8:30 or 10:00 P.M. and has not had a resident request cash after Receptionist A left the building; -He/She may need to educate residents on the availability of funds after Receptionist A leaves for the day. <p>During an interview on 9/19/24 at 3:47 P.M. Corporate Accounting said:</p> <ul style="list-style-type: none"> -The BOM made a request to have cash in facility increased; -The max on hand in the facility was \$500.00 which did not meet resident request needs; -In July cash on hand was increased to \$1500.00 <p>During an interview on 9/23/24 at 3:33 P.M., Administrator said:</p> <p>(continued on next page)</p>

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Funds were available during banking hours;</p> <p>-He/She was the only facility staff who was authorized to go to the bank to cash checks;</p> <p>-There had been a delay in obtaining cash on hand for residents in the facility when he/she had been off work as there had been no staff designated to go obtain cash to replenish the petty cash on hand in the facility;</p> <p>-Residents were able to get funds on same day of their request;</p> <p>-There had been an instance prior to the increase in the in house funds amount that residents were denied access to personal funds as the facility did not have funds on hand.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>51166</p> <p>Based on observation, interview and record review, the facility failed to ensure the code status matched in all places of the clinical record for one resident (Resident #35) out of 23 sampled residents. The facility census was 104.</p> <p>The facility's Advance Directive policy was not provided.</p> <p>1. Review of Resident #35's Admission Minimum Data Set (MDS) assessment, a federally mandated assessment instrument completed by facility staff, dated 7/17/24 showed:</p> <p>Diagnoses included: mild cognitive impairment; Diabetes; Kidney Failure; High Blood Pressure; Gastroesophageal reflux disease (GERD); and Obstructive uropathy (urinary blockage)</p> <p>Review of resident's physician's orders, dated 7/16/2024, showed:</p> <p>-Full code (Provide life saving measures) status.</p> <p>Review of the resident's Outside the Hospital Do Not Resuscitate Order form (OHDNR) signed on 8/22/24 showed:</p> <p>-Code status as a DNR (Do Not Resuscitate).</p> <p>Review of resident's undated care plan showed:</p> <p>-Resident was a full code status.</p> <p>During an interview on 09/23/24 at 10:16 A.M, certified nurse aide (CNA) A said the resident's code status is in residents' chart and he/she had memorized who is a full code and who is not.</p> <p>During an interview on 09/23/24 at 09:55 A.M., registered nurse (RN) A said Resident #35 was listed as a full code per the medical record. He/she noticed the discrepancy in the resident's chart during the interview and changed the code status to DNR.</p> <p>During an interview on 09/23/24 at 04:20 P.M., the Director of Nursing (DON) and Administrator said:</p> <p>-The protocol for handling an unresponsive resident includes triage, code blue, and determine the code status.</p> <p>-The DON and Administrator expect staff to check the code book and the chart to find a resident's code status.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>46706</p> <p>Based on observation, interview, and record review, the facility failed to ensure confidentiality of records was maintained for two of 21 sampled residents (Resident #80 and #153) when durable power of attorney document (DPOA) paperwork for Resident #80 was given to an unauthorized person by facility staff and when empty medication packaging was observed outside the facility on the ground with Resident #153's personal information on the label. The facility census was 104.</p> <p>Review of the facility's Health Insurance Portability and Accountability Act (HIPAA) Policy dated, 9/1/21, showed in part:</p> <p>-It is the facility's policy to implement reasonable an appropriate measures to protect and maintain the confidentiality, integrity and availability of the resident's identifiable information or records;</p> <p>-Security measures will be implemented to manage risks and vulnerabilities.</p> <p>Review of the facility's Resident Rights Policy revised, 9/1/22 did not address the residents right to privacy and confidentiality.</p> <p>Review of the Missouri Resident [NAME] of Rights, provided through the state long term care ombudsman (a person who represents the interests of residents) program included residents have the right to privacy, to be treated with consideration, respect, and dignity, recognizing each resident's individuality.</p> <p>1. Review of Resident #80's care plan revised, 6/13/24, showed:</p> <p>-The resident has the right to privacy and confidentiality.</p> <p>Review of the resident's medical record showed:</p> <p>-A DPOA document, (a legal document that names a person/agent who may continue to act on your behalf even after you have an incapacitating illness or accident);</p> <p>-The resident's family member A was listed as the agent.</p> <p>Review of the resident's nurse's note dated 5/14/24 showed:</p> <p>-Social services note: Family member A is the only person to have access to health information and other protected information.</p> <p>During an interview on 9/17/24, at 1:22 P.M., family member A said:</p> <p>- An unauthorized family member came to the facility and told the administrator he/she was family member A;</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The administrator gave a copy of the resident's DPOA to the unauthorized family member;</p> <p>-He/she expected the facility to verify the identify of the person asking for the resident's protected personal information;</p> <p>-He/she expects the facility to protect the resident's right to privacy.</p> <p>During an interview on 09/17/24, at 11:10 A.M., the administrator said:</p> <p>-An unauthorized family member came to the facility and said he/she was the resident's DPOA;</p> <p>-He/she gave the unauthorized family member a copy of the DPOA paper work;</p> <p>-He/she realized after a phone call from the DPOA that he/she had given the DPOA paper work to an unauthorized person;</p> <p>-He/she should have asked for photo identification;</p> <p>-He/she expects confidentiality of resident records to be maintained.</p> <p>2. Review of Resident #153's care plan, undated, showed the resident has a right to privacy and confidentiality.</p> <p>Observation outside at back of facility on 9/23/24 at 11:57 P.M., showed a tipped over locked shred box laying on the ground behind the D hall unit. The shred box had visible documents including medication bubble packs with identifying information that belonged to the resident.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said resident information should be protected and he/she did not expect resident information to be visible and exposed at the back of the facility building.</p> <p>MO241172</p> <p>MO241359</p> <p>47195</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</p> <p>Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary, orderly and comfortable interior throughout the facility. Additionally, the facility failed to ensure furnishings were in good repair. The facility census was 104.</p> <p>Review of the facility provided policy Routine Cleaning and Disinfection dated 9/1/21 showed:</p> <ul style="list-style-type: none"> -It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment; -Cleaning refers to the removal of visible soil from objects and surfaces; -Horizontal surfaces with infrequent hand contact (window sills and hard surface flooring) in routine areas should be cleaned on a regular basis; when soiling or spills occur; when a resident is discharged ; -Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. <p>Review of the facility provided, undated, policy Safe and Homelike Environment included, in accordance with resident rights the facility will provide a safe, clean, comfortable and homelike environment.</p> <p>Observation on 09/18/24 at 8:03 A.M. showed the special care unit with a strong odor of urine.</p> <p>Observation on 09/18/24 at 12:33 P.M. showed on the Special Care Unit:</p> <ul style="list-style-type: none"> -Resident room [ROOM NUMBER]A, the baseboards peeled away from the wall, had a strong odor of urine, and the entry door had multiple scuff marks; -Resident wheelchairs with torn arm rests, exposing foam underneath; -Resident wheelchairs with dirt and debris, caked on the metal frames, seats and cushions. <p>During an interview on 9/19/24 at 11:33 A.M., Physical Therapy Assistant A said:</p> <ul style="list-style-type: none"> -He/She tells the Central Supply Manager when a new wheelchair or part is needed; -The facility was aware there were wheelchairs in disrepair. <p>During an interview on 9/19/24 at 11:33 A.M. the Director of Physical Therapy (PT) said:</p> <ul style="list-style-type: none"> -He/She had placed an order for 20 new wheelchairs from central supply recently; <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-PT is in charge of ensuring all wheelchairs are in good repair and working order.</p> <p>During an interview on 9/19/24 at 11:33 A.M. the Central Supply Manager said:</p> <ul style="list-style-type: none"> -He/She had not ordered any wheelchairs since January 2024; -Therapy will let him/her know if wheelchairs or parts are needed; -If a wheelchair is torn and foam is showing a new one needs ordered; -He/She has not had any recent orders for new wheelchairs. <p>During an interview on 9/19/24 at 11:33 A.M. the Corporate Nurse said:</p> <ul style="list-style-type: none"> -The facility was aware wheelchairs needed to be replaced; -No one in the facility ensured a system was in place for replacing wheelchairs; -There was a system breakdown in this area. <p>Observations beginning on 09/16/24 at 12:58 P.M. on [NAME] Hall showed:</p> <ul style="list-style-type: none"> -Multiple room doors with scratches and nicks in the kick plate. <p>Observation on 9/23/24 at 11:26 A.M. showed:</p> <ul style="list-style-type: none"> - Room A20 privacy curtain had multiple stains and small tears. The second curtain was missing multiple hooks; -Room A22 privacy curtain had a hole in the mesh at the top of the curtain; -Room A23 privacy curtain had stains and small tears over the curtain; -Room A18 privacy curtain had holes in the mesh at the top of the curtain. <p>Observation on 9/16/24 at 9:36 A.M., showed dirty dishes sitting in the common area between the [NAME] and Maple halls. No residents present.</p> <p>Observation on 9/16/24 at 10:13 A.M., showed room A-1 on Maple hall had caked on dirt and food with sticky spots on the floor. Chew spit was also observed on floor of resident's room.</p> <p>Observation on 9/16/24 at 6:55 P.M., showed dead bugs in base of holder of hand sanitizer dispensers on Maple hall.</p> <p>Observation on 9/17/24 at 6:59 A.M., showed a strong odor of urine in hallway by the nurses station on Maple hall.</p> <p>During an interview on 09/23/24 at 7:33 A.M., Housekeeper A said:</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She completed daily cleaning of the resident bathrooms and mops the floor;</p> <p>-One person cannot complete everything that needed to be completed;</p> <p>-There is a floor technician in the evening to buff floors;</p> <p>-There was no check off list for completed tasks.</p> <p>During an interview on 09/23/24 at 8:17 A.M., the Housekeeping Supervisor said:</p> <p>-The Administrator expects the facility to be clean and odor free;</p> <p>-Cleaning is completed daily by a list;</p> <p>-He/She expects the facility to be clean, odor free and floors and ceilings to be free of dirt and debris.</p> <p>During an interview on 9/23/24 at 9:11 A.M., the Maintenance Director said:</p> <p>-He had been employed in the facility four months;</p> <p>-Morning meetings are where he finds out repairs that are needed, or staff can fill out a work order;</p> <p>-He completed weekly walk through inspections with Administration;</p> <p>-He expects things to be in good repair;</p> <p>-The baseboards are paint stained. Housekeeping is responsible for cleaning baseboards;</p> <p>-Repairs are prioritized by need;</p> <p>-Housekeeping is responsible for all floors, dusting and baseboard cleaning;</p> <p>-He used a log book to know what needs fixed. If it was not on the log then it would not be fixed;</p> <p>-Log books were at each nurses station and any staff can write in them.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said:</p> <p>-Housekeeping was to complete daily cleaning to include dusting and high dusting;</p> <p>-She expected the facility to attempt to be odor free as much as possible;</p> <p>-Vents, floors and ceilings should be cleaned by housekeeping and maintenance as a collaborative effort;</p> <p>-Anyone can put a work order in if something is broken;</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Each Department Head completes weekly rounds and would make a note of any issues that need addressed by a different department;</p> <p>-She would expect work orders to be completed if the department head found a concern for maintenance;</p> <p>-They have made progress in the cleanliness of the building but had more to go.</p> <p>MO#241807</p> <p>46706</p> <p>47195</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</p> <p>Based on observation, interview, and record review, the facility failed to ensure a comprehensive care plan was developed and implemented for two sampled residents (Resident #153 and #52) out of 21 sampled residents. The facility census was 104.</p> <p>Review of the facility provided policy Comprehensive Care Plans, dated 9/1/21 showed:</p> <p>-It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident; to meet the resident's medical, nursing, and mental and psychological needs identified in the resident's assessment.</p> <p>-The comprehensive care plan will describe, at a minimum: services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial wellbeing; Any specialized services; and the resident's goals.</p> <p>1. Review of Resident #153 Initial Activity Assessment completed on 11/8/21 showed he/she liked:</p> <ul style="list-style-type: none"> -visits with family/friends; -poker; -gardening/outdoor activity; -movies/tv; -music/talk radio; -pet visits; -smoking. <p>Review of the resident's Face Sheet showed an initial admitted [DATE] and a readmitted [DATE].</p> <p>Review of the resident's Admission Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff) dated 7/12/24 showed:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status of 99; indicated severe cognitive deficit; -Daily preference not completed; -Activity preference not completed; -He/she was dependent on staff for all cares; <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Use of Foley catheter (a sterile tube inserted into the bladder to drain urine);</p> <p>-Nutrition via tube (he/she is fed through a tube surgically implanted in his/her stomach);</p> <p>-Nothing by mouth;</p> <p>-He/she had a tracheostomy (a surgical opening into the neck and windpipe, fitted with a plastic tube, to allow air to fill the lungs);</p> <p>-He/She did not speak;</p> <p>-Diagnoses of Respiratory Failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood), Encephalopathy (brain disease that alters brain function or structure), Need for assistance with personal care, and Chronic Obstructive Pulmonary Disease (COPD:common lung disease causing restricted airflow and breathing problems).</p> <p>Review of the resident's physician order sheets for September 2024 showed:</p> <p>-Complete tube site care, every hour as needed, cleanse with soap and water, apply a dry dressing if indicated. Monitor for signs and symptoms of infection;</p> <p>-Change inner tracheostomy cannula every day and as needed, change the cannula anchor weekly and as needed.</p> <p>Review of Resident #153's Comprehensive Care Plan dated 7/19/24 showed:</p> <p>-The resident has little or no activity involvement;</p> <p>-The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date;</p> <p>-No care plan for activity preferences;</p> <p>-No care plan for use and care of the tracheostomy.</p> <p>2. Review of Resident #52's admission MDS dated [DATE], showed:</p> <p>-His/Her cognitive status was undetermined;</p> <p>-He/She had no speech;</p> <p>-He/She rarely or never understand others;</p> <p>-He/She had adequate vision;</p> <p>-He/She did not wear corrective lenses;</p> <p>-He/She had limited range of motion in upper and lower extremities on both sides;</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She was dependent on a wheelchair for mobility;</p> <p>-He/She was dependent for all cares and mobility;</p> <p>-Diagnoses included anxiety disorder, aphasia (a language disorder that affected a person's ability to understand and express language, as well as read and write), depression, and respiratory failure.</p> <p>Review of resident's face sheet, showed:</p> <p>-He/She was admitted to facility on 7/23/24.</p> <p>Review of the resident's care plan, dated 7/31/24, showed:</p> <p>-Encourage social interactions and participation in activities with others that have similar interests;</p> <p>-Provide emotional and spiritual support for resident and/or family/guardian decisions as needed;</p> <p>-He/She had no activity preferences care planned.</p> <p>3. During an interview on 9/23/24 at 3:33 P.M., Administrator said:</p> <p>-He/She expected one on one activities to be care planned;</p> <p>-He/She expected a tracheostomy to be care planned.</p> <p>47195</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observation, interview, and record review, the facility failed to provide assistance to dependent residents with grooming, and showers at least twice a week for nine of 21 sampled residents (Resident #12, #13, #14 #49, #67, #74, #80, #87, and #91). The facility failed to provide shaving assistance and nail care for one resident (Resident #14). The facility failed to provide incontinent care for two residents (Resident #13 and #80). The facility census was 104</p> <p>Review of facility policy, Activities of Daily Living, dated 9/1/21, showed:</p> <p>-The facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable including ability to bathe, dress, groom, and toilet.</p> <p>-The facility shall provide a maintenance and restorative program to assist the resident in maintaining the highest practicable outcome based on the comprehensive assessment.</p> <p>-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Review of facility policy, resident showers, dated 9/1/21, showed:</p> <p>-It was practice of facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice.</p> <p>-Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.</p> <p>Review of facility policy, Bathing a Resident, dated 9/1/21, showed:</p> <p>-It was practice of facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues.</p> <p>1. Review of Resident #12's, quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 9/6/24, showed:</p> <p>-He/She was cognitively impaired;</p> <p>-He/She had moderate difficulty with hearing, speaker has to increase volume and speak distinctly;</p> <p>-He/She had clear speech and was able to make self understood and understand others;</p> <p>-He/She had no impairment to upper or lower extremities;</p> <p>-He/She was dependent on a walker/wheelchair;</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She required supervised or touching assistance with bathing, sit to stand and chair to bed transfers;</p> <p>-Diagnosis included lack of coordination, difficulty walking, muscle weakness, unsteadiness on feet, depression, bipolar disorder (mental illness that causes extreme mood swings).</p> <p>Review of care plan, revised 9/1/24, showed:</p> <p>-He/She had an ADL self-care performance deficit due to stroke and chronic obstructive pulmonary disease (COPD);</p> <p>-Resident required assistance from one staff with showering twice weekly and as necessary;</p> <p>-Check nail length and trim and clean on bath day and as necessary;</p> <p>Observation on 9/16/24 at 10:06 A.M. showed:</p> <p>-Resident's hair was greasy and had not been brushed;</p> <p>-He/She had long nails with black/brown color underneath his/her nail bed.</p> <p>During an interview on 9/16/24 at 10:06 A.M., the resident said:</p> <p>-He/She did not get showers or baths when he/she wanted them;</p> <p>-He/She had gone 7-8 days without a shower;</p> <p>-He/She wanted a shower twice a week on Mondays and Fridays;</p> <p>-He/She had scheduled shower days but he/she never got showers on his/her scheduled shower days;</p> <p>-He/She was lucky because he/she got one shower on Saturday during the past week.</p> <p>Review of shower schedule, dated 4/30/24, showed Resident #12's room number had shower days on Monday and Thursdays.</p> <p>Review of shower sheets, dated 6/1/24 to 9/17/24 , showed:</p> <p>-He/She received one shower out of five scheduled opportunities in September on 9/17/24, which was nineteen days from his/her last prior shower in August;</p> <p>-He/She received five showers in August on 8/1, 8/7, 8/13, 8/26, and 8/29 out of nine scheduled opportunities;</p> <p>-He/She received four showers in July on 7/2, 7/9, 7/19, and 7/23 out of nine scheduled opportunities;</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She received three showers in June on 6/17, 6/20, and 6/26 out of eight scheduled opportunities.</p> <p>2. Review of Resident #49's quarterly MDS, dated [DATE], showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She had clear speech, and was able to make self-understood and understand others;</p> <p>-He/She felt down, depressed or hopeless half or more days;</p> <p>-He/She had no behavioral symptoms or rejection of care;</p> <p>-He/She had impairment on one side of upper and lower extremities;</p> <p>-He/She was dependent on walker and wheelchair;</p> <p>-He/She required substantial/maximal assistance with bathing</p> <p>-He/She was frequently incontinent;</p> <p>-Diagnoses included stroke (condition causing damage to the brain from an interruption of its blood supply), hemiplegia (condition causing weakness on one side of the body), heart failure, high blood pressure, diabetes (too much sugar in the blood), depression, post traumatic stress disorder (PTSD) (a mental health condition that can develop after a person experiences a traumatic event), unsteadiness on feet, lack of coordination, pain in left shoulder, need for assistance with personal care, osteoarthritis of the right shoulder (a chronic joint disease that causes the cartilage in one or more joints to break down over time).</p> <p>Review of the resident's care plan, revised 7/30/24, showed:</p> <p>-He/She had an ADL self-care performance deficit due to hemiplegia;</p> <p>-He/She required extensive assistance with one person assist for shower twice weekly and as necessary;</p> <p>-He/She required assistance washing under his/her arm, abdominal folds, and lower body;</p> <p>-He/She had a rash under breast and pannus due to moisture;</p> <p>-Preventive skin care as ordered, keep area under breast and pannus clean and dry.</p> <p>During an interview on 9/16/24 at 6:24 P.M., the resident said:</p> <p>-Showers were very infrequent;</p> <p>-The last shower he/she had was less than a week ago and the shower prior to that was about 2 weeks in between showers;</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Not having showers regularly made him/her feel dirty and disgusting;</p> <p>-Prior to his/her stroke he/she was taking two or three showers a day;</p> <p>-He/She would like to receive at minimum of two showers a week;</p> <p>-He/She was scheduled to have showers on Tuesdays and Fridays but he/she rarely received showers as scheduled;</p> <p>Review of shower schedule, dated 4/30/24, showed Resident #49's room number had showers scheduled on Mondays and Thursdays.</p> <p>Review of shower sheets, dated 6/1/24 to 9/17/24 , showed:</p> <p>-He/She received one shower in September on 9/5 out of five scheduled opportunities;</p> <p>-He/She received two showers in August on 8/6 and 8/21 out of nine scheduled opportunities;</p> <p>-He/She received two showers in July on 7/9 and 7/21 out of nine scheduled opportunities;</p> <p>-He/She received two showers in June on 6/15 and 6/25 out of eight scheduled opportunities</p> <p>-He/She received a shower 7 out of 31 opportunities from June to September.</p> <p>3. Review of Resident #87's quarterly MDS, dated [DATE], showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She had clear speech, was able to make self-understood, and understand others;</p> <p>-He/She had impairment on one side of upper extremity, and impairment on both sides of lower extremities;</p> <p>-He/She was dependent on a wheelchair;</p> <p>-He/She was dependent for bathing and tub transfers;</p> <p>-Diagnosis included traumatic spinal cord dysfunction, central cord syndrome as an after effect of disease, condition, or injury at the fifth cervical vertebra level of the cervical spinal cord (type of incomplete spinal cord injury characterized by weakness, loss of sensation below injury site, loss of bladder control, pain such as tingling and burning), paraplegia (paralysis of legs and lower body caused by spinal injury), spinal stenosis in cervical region (a chronic condition that occurs when spinal canal narrows, putting pressure on spinal cord and nerve roots), muscle weakness, and difficulty walking.</p> <p>Review of the resident's care plan, revised 1/31/24, showed:</p> <p>-Resident had an ADL self-care performance deficit.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She was dependent on two staff for transfers from chair to bed, and shower;</p> <p>-He/She required set up, supervision, and physical assistance to maintain personal hygiene.</p> <p>-Revision 7/5/24 showed patient refused shower that morning because he/she said shower aide was a witch and that his/her potions and lotions cause him/her to burn and itch.</p> <p>During an interview on 9/16/24 at 10:40 A.M., the resident said:</p> <p>-He/She received a shower one time every two weeks;</p> <p>-He/She felt like garbage when he/she had to go so long without showers;</p> <p>-He/She had a shower on 9/14, prior to that his/her last shower was two weeks prior;</p> <p>-He/She would like to have a shower every day;</p> <p>-He/She completed his/her own shaving.</p> <p>Review of the shower schedule, dated 4/30/24, showed Resident #87's room number had assigned shower days on Wednesday and Saturdays.</p> <p>Review of shower sheets, dated 6/1/24 to 9/17/24 , showed:</p> <p>-He/She had no documented showers in September out of four opportunities, and he/she had one documented refusal on 9/17/24;</p> <p>-He/She received three showers in August on 8/7, 8/17, and 8/31 out of nine scheduled opportunities, with no documented refusals;</p> <p>-He/She received two showers in July on 7/3 and 7/7 out of nine opportunities with 2 refusals on 7/19 and 7/24.</p> <p>-He/She received three showers in June on 6/5, 6/19, and 6/26 out of nine scheduled opportunities, no documented refusals;</p> <p>-He/She received 8 out of 31 opportunities for showers, and 3 refusals out of 31 scheduled opportunities for showers.</p> <p>During an interview on 9/16/24 at 12:11 P.M., Certified Nurse Aide (CNA) A said:</p> <p>-He/She was a shower aide, but he/she was pulled from completing showers to work the floor all the time;</p> <p>-Residents go without showers for much longer than a week at a time;</p> <p>-He/She has given showers and the white towels will be black.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/16/24 at 7:48 P.M., Certified Medication Technician (CMT) A said:</p> <ul style="list-style-type: none"> -Showers were not getting done; -The hall had only one Certified Nurse Aide scheduled; -Staffing is an issue which has resulted in patient care not getting done. -the shower aide was constantly pulled to floor to work as a CNA, so showers were not getting completed. <p>During an interview on 9/23/24 at 10:05 A.M., Registered Nurse (RN) A said:</p> <ul style="list-style-type: none"> -Showers are a problem throughout the facility, not just on one hall. -Showers are not done due to insufficient staff. <p>During an interview on 9/23/24 at 3:33 P.M., Administrator said:</p> <ul style="list-style-type: none"> -Residents should be offered showers at a minimum of one time a week but facility goal was to offer twice weekly; -He/She expected same for resident's nail care, hair care, and shaving. -There had been time goal had not been met due to staffing in facility. <p>4. Review of Resident #13's care plan revised, 3/27/24, showed:</p> <ul style="list-style-type: none"> -The resident has an ADL self care performance deficit; -The resident is dependent on staff for toileting; -Clean peri-area after each incontinent episode; -The resident has the potential for pressure ulcer development related to incontinence; -The resident requires total assistance of one staff for transfers; -The resident has the right to be treated with dignity. <p>Review of the resident's quarterly MDS dated , 6/20/24, showed:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Dependent on staff for Activities of ADLs; -Incontinent of bowel and bladder; <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses included, dementia, high blood pressure and anxiety.</p> <p>Continuous observation beginning on 09/16/24 at 09:20 A.M., showed:</p> <p>-09:20 A.M., the resident sat at the table in the dining room in his/her wheelchair;</p> <p>-10:13 A.M., the resident sat at the table in the dining room in his/her wheelchair. Facility staff had not offered to toilet the resident;</p> <p>10:59 A.M. the resident sat in his/her wheelchair at the table, with his/her eyes closed;</p> <p>-11:03 A.M., the resident sat in his/her wheelchair at the table. LPN B walked by the resident and did not provide incontinent care for the resident;</p> <p>-11:25 A.M., CNA D walked by the resident who sat in his/her wheelchair at the table CNA D did not offer to provide incontinent care for the resident;</p> <p>-12:26 P.M., lunch was delivered to the memory care unit. The resident sat in his/her wheelchair at the table with his/her eyes closed;</p> <p>-12:42 P.M., Lunch was delivered to the resident at the table, while he/she sat in his/her wheelchair;</p> <p>-12:46 P.M., No staff offered to reposition or toilet the resident;</p> <p>- 01:01 P.M., The resident finished his/her lunch and sat in his/her wheelchair at the table. No staff provided incontinent care for the resident;</p> <p>-01:25 P.M., the resident sat at the table in his/her wheelchair. No staff had toileted the resident.</p> <p>Observation on 09/17/24 at 05:22 A.M., showed:</p> <p>-The resident's room had a strong smell of urine;</p> <p>-CNA D changed the resident's brief;</p> <p>-The resident's brief was saturated with a yellow substance and smelled of urine;</p> <p>-CNA D performed perineal care and applied a new brief.</p> <p>Continuous observation beginning on 09/17/24 at 05:39 A.M., showed:</p> <p>-05:39 A.M., the resident sat at the table in the dining room in his/her wheelchair;</p> <p>-06:15 A.M., the resident sat at the table in the dining room in his/her wheelchair. No staff offered to toilet the resident;</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-07:30 A.M., the resident sat in his/her wheelchair at the table;</p> <p>-08:30 A.M., the resident sat at the table in the dining room in his/her wheelchair;</p> <p>-09:30 A.M., the resident sat at the table in the dining room in his/her wheelchair. No staff offered to toilet the resident.</p> <p>5. Review of Resident #67's annual MDS dated , 7/17/24, showed:</p> <p>-Moderate cognitive impairment;</p> <p>-Visual impairment;</p> <p>-Substantial assistance from staff for toileting;</p> <p>-Supervision of staff for dressing;</p> <p>-Incontinent of urine;</p> <p>-Diagnoses included, stroke, depression, high blood pressure and cataracts (a clouding of the eye's lens that can lead to vision loss).</p> <p>Review of Resident #67's undated care plan showed:</p> <p>-The resident has an ADL self care performance deficit;</p> <p>-The resident requires supervision for dressing;</p> <p>-The resident requires supervision with personal hygiene;</p> <p>-The resident requires assistance with toileting;</p> <p>-The resident has the right to be treated with dignity.</p> <p>Observation on 09/16/24 at 09:50 A.M., showed:</p> <p>-The resident walking into the dining room;</p> <p>-The resident's hair was unkempt and his/her glasses had white specks on the lenses;</p> <p>-The resident's pants and shirt had black stains on them.</p> <p>Observation on 09/16/24 at 12:24 P.M., showed:</p> <p>-The resident sat in the dining room at a table;</p> <p>- The resident's glasses had white specks on the lenses;</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-11:25 A.M., CNA D walked by the resident setting in his/her wheel chair at the table and did not offer to provide incontinent care for the resident;</p> <p>-12:26 P.M., lunch was delivered to the memory care unit and the resident still sat in his/her wheel chair at the table with his/her eyes closed;</p> <p>-12:42 P.M., lunch was delivered to the resident and he/she sat at the table in his/her wheel chair;</p> <p>-12:46 P.M., no staff had repositioned or toileted the resident;</p> <p>- 01:01 P.M., the resident finished his/her lunch and sat in his/her wheel chair at the table. No staff provided incontinent care for the resident;</p> <p>-01:25 P.M., the resident sat at the table in his/her wheel chair with his/her eyes closed. No staff toileted the resident.</p> <p>Continuous observation beginning on 09/17/24 at 05:39 A.M., showed:</p> <p>-05:39 A.M., the resident sat at the table in the dining room in his/her wheel chair;</p> <p>-06:15 A.M., the resident sat at the table in the dining room in his/her wheel chair. No staff offered to toilet the resident;</p> <p>-07:30 A.M., the resident sat in his/her wheel chair at the table. The DON delivered breakfast to him/her and did not offer to reposition or toilet the resident;</p> <p>-08:30 A.M., the resident sat at the table in the dining room in his/her wheel chair;</p> <p>-09:30 A.M., LPN B said good morning to the resident, but did not offer to toilet the resident.</p> <p>During an interview on 9/18/24 at 1:14 P.M., CNA D said:</p> <p>-He/she tries to toilet incontinent residents at least every two hours;</p> <p>-It gets busy sometimes and he/she does not have time;</p> <p>-Incontinent residents should be toileted at least every two hours.</p> <p>During an interview on 9/18/24 at 1:28 P.M., LPN B said:</p> <p>-The CNAs usually toilet the residents;</p> <p>-He/she expects the residents to have incontinence care every two hours or as needed;</p> <p>-He/she was not aware the incontinent residents had not been toileted for over two hours;</p> <p>-Incontinent residents should be toileted at least every two hours.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/18/24 at 1:42 P.M., the DON said</p> <ul style="list-style-type: none"> -He/she expects residents to have incontinence care every two hours or as needed; -He/she was not aware the incontinent residents had not been toileted for over two hours; -He/she expects incontinent residents be provided peri care and changed at least every two hours. <p>7. Review of Resident #14's quarterly Minimum Data Set (MDS), dated , 7/22/24, showed:</p> <ul style="list-style-type: none"> -Brief interview for mental status (BIMS) score of 13, indicating the resident was not cognitively impaired; -Partial/moderate assistance for oral care, toileting, showering, lying to sitting on side of bed, transfers to/from bed -Supervision for dressing, personal hygiene, sit to stand, toilet transfer; -Utilizes a walker for mobility; - Occasionally incontinent of urine, always continent of bowel; - Diagnoses included Parkinson's Disease (brain disorder affecting body movements), hypertension (high blood pressure), diabetes (chronic disease of the Pancreas). <p>Review of the resident's care plan, dated 3/28/24, showed:</p> <ul style="list-style-type: none"> - The resident has an ADL self-care performance deficit. Impaired mobility, cognition impaired, memory impaired, impaired eyesight that may worsen; -Resident needs cues and supervision with all self care. Resident sometimes requires more physical assistance when feeling weaker than normal or is having tremors. -Personal Hygiene: The resident requires supervision and periodic assist with set up by (1) staff with personal hygiene and oral care. Resident needs staff to comb hair and to shave. <p>Observation on 9/17/24 at 11:42 A.M., showed, Resident #14 had long hair, their nails were long, his beard growth was uneven and about one half inch long.</p> <p>During an interview on 9/17/24 at 11:42 A.M., Resident #14 stated his last shower was two weeks ago. He prefers a shower every day but getting one every other week right now. The resident said he would like his beard shaved but he/she has no utensils to do it and needs staff to do this for them. He can't remember his last shave but it's been a while. He also would like his nails cut and they hurt sometimes because they are so long,. Staff told him/her they did not have the tools to cut his/her nails.</p> <p>Observation on 9/18/24 at 11:40 A.M., showed Resident #14 still long nails and no hair cut and beard was not shaved.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 9/23/24 at 3:30 P.M., Administrator and Director of Nursing (DON) stated:</p> <ul style="list-style-type: none"> -Expectations for resident grooming is that they receive a shave, fingernails cut, clean appearance and odor free clothes; -Residents are offered and receive showers twice a week. The goal is to bathe residents twice a week, and provide some nail and hair care as well. There have been times when they have not met that goal, but they try their best on the floor. <p>8. Review of Resident #74's admission MDS assessment, completed by facility staff, dated 9/10/24, showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -Always incontinent of both bowel and bladder; -Diagnoses included brain disease; shortness of breath; urinary tract infection; kidney disease; asthma; heart disease; depression; osteoarthritis; malnutrition. <p>Review of the undated care plan, showed:</p> <ul style="list-style-type: none"> -Resident's autonomy and dignity will be honored in the personal choices they make; -Resident had an ADL (activities of daily living self-care) performance deficit; -Resident was at risk for falls. <p>Review of progress notes dated 9/14 showed:</p> <ul style="list-style-type: none"> -Resident continued ABT (antibiotic therapy) for UTI (urinary tract infection) with no adverse drug reaction (ADR) noted. Fluids encouraged while awake. <p>Review of progress notes dated 9/15 showed:</p> <ul style="list-style-type: none"> -Resident remained on ABT/UTI without any adverse reaction. <p>Review of Progress notes dated 9/16 showed:</p> <ul style="list-style-type: none"> -Resident continued ABT/UTI with no adverse reaction. Resident was incontinent with some control. Assist of one with toileting and cares. Fluids encouraged while awake. <p>Review of progress notes, dated 9/17, showed:</p> <ul style="list-style-type: none"> -Continued Cipro (antibiotic) for UTI; encouraged to increase water intake. <p>Observation and interview on 09/16/24 09:59 A.M. showed:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident sat on the bed in a hospital gown. The resident stated he/she had been waiting since 8:30 A.M. and expressed frustration that he/she was not dressed yet.</p> <p>-Resident stated he/she often doesn't get help to the bathroom in time and sometimes soils himself/herself while waiting for assistance.</p> <p>During an interview on 09/17/24 at 11:19 A.M., the resident's daughter said:</p> <p>-She is concerned the resident has not had a bath since he/she was admitted (admitted : 9/08/24) and said the resident has started scratching at his/her head due to his/her hair and scalp being dirty.</p> <p>Observation and interview on 09/23/24 at 09:13 A.M. showed the resident unshaven and stating he/she asked several days ago for assistance. He/she said there is not enough staff at the facility to help the resident shave.</p> <p>During an interview on 09/18/24 at 03:35 P.M., Nurse B said the resident shaving/shower schedule depends on resident preference vs. resident schedule and there are residents that are scheduled for twice a week.</p> <p>During an interview on 09/19/24 at 07:08 A.M. CNA B said he/she checks on the resident every couple of hours to see if he/she needs to use the bathroom and the resident uses a urinal.</p> <p>9. Review of Resident #91's annual minimum data set assessment (MDS), completed by facility staff, dated 7/10/24, showed:</p> <p>-Resident is cognitively intact;</p> <p>-Diagnoses include anemia, heart failure, hip fracture, high blood pressure, kidney failure, urinary blockage, arthritis, lung disease, blood clot in lung.</p> <p>-Resident requires substantial assistance to maintain personal hygiene.</p> <p>-Resident is completely dependent on assistance with toileting and bathing.</p> <p>Review of resident's care plan, dated 4/19/24 showed:</p> <p>-Check resident every two hours and assist with toileting as needed.</p> <p>-Clean peri-area with each incontinence episode.</p> <p>During an interview on 09/16/24 at 10:39 A.M., the resident said:</p> <p>-He/she often waits an hour for call light to be answered to be changed.</p> <p>-He/she prefers to get up by 8:00 A.M. but frequently does not get assistance to get up until 11:00 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</p> <p>Based on observation, interview, and record review, the facility failed to provide an ongoing activities program to support the needs of three of 21 sampled residents (Resident #153, #93, and #52). The facility census was 104.</p> <p>Review of the facility provided policy, Activities, dated 9/1/21 showed:</p> <p>-It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental and psychological well being of each resident.</p> <p>-Activities refer to any endeavor, other than routine ADLs(Activities of Daily Living: tasks completed in a day to care for oneself, such as using the toilet, bathing, nail care, brushing hair and teeth.)in which the resident participates that is intended to enhance his/her sense of well being and to promote or enhance physical, cognitive and emotional health.</p> <p>-Activities will be designed with the intent to:</p> <ul style="list-style-type: none"> -Enhance the resident's sense of well-being, belonging and usefulness; -Promote or enhance physical activity; -Promote or enhance cognition; -Promote or enhance emotional health; -Promote self esteem, dignity, pleasure, comfort, education, creativity, success and independence; -Reflect the resident's interests and age; -Reflect cultural and religious interests; -Reflect choices of the residents. <p>-Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs.</p> <p>1. Review of Resident #153's Initial Activity Assessment completed on 11/8/21, showed he/she liked:</p> <ul style="list-style-type: none"> -visits with family/friends; -poker; <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-gardening/outdoor activity;</p> <p>-movies/tv;</p> <p>-music/talk radio;</p> <p>-pet visits;</p> <p>-smoking.</p> <p>Review of the resident's face sheet showed an initial admitted [DATE] and a readmitted [DATE].</p> <p>Review of the resident's Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 7/12/24 showed:</p> <p>- Brief Interview of Mental Status of 99; indicated severe cognitive deficit;</p> <p>-Daily preference not completed;</p> <p>-Activity preference not completed;</p> <p>-He/she was dependent on staff for all activities of daily living (ADLs: tasks completed in a day to care for oneself);</p> <p>-Use of foley catheter (a sterile tube inserted into the bladder to drain urine);</p> <p>-Nutrition via tube (Gastrostomy: a tube surgically implanted in his/her stomach to provide liquid nutrition);</p> <p>-Nothing by mouth;</p> <p>-He/she had a tracheostomy (a surgical opening into the neck and windpipe, fitted with a plastic tube, to allow air to fill the lungs);</p> <p>-He/She did not speak;</p> <p>-Diagnoses of Respiratory Failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood), Encephalopathy (brain disease that alters brain function or structure), Need for assistance with personal care, Chronic Obstructive Pulmonary Disease (COPD:common lung disease causing restricted airflow and breathing problems).</p> <p>Review of Resident #153 Comprehensive Care Plan dated 7/19/24 showed:</p> <p>-The resident has little or no activity involvement;</p> <p>-He/she prefers television drama and sports;</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date.</p> <p>-No care plan for activity preferences.</p> <p>Review of the resident's record of activities for July 2024 showed:</p> <p>-5th: the resident met with his/her brother, marked as a 1:1 visit;</p> <p>-8th: music therapy and staff combed his/her hair;</p> <p>-10th: staff provided nail care;</p> <p>-12th: church on television;</p> <p>-15th: music therapy;</p> <p>-17th: staff provided nail care;</p> <p>-20th: church music played;</p> <p>-22nd: rock music played;</p> <p>-24th: staff provided nail care;</p> <p>-26th: church on television;</p> <p>-28th: music played ;</p> <p>-30th: staff provided nail care.</p> <p>Review of the resident's record of activities for August 2024 showed:</p> <p>-5th: staff talked to him/her a bit;</p> <p>-8th: staff talked to him/her while the foot doctor worked on his/her feet;</p> <p>-10th: television was playing a show;</p> <p>-12th: staff went to talk to him/her;</p> <p>-14th: some peers visited him/her;</p> <p>-16th: music was on, and staff said good morning;</p> <p>-18th: television was playing the weather;</p> <p>-21st: staff saw him/her and checked his/her nails;</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-24th: staff turned television to music;</p> <p>-28th: staff put on rock and roll music;</p> <p>-30th: television playing.</p> <p>Review of the resident's record of activities for September 2024 showed:</p> <p>-1st: staff turned on music and gave him/her a hand massage;</p> <p>-3rd: staff combed his/her hair and talked about leaves falling;</p> <p>-5th:sleeping;</p> <p>-7th:sleeping;</p> <p>-8th to the 13th he/she was hospitalized .</p> <p>Observations showed:</p> <p>-On 9/17/24 at 5:15 A.M., the resident was in bed; his/her television on without sound;</p> <p>-On 09/17/24 at 9:08 A.M., he/she was in bed; his/her television on without sound;</p> <p>-On 09/18/24 at 10:26 A.M., he/she was in his/her room, in bed, television on menu of available channels and without sound;</p> <p>-On 09/18/24 at 2:24 P.M., he/she was in his/her room, in bed, television on menu of available channels and without sound. Live music program was in the dining room.</p> <p>2. Review of Resident #93 Quarterly MDS dated [DATE] showed:</p> <p>-BIMS of 99; indicated significant cognitive impairment;</p> <p>-He/She was dependent on staff for all ADLs;</p> <p>-Use of foley catheter;</p> <p>-Nutrition via tube (Gastrostomy: a tube surgically implanted in his/her stomach to provide liquid nutrition);</p> <p>-Nothing by mouth;</p> <p>-He/she had a tracheostomy (a surgical opening into the neck and windpipe, fitted with a plastic tube, to allow air to fill the lungs);</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses of Nontraumatic Intracerebral Hemorrhage in the Brain Stem (a condition where blood pools in the brain stem after a stroke), Hemiplegia (muscle weakness or loss of movement on one side of the body), Tracheostomy , Gastrostomy, Cerebral Infarction (also known as a stroke: where blood flow to part of the brain is stopped, causing damage to the brain).</p> <p>Review of the resident's Comprehensive Care Plan dated 7/22/24 showed:</p> <p>-No care plan for activities.</p> <p>Review of Resident #93's One to One Activity Record for July 2024 showed:</p> <p>-3rd: staff talked about his/her new room;</p> <p>-4th: staff went to read to him/her, the resident was asleep, popped in later and said hello;</p> <p>-8th: he/she was asleep;</p> <p>-11th: staff talked with him/her, he/she used his/her eyes to communicate;</p> <p>-15th: staff read the chronicle to him/her;</p> <p>-18th: he/she was asleep;</p> <p>-20th: he/she was asleep;</p> <p>-22nd: he/she was asleep;</p> <p>-25th: he/she was watching TV and enjoyed it;</p> <p>-29th: he/she was asleep.</p> <p>Review of Resident #93's One to One Activity Record for August 2024 showed</p> <p>-2nd: staff talked to him/her about getting new books;</p> <p>-5th: staff asked him/her if he/she wanted a book read, he/she shook his/her head no;</p> <p>-6th: he/she was asleep;</p> <p>-8th: 8th: staff talked to him/her while the foot doctor worked on his/her feet;</p> <p>-12th: he/she did not want to be read to;</p> <p>-14th: he/she was asleep;</p> <p>-16th: staff combed his/her hair, listened to music;</p> <p>-18th: staff talked to him/her;</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-21st: listened to music;</p> <p>-24th: staff read a book to him/her;</p> <p>-26th: he/she did not seem to want to wake up;</p> <p>-28th: staff played music for him/her;</p> <p>-30th: staff brushed his/her hair and told a story about staff members child.</p> <p>Review of Resident #93's One to One Activity Record for September 2024 showed:</p> <p>-1st: staff talked about children and start of school;</p> <p>-3rd: staff massaged hands and cut fingernails;</p> <p>-5th: staff brushed his/her hair and sang;</p> <p>-7th: listened to music;</p> <p>-9th: staff read a book;</p> <p>-11th: listened to music;</p> <p>-13th: he/she was sleeping;</p> <p>-15th: staff read a book;</p> <p>-17th staff massaged hands and fingernails.</p> <p>Observation on 09/16/24 at 1:05 P.M. showed:</p> <p>-The resident was in bed, faced toward TV with soap opera on. Hand written sign below the TV showed the resident likes: crime shows, documentaries, and a local football team.</p> <p>Observation on 9/17/24 at 6:32 A.M. showed:</p> <p>-The resident was in bed, turned away from the TV. The TV was on without sound.</p> <p>Observation on 9/18/24 at 9:52 AM showed:</p> <p>-The resident was in bed, turned toward the TV. The TV was on without sound.</p> <p>Observation on 9/18/24 at 4:25 P.M. showed:</p> <p>-The resident was in bed, turned toward the TV. The TV was on without sound.</p> <p>3. Review of Resident #52's admission MDS dated [DATE], showed:</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-His/Her cognitive status was undetermined;</p> <p>-He/She had no speech;</p> <p>-He/She rarely or never understand others;</p> <p>-He/She had adequate vision;</p> <p>-He/She did not wear corrective lenses;</p> <p>-He/She had limited range of motion in upper and lower extremities on both sides;</p> <p>-He/She was dependent on a wheelchair for mobility;</p> <p>-He/She was dependent for all cares and mobility;</p> <p>-Diagnoses included anxiety disorder, aphasia (a language disorder that affected a person's ability to understand and express language, as well as read and write), depression, and respiratory failure.</p> <p>Review of resident's face sheet, showed:</p> <p>-He/She admitted to facility on 7/23/24.</p> <p>Review of the resident's care plan, dated 7/31/24, showed:</p> <p>-Encourage social interactions and participation in activities with others that have similar interests;</p> <p>-Provide emotional and spiritual support for resident and/or family/guardian decisions as needed;</p> <p>-He/She had no activity preferences care planned.</p> <p>Review of activities evaluation, dated 9/19/24, showed:</p> <p>-He/She found strength in faith and religion and was of catholic affiliation;</p> <p>-He/She enjoyed arts and crafts, going to the beauty/barber shop, community outings, education programs, exercise/sports, family/friend visits, parties/social events, pet visits, reading/writing, and religious activities;</p> <p>-He/She loved rabbits;</p> <p>-He/She enjoyed stuffed animal dolls but preferred them to be called dolls;</p> <p>-He/She enjoyed bowling, gardening movies, television, music, talk radio;</p> <p>-He/She enjoyed doing activities in his/her room and preferred one on one activities;</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She preferred to do activities in the afternoon or evening times;</p> <p>-He/She could hear and loved being talked to.</p> <p>Review of facility record of activities showed in July:</p> <p>-On 7/23, he/she talked with his/her family when they visited;</p> <p>-On 7/25, resident had a room visit and staff read a book;</p> <p>-On 7/28, he/she received nails and hand massage.</p> <p>Review of facility record of activities showed in August:</p> <p>-On 8/5, staff went to talk to resident and got no response;</p> <p>-On 8/16, resident listened to country music;</p> <p>-On 8/18, resident was read a book;</p> <p>-On 8/21, resident had his/her nails checked and staff talked with him/her;</p> <p>-On 8/24, staff read a book to resident;</p> <p>-On 8/26, staff talked to resident about his/her dolls;</p> <p>-On 8/28, resident listened to country music;</p> <p>-On 8/30, staff read resident a book.</p> <p>Review of facility record of activities showed in September:</p> <p>-On 9/1, resident listened to music and staff did his/her nails;</p> <p>-On 9/3, resident was read a book and received a hand massage;</p> <p>-On 9/5, music was played for resident;</p> <p>-On 9/7, music was played for resident;</p> <p>-On 9/9, resident was read a book;</p> <p>-On 9/11, resident was sleeping and had music on;</p> <p>-On 9/13, resident was sleeping and had music on and was read a book;</p> <p>-On 9/15, resident had music on;</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 9/17, resident was read a book.</p> <p>Observation on 9/16/24 at 7:30 P.M. showed the resident awake and alert during a visit from family members. Resident was able to give family a thumbs up to acknowledge understanding and excitement. Family engaged with resident by turning on his/her radio, showing pictures on his/her phone, and talking about various family events. Resident had eye contact with family during their visit and seemed in tune to his/her surroundings.</p> <p>Observation on 9/17/24 at 9:46 A.M.-12:01 P.M., resident did not have any activity engagement. Activity staff went into room and told roommate about morning activity, but did not engage with resident.</p> <p>Observation on 9/18/24 from 8:01 A.M.-11:58 A.M. showed no activity engagement with resident. RN A went into resident's room to provide tube feeding at 9:48 A.M. RN A replaced wash cloth, provided oral care, and gave medications. Resident rubbed head with arm.</p> <p>Observation on 9/18/24 at 10:20 A.M. showed an activity calendar hanging on wall was from August- the calendar had not been updated to September. The resident was observed rubbing her head making motion like he/she wanted his/her head rubbed.</p> <p>During an interview on 9/18/24 at 3:14 P.M., the MDS Coordinator said he/she wrote most of care plans but activities staff were supposed to complete their section.</p> <p>During an interview on 9/23/24 at 10:43 A.M., the Activities Director said:</p> <ul style="list-style-type: none"> -Activity staff went into resident's rooms every other day; -Staff will brush his/her hair or do residents nails; -Resident #52's mother said resident #52 liked dolls so he/she sometimes put dolls and stuff on resident's bed; -He/She has read children's book to residents; -He/She has not turned on television for resident but he/she knew resident #52 liked cartoons; -His/Her part time staff typically do the one on ones with residents; -He/She had church services scheduled every Sunday; -Activities should be care planned; -He/She documented activities on activity sheets. <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -Activities calendars should be updated monthly; -He/She expected one on one activities to be care planned; <p>(continued on next page)</p>		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She expected one on one activities to be individualized. MO#241359 47195

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>47195</p> <p>Based on observation, interview and record review, the facility failed to employ a qualified activity professional to oversee the activity program for the facility. The designated employee was employed as the full time activity director for one year, however, had not completed an approved activity professional training program. The facility census was 104.</p> <p>Review of the facility's Activity Director Qualifications, dated 2023, showed:</p> <ul style="list-style-type: none"> -Activity Director, at a minimum, shall meet the following qualifications: -Licensed or registered by the state in which practicing; -One or more of the following: -Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; -Has 2 years of experience in a social or recreational program within the last 5 year, one of which was full-time in a therapeutic activities program; -Is a qualified occupational therapist or occupational therapy assistant; or -Has completed a training course approved by the state; -Qualifications shall be verified prior to hire as Activity Director, and verified annually as part of the employee's performance appraisal process. Documentation of the employee's qualifications shall be maintained in the employee's personnel file; -It is the responsibility of the employee to fulfill requirements for maintaining licensure or registration and providing the facility with documentation of renewals, revocations, surrenders, or suspensions of such licensure or registration. <p>Review of facility Activities Director job description, signed 6/3/24, showed:</p> <ul style="list-style-type: none"> - Accreditation as a certified activity director; completion of a state approved activity director training course; -Bachelor's degree in recreation therapy or related area. Should be licensed or registered either nationally or by the state in which practicing; -One year experience as an Activity Director in long term care; -Two years of experience conducting social/recreational programs within the past five years, one of which was full time in a resident activities program in a health care setting; <p>(continued on next page)</p>		

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Attends and participates in scheduled training, educational classes, and meetings to maintain current certification as applicable. Attends and participates in in-service training as mandated by regulatory agencies and company policy.</p> <p>Review of facility provided invoice, dated 8/12/24, showed:</p> <p>-Missouri Health Care Association billed Activity Director on 8/12/24 for purchase of online activity director workshop and long term care for activity and social services textbook.</p> <p>During an interview on 9/23/24 at 11:10 A.M., the Activity Director said:</p> <p>-He/She had not been trained on working in activities;</p> <p>-He/She worked twenty-five years in housekeeping;</p> <p>-He/She went to a sister facility to train for one day with activity staff member;</p> <p>-He/She had not been enrolled in any training course for activity certification;</p> <p>-He/She had been in position for one year.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said:</p> <p>-Activity Director needed certifications;</p> <p>-Facility had determined to invest in the Activity Director and purchased a course for him/her to participate in during September 2024;</p> <p>-Activity Director was anticipated to complete coursework in October 2024.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47195</p> <p>Based observation, interview, and record review, the facility staff failed to follow physician's orders and apply a resident's cervical collar (neck brace) as ordered daily for one resident (Resident #52) who was dependent upon staff for mobility and assistance with care. This affected one of twenty-one sampled residents. The facility census was 104.</p> <p>Review of facility policy, provision of physician ordered services, dated 2022, included professional standards of quality means that care and services are provided according to accepted standards of clinical practice.</p> <p>1. Review of Resident #52's admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 7/26/24, showed:</p> <ul style="list-style-type: none"> -His/Her cognitive status was not testable; -He/She had no speech; -He/She rarely or never understand others; -He/She had limited range of motion in upper and lower extremities on both sides; -He/She was dependent on a wheelchair for mobility; -He/She was dependent for all cares and mobility; -He/She had applications of ointments/medications for pressure ulcer; -He/She was not on a turning/repositioning program; <p>-Diagnoses included: aphasia (a language disorder that affects a person's ability to understand and express language), muscle weakness, lack of coordination, epilepsy (a chronic brain disorder that causes seizures, which are brief episodes of involuntary movement or altered consciousness), and retts syndrome (a rare genetic disorder that affects the brain and causes a loss of skills and abilities).</p> <p>Review of the resident's physician's orders, dated 9/17/24, showed:</p> <ul style="list-style-type: none"> -An order dated 9/5/24, for occupational therapy to provide a soft cervical collar and right hand palm guard splint. Splinting schedule posted above patient head of bed. Cervical collar to be worn during day and doffed each night with skin checks. Palm guard to be worn at all times except for daily hand hygiene. One time for six weeks. <p>Review of the resident's care plan, revised 9/16/24, directed staff to administer treatments as ordered and monitor for effectiveness.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/16/24 at 7:30 P.M., the resident's representative said:</p> <ul style="list-style-type: none"> -The resident wore a neck brace due to severe contracture; -The neck brace was excessively dirty; -He/She was also to wear hand brace on right hand. <p>Observation of the resident on 9/16/24 at 7:30 P.M. showed:</p> <ul style="list-style-type: none"> -His/her right hand brace was on; -He/she was not wearing a neck brace. The neck brace was laying on bedside table; -The neck brace had discoloration to the white and showed black and brown discoloration appearing dirty. <p>Observation on 9/17/24 at 9:45 A.M., showed the resident laying in bed, he/she did not have on a cervical collar. The Cervical collar was observed on the bedside table.</p> <p>Observation on 9/17/24 at 11:09 A.M., showed resident did not have on cervical collar. The cervical collar was on the bedside table.</p> <p>Observation on 9/17/24 at 11:47 A.M., showed resident's cervical collar had not been applied as ordered. The cervical collar remained on bedside table. The collar was noted to be dirty with discoloration of dirt and brown like substance on white color.</p> <p>Observation on 9/17/24 at 1:25 P.M., showed resident's cervical collar was on bedside table noted with brown discoloration and dirt.</p> <p>Observation on 9/18/24 at 8:00 A.M., showed resident did not have on cervical collar. A sign above resident's bed directed staff to put the cervical collar on the resident in morning and place the palm protector on the residents hand during the day and leave it off at bedtime.</p> <p>Observation on 9/19/24 at 12:18 P.M., showed the resident without a cervical collar.</p> <p>Observation on 9/19/24 at 2:09 P.M., showed Occupational Therapy in resident's room providing therapy.</p> <p>Observation on 9/19/24 at 5:39 P.M., showed resident laying in bed with his/her cervical collar on.</p> <p>During an interview on 9/19/24 at 2:09 P.M., Occupational Therapist said:</p> <ul style="list-style-type: none"> -The resident was supposed to have his/her cervical collar on; -He/She thought the cervical collar had been taken to be washed due to excessive dirt on the collar. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/23/24 at 10:05 A.M., Registered Nurse A said:</p> <ul style="list-style-type: none"> -The resident was supposed to have cervical collar on at all times; -Last week there were a few days when the resident had been without his/her cervical collar and he/she believes that was because it had been taken to be washed. <p>During an interview on 9/23/24 at 3:33 P.M., the Director of Nursing said:</p> <ul style="list-style-type: none"> -He/She expected staff to follow the residents physician's orders unless a resident refused; -A resident who refused cares or should be documented in the residents chart. <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said he/she expected staff to follow the physician's orders.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024
NAME OF PROVIDER OR SUPPLIER Avalon View Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 West College Street Liberty, MO 64068	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46706</p> <p>Based on observation, interview, and record review, the facility failed to ensure the environment for three of 21 sampled residents (Resident #3, #67, and #89) was free from accident hazards when observations of the memory care unit showed residents had access to the unlocked clean utility room that contained three open electrical boxes, two tanks of oxygen, and cleaning supplies, and the unlocked biohazard room that contained sharps, as well as hazardous chemicals, and the unlocked area behind the nurses desk that contained a jug of drug destroyer and a bottle of multipurpose cleaner. The facility census was 104.</p> <p>Review of the facility's Accidents and Supervision Policy, dated, 9/1/2021, showed in part:</p> <ul style="list-style-type: none"> -The resident's environment will remain free of accident hazards as is possible; -Each resident will receive adequate supervision to prevent accidents; -This includes <ul style="list-style-type: none"> - Identifying hazards and risks; - Evaluating and analyzing hazards and risks; - Implementing interventions to reduce hazards and risks; - Monitoring for effectiveness and modifying interventions when necessary. -All staff are to be involved in observation and identifying potential hazards in the resident's environment; -The facility should make reasonable efforts to identify the hazards and risk factors for each resident; -Various sources provide information about hazards and risks in the resident environment; <ul style="list-style-type: none"> - These sources may include: <ul style="list-style-type: none"> - Environmental rounds; - Individual observations. <p>1. Observation of the memory care unit on 9/16/24, at 9:23 A.M., showed:</p> <ul style="list-style-type: none"> - The clean utility room was unlocked; - Three electrical boxes were open on the wall inside the unlocked clean utility room; <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - A tank of oxygen sitting in a trolley; - The gauge on the oxygen tank said the tank had 100% of oxygen in it; - An empty tank of oxygen was sitting in the clean utility room in a trolley; - Five cans of shaving cream were sitting on the sink in an unlocked clean utility room; - A cup of clear liquid was sitting on the counter by the sink in the unlocked clean utility room; - There was an orange stick sitting on the counter by the sink in the unlocked clean utility room; - Trash was overflowing with used gloves and cigarette packages in the unlocked clean utility room; - There was a black substance on the wall behind the trash can in the unlocked clean utility room. <p>Observation on 9/16/24, at 9:43 A.M. showed:</p> <ul style="list-style-type: none"> -The door to the clean utility was still unlocked: -The Social Services Director (SSD) walked into the clean utility and came out with a pillow case; -The SSD did not lock the door of the clean utility when he/she left the clean utility room; -The area behind the nurses desk was unlocked; -The area behind the nurses desk contained a bottle of multi-purpose cleaner, a bottle of perfume setting on the nurses desk and bottle of drug destroyer on the floor next to the shred box behind the nurses desk. <p>During an interview on 9/16/24, at 9:48 A.M., the SSD said:</p> <ul style="list-style-type: none"> -He/she did not know if the clean utility room should be locked or not; -Residents should not have access to areas with unlocked electrical boxes or unsafe areas. <p>2. Review of Resident #3's care plan dated 8/6/24, showed:</p> <ul style="list-style-type: none"> -The resident has an Activities of Daily Living (ADLs) self care performance deficit; -The resident has impaired cognitive function related to dementia; -The resident resists cares. <p>Review of the Resident's PPS 5-Day Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated, 8/12/24, showed:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Physical and verbal behaviors directed towards others;</p> <p>-Takes antipsychotics and antidepressants daily;</p> <p>-Supervision with mobility using a wheelchair;</p> <p>-Diagnoses included, dementia, anxiety, asthma, and stroke.</p> <p>Observation on 9/16/24, at 9:50 A.M. showed:-The resident propelling himself/herself in a wheelchair along the wall next to the unlocked clean utility room:</p> <p>-The resident grabbed the door knob of the clean utility room door on his/her way by; (he/she was not able to turn the door knob);</p> <p>-No staff were present on the hall;</p> <p>-The clean utility door remained unlocked.</p> <p>Observation on 9/16/24, at 9:58 A.M. showed:-The door to the biohazard room unlocked;</p> <p>-The biohazard room contained a bucket with black water and a mop setting in it;</p> <p>-A tall cardboard box with multiple sharps containers full with sharps;</p> <p>-A container of caulking compound open and sitting in the room;</p> <p>-Certified Nurses Aide (CNA) D pushed two dirty linen barrels in to the biohazard room;</p> <p>-CNA D closed the door and did not lock it.</p> <p>Observation on 9/16/24 at 10:00 A.M. showed</p> <p>-The biohazard door unlocked;</p> <p>-The resident propelling himself/herself in a wheelchair by the unlocked biohazard door;</p> <p>-There were no staff near the unlocked biohazard room or the unlocked clean utility room.</p> <p>Observation 9/16/24 at 10:05 A.M. showed:</p> <p>-10:05 A.M., CNA E and Licensed Practical Nurse (LPN) B walked into the unlocked clean utility room;</p> <p>-10:35 A.M., CNA E and LPN B came out of the clean utility room and did not lock the door;</p> <p>-10:42 A.M., CNA E and LPN B walked by the unlocked biohazard door;</p> <p>-10:45 A.M., Neither CNA E or LPN B checked to see if the biohazard door was locked;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-10:55 A.M., CNA D took a trash barrel into the unlocked biohazard room;</p> <p>-11:05 A.M., CNA D came out of the biohazard room and did not lock the door.</p> <p>Observation 9/18/24 at 8:03 A.M. showed:</p> <ul style="list-style-type: none"> - The clean utility room unlocked; - The clean utility room still contained the linen cart; - Three electrical boxes were open on the wall inside the unlocked clean utility room; - Five cans of shaving cream were sitting on the sink in unlocked utility room; - A cup of clear liquid was sitting on the counter by the sink; - There was an orange stick still sitting on the counter by the sink; - Trash was overflowing with used gloves and cigarette packages; - There was a still a black substance on the wall behind the trash can; <p>-The resident propelling himself/herself in a wheelchair up and down the hall along the walls next to the unlocked clean utility room and the unlocked biohazard room;</p> <p>-There were no staff near the unlocked biohazard room or the unlocked clean utility room.</p> <p>3. Review of Resident #89's care plan dated 2/22/24, showed:</p> <ul style="list-style-type: none"> -The resident has an ADL self care performance deficit; -The resident has impaired cognitive function related to dementia; -The resident resists cares. <p>Review of the resident's Significant Change MDS, dated , 8/9/24, showed:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Impairment on one side of upper and lower extremity; -Uses a wheelchair for mobility with supervision; <p>-Diagnoses included, dementia, anxiety, and osteoporosis (a condition that causes bones to become weak and brittle).</p> <p>Observation 9/16/24 at 10:10 A.M. showed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident came out of his/her room and pushed on the wall by the unlocked biohazard room door;</p> <p>-The resident pushed on the unlocked biohazard door as he/she went up the hall;</p> <p>-The door to the nurses station remained unlocked as the resident pushed along the wall next to the nurses station;</p> <p>-No staff were present near the resident or the unlocked rooms or nurses station.</p> <p>Observation 9/18/24 at 8:03 A.M. showed:</p> <ul style="list-style-type: none"> - The clean utility room unlocked; - The clean utility room contained the linen cart; - Three electrical boxes were open on the wall inside the unlocked clean utility room; - Five cans of shaving cream were sitting on the sink in unlocked utility room; - A cup of clear liquid was sitting on the counter by the sink; - There was an orange stick sitting on the counter by the sink; - Trash was overflowing with used gloves and cigarette packages; - There was a still black substance on the wall behind the trash can; <p>-The resident propelling himself/herself in a wheelchair up and down the hall along the walls next to the unlocked clean utility room and the unlocked biohazard room;</p> <p>-There were no staff near the unlocked biohazard room or the unlocked clean utility room.</p> <p>4. Review of Resident #67's Annual MDS, dated , 8/9/24, showed:</p> <ul style="list-style-type: none"> -Moderate cognitive impairment; -Impairment on one side upper extremity; <p>-Diagnoses included, dementia, anxiety, stroke and psychotic disorder(a disorder when people lose contact with reality).</p> <p>Review of the resident's undated care plan showed:</p> <ul style="list-style-type: none"> -The resident is dependent on staff for meeting emotional, intellectual, physical and social needs; -The resident has an ADL self-care performance deficit related to confusion from stoke; -The resident has impaired cognitive function and impaired thought process related to dementia. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 9/17/24 at 10:15 A.M. showed:</p> <ul style="list-style-type: none"> - The clean utility room remained unlocked; - The clean utility room still contained the linen cart; - Three electrical boxes were still open on the wall inside the unlocked clean utility room; - Five cans of shaving cream were still sitting on the sink in unlocked utility room; - A cup of clear liquid was still sitting on the counter by the sink; - There was an orange stick still sitting on the counter by the sink; - Trash was still overflowing with used gloves, cigarette packages; - There was a still black substance on the wall behind the trash can. <p>Observation on 9/17/24 at 10:19 A.M. showed:</p> <ul style="list-style-type: none"> -The resident walking up and down both sides of the by the unlocked clean utility room, and the unlocked biohazard room. <p>Observation 9/18/24 at 08:03 A.M. showed:</p> <ul style="list-style-type: none"> - The clean utility room unlocked; - The clean utility room contained the linen cart; - Three electrical boxes were open on the wall inside the unlocked clean utility room; - Five cans of shaving cream were sitting on the sink in unlocked utility room; - A cup of clear liquid was sitting on the counter by the sink; - There was an orange stick sitting on the counter by the sink; - Trash was overflowing with used gloves and cigarette packages; - There was a still black substance on the wall behind the trash can; -The resident walking up and down both sides of the by the unlocked clean utility room, and the unlocked biohazard room. -There were no staff near the unlocked biohazard room or the unlocked clean utility room. <p>During an interview on 9/16/2024, at 10:12 A.M., CNA E said:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-This was his/her first day;</p> <p>-He/she usually worked at a sister facility;</p> <p>-He/she would expect the doors to the clean utility room, biohazard room, and nurses desk to be locked;</p> <p>-The doors to the clean utility room and the biohazard room have been unlocked since he/she came in;</p> <p>-Residents should not have access to sharps, dangerous chemicals, or any accident hazards.</p> <p>During an interview on 9/23/2024, at 9:18 A.M., CNA D said:</p> <p>-He/she was not sure if the doors to the clean utility room, biohazard room, and nurses desk should be locked;</p> <p>-The doors to the clean utility room and the biohazard room have always been unlocked;</p> <p>-Residents should not have access to sharps, dangerous chemicals, or any accident hazards.</p> <p>During an interview on 9/23/2024, at 9:38 A.M., LPN B said:</p> <p>-The lock broke on the nurse's station last night;</p> <p>-The door to the nurse's station should be locked;</p> <p>-He/she did not know if a work order had been filled out for the broken door;</p> <p>-The doors to the clean utility and the biohazard room should be locked;</p> <p>-Resident's should not have access to areas with sharps, open electrical boxes, or hazardous chemicals.</p> <p>During an interview on 9/23/24 at 9:11 A.M., the Maintenance Director said:</p> <p>-He/she tries to do a walk through every week and write on a list the things that need repaired;</p> <p>-He/she would not expect the electrical boxes on the memory care unit to be accessible to the residents;</p> <p>-He/she expects the door to the room containing the electrical boxes to be locked;</p> <p>-He/she expects the door to the biohazard room to be locked;</p> <p>-The nurses have keys to both of those rooms and they should be kept locked;</p> <p>-The area behind the nurse's desk should be locked.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -The door to the nurse's station should be locked; -The doors to the clean utility and the biohazard room should be locked; -Resident's should not have access to areas with sharps, open electrical boxes, or hazardous chemicals; -He/she expects the nurses to ensure those rooms are not accessible to the residents.

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51166</p> <p>Based on observation, interview and record review, the facility failed to ensure residents had water at bedside that was easily accessible for four of 23 residents sampled (#90 #49, #87, and #12). The facility census was 104.</p> <p>Review of the facility's undated policy for hydration showed, in part:</p> <ul style="list-style-type: none"> -The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. - Nursing staff shall assess hydration status upon admission and throughout the resident's stay in accordance with assessment protocols; the dietary manager or designee shall obtain the resident's beverage preferences upon admission, significant change in condition, and periodically throughout his or her stay; the dietician will assess hydration as part of the comprehensive nutritional assessment within 72 hours of admission, annually, and upon significant change in condition. -The assessment shall clarify the resident's current hydration status and individual risk factors for dehydration or fluid imbalance; the dietician shall use the data gathered from the nutritional assessment to the resident's fluid needs and whether intake is adequate to meet those needs. -Interventions will be individualized to address the specific needs of the resident such as offering the resident a variety of fluids during and in between meals; provide assistance with drinking; ensure beverages are available and within reach; evaluate resident's medications that may place the resident at risk for dehydration; offer alternative fluids such as broths, popsicles, gelatin, and ice cream. <p>1. Review of Resident #90's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/19/2024 showed:</p> <ul style="list-style-type: none"> -Resident has minor cognitive impairment. -Resident is dependent on a staff for eating. -Resident needs partial/moderate assistance with oral hygiene. -Diagnoses include stroke; high blood pressure; and paralysis of one side of the body. <p>Review of the resident's undated care plan showed:</p> <ul style="list-style-type: none"> -Resident has dehydration or potential fluid deficit related to poor intake. -Resident has a swallowing problem. Resident at risk for impaired nutrition and dehydration due to dependence on tube feeding for all nutrition and hydration needs. All staff is to be informed of resident's special dietary and safety needs. <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's active physician order sheet (POS), dated 9/18/24 showed:</p> <ul style="list-style-type: none"> -Regular diet, mechanical soft texture, nectar thick liquids consistency. Start date 7/10/24. <p>Review of progress notes dated 9/19/2024 2:22 PM showed:</p> <ul style="list-style-type: none"> -Resident was on antibiotics (ABT) for UTI (urinary tract infection) and has requested to not get out of bed thus far on this shift. <p>Review of progress notes dated 9/20/2024, unknown time, showed:</p> <ul style="list-style-type: none"> -Resident had ABT/UTI. Dependent on staff for cares; fluids encouraged. <p>Review of progress notes dated 9/22/2024, unknown time, showed:</p> <ul style="list-style-type: none"> -Continue ABT/UTI monitoring; fluids encouraged. <p>Observation and interview on 09/16/24 04:02 P.M. showed, the resident did not have water at bedside. The resident's daughter said when he/she asked for water, the staff brought flavored water, but the resident would prefer unflavored water.</p> <p>Observation on 9/19/24 08:19 A.M., showed there was no water at bedside.</p> <p>Observation on 09/19/24 11:54 A.M., showed there was no water at bedside.</p> <p>Observation on 09/23/24 09:02 A.M., showed no thickened water.</p> <p>During an interviews on 09/23/24 09:55 A.M., RN A said water is passed once in the morning and once in the afternoon before dinner.</p> <p>During an interview on 09/23/24 10:16 A.M., CNA A said day shift passes water once during breakfast pass and once during lunch pass.</p> <p>Observation on 09/23/24 11:15 A.M. showed no water being passed on Maple Hall between 9:00 A.M. and 11:15 A.M.</p> <p>Observation and interview on 09/23/24 11:30 A.M. showed, RN A said the resident has a UTI. Observation showed the resident did not have water at bedside.</p> <p>47195</p> <p>2. Review of Resident #12's, Quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -He/She was cognitively impaired; -He/She required supervised or touching assistance with eating; <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnosis included lack of coordination, difficulty walking, muscle weakness, unsteadiness on feet, depression, and bipolar disorder (mental illness that causes extreme mood swings).</p> <p>Review of the resident's care plan, revised 1/25/24, showed:</p> <p>-He/She was at risk for dehydration and/or potential fluid deficit due to diuretic use (Lasix) and history of poor intake;</p> <p>-Monitor and document intake and output as per facility policy;</p> <p>-Monitor vital signs as ordered per protocol and record. Notify medical doctor of significant abnormalities;</p> <p>-Monitor/document/report as needed any signs and symptoms of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness, or sitting/standing, increase pulse, headache, fatigue,/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes</p> <p>-Notify Physician if: Persistent symptoms of diarrhea, nausea/vomiting unresolved past 48 hours; persistent output exceeding intake past 48 hours; abnormal lab. Date Initiated: 12/08/2023</p> <p>-Obtain and monitor lab/diagnostic work as ordered. Report results to medical doctor and follow up as indicated.</p> <p>-Offer and encourage adequate fluid as long as not contraindicated i.e.: signs of fluid overload.</p> <p>Review of the physician's orders, dated 9/17/24, showed:</p> <p>-Ordered 5/31/24, Regular diet, regular texture, regular/thin consistency.</p> <p>During an interview on 9/16/24 at 10:27 A.M., the resident said:</p> <p>-The facility did not pass water very often;</p> <p>-He/She had no water in his/her room right now.</p> <p>Observation on 9/18/24 at 8:00 A.M., showed the resident had no water in his/her room.</p> <p>Observation on 9/18/24 at 8:16 A.M., showed the resident wheeled him/herself up the hallway next to the cooler and waited for staff to come by to have his/her water cup filled. No staff were observed in the area. The resident sat next to the cooler waiting for eight minutes. CNA A obtained ice for the resident when the resident said something to him/her.</p> <p>3. Review of Resident #49's Quarterly MDS, dated [DATE], showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She had impairment on one side of upper and lower extremities;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avalon View Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 West College Street Liberty, MO 64068	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She required set up or clean up assistance with eating;</p> <p>-Diagnoses included stroke (condition causing damage to the brain from an interruption of its blood supply), hemiplegia (condition causing weakness on one side of the body), heart failure, high blood pressure, diabetes (too much sugar in the blood), depression, post traumatic stress disorder (PTSD) (a mental health condition that can develop after a person experiences a traumatic event), unsteadiness on feet, lack of coordination, pain in left shoulder, need for assistance with personal care, and osteoarthritis of the right shoulder (a chronic joint disease that causes the cartilage in one or more joints to break down over time).</p> <p>Review of the resident's care plan, revised 7/30/24, showed:</p> <p>-He/She had an ADL self-care performance deficit due to a stroke;</p> <p>-He/She was able to feed him/herself but staff needed to set up his/her meals;</p> <p>-Monitor and document any signs or symptoms of increased thirst and appetite;</p> <p>-Ensure commonly used items (ice water) are within reach of resident prior to leaving room;</p> <p>-He/She was on a diuretic medication due to edema.</p> <p>Review of the physician's orders, dated 9/17/24, showed:</p> <p>-Ordered 4/29/22, Regular diet, regular texture, regular/thin consistency.</p> <p>During an interview on 9/16/24 at 6:22 P.M., the resident said:</p> <p>-Water was passed only one time per day;</p> <p>-He/She had never had his/her water cup changed out or washed.</p> <p>Observation on 9/18/24 at 7:57 A.M., showed the water cup was half empty.</p> <p>During an interview on 9/18/24 at 7:57 A.M., the resident said:</p> <p>-He/She last received water and ice sometime yesterday afternoon.</p> <p>Observation on 9/19/24 at 6:22 P.M., showed the resident had only 1/4 cup of water left in cup, no ice.</p> <p>During an interview on 9/19/24 at 2:08 P.M., the resident said:</p> <p>-He/She had not received ice or water pass yet today.</p> <p>During an interview on 9/19/24 at 5:31 P.M., the resident said:</p> <p>-Water was passed for the first time all day at 4:15 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 9/23/24 at 10:10 A.M., showed the resident was asleep. He/She had no water or ice in his/her cup.</p> <p>4. Review of Resident #87's Quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -He/She had impairment on one side of upper extremity, and impairment on both sides of lower extremities; -Diagnosis included traumatic spinal cord dysfunction, central cord syndrome as an after effect of disease, condition, or injury at the fifth cervical vertebra level of the cervical spinal cord (type of incomplete spinal cord injury characterized by weakness, loss of sensation below injury site, loss of bladder control, pain such as tingling and burning), paraplegia (paralysis of legs and lower body caused by spinal injury), spinal stenosis in cervical region (a chronic condition that occurs when spinal canal narrows, putting pressure on spinal cord and nerve roots), muscle weakness, and difficulty walking. <p>Review of the resident's care plan, revised 1/31/24, showed:</p> <ul style="list-style-type: none"> -He/She had diabetes mellitus; -Observe for signs and symptom hyperglycemia including increased thirst; -Ensure commonly used items (ice water) were within reach prior to leaving room; -He/She had renal insufficiency due to kidney disease; -He/She had potential for impairment of skin integrity; -Resident will have no signs and symptoms of complications due to fluid deficit through the review date. -The resident will have no signs and symptoms of complications related to fluid overload through the review date. <p>Review of the physician's orders, dated 9/17/24, showed:</p> <ul style="list-style-type: none"> -Ordered 1/25/24, Regular diet, regular texture, regular/thin consistence. Double portions every meal. <p>During an interview on 9/16/24 at 11:07 A.M., the resident said:</p> <ul style="list-style-type: none"> -It had taken the facility over a week to change out water; -The facility did not pass ice or water everyday. <p>Observation on 9/16/24 at 11:15 A.M., showed no ice water had been passed.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 9/17/24 at 5:30 A.M., showed no ice water had been passed.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Director of Nursing said ice and water should be passed two times per shift.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -Ice water should be passed twice per each shift; -Staff work 12 hour shifts.

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observation, record review, and interview, the facility failed to provide trauma informed care to one sampled resident (Resident #49) with a diagnosis of Post-Traumatic Stress Disorder (PTSD, a mental health condition that is triggered by a traumatic event). The facility failed to mitigate triggers of loud noises that caused re-traumatization for one resident (Resident #49) who was residing on a hall with several residents who scream and yell out. The failed to identify and mitigate triggers for one resident (Resident #87) when the resident had identified several traumatic events. The facility also failed to identify and communicate interventions to staff for both residents to assist in promoting a sense of safety for both residents (Resident #49 and #87). The facility census was 104.</p> <p>Review of facility policy, Trauma Informed Care, dated 9/1/22, showed:</p> <ul style="list-style-type: none"> -It is policy of facility to provide care and services which are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. -The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which retraumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be addend to the residents care plan. -The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understanding if interventions must be modified. -In situations where a trauma survivor is reluctant to share their history, the facility will still try and identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. <p>1. Review of Resident #49 quarterly, minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 7/22/24, showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -He/She had clear speech, and was able to make self-understood and understand others; -He/She felt down, depressed or hopeless half or more days; -He/She had impairment on one side of upper and lower extremities; -He/She was dependent on walker and wheelchair; -He/She was taking an antidepressant; <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-His/Her mood severity score was a 12 (indicating moderate depression);</p> <p>-He/She had trouble falling asleep or staying asleep or sleeping too much nearly every day;</p> <p>-He/She felt tired or had little energy nearly every day;</p> <p>-He/She exhibited a poor appetite or overeating on more than half of the days;</p> <p>-He/She had trouble concentrating on things such as reading the newspaper or watching television on half or more of the days;</p> <p>-Diagnoses included post traumatic stress disorder (PTSD) (a mental health condition that can develop after a person experiences a traumatic event), unsteadiness on feet, and lack of coordination</p> <p>Review of the resident's care plan, revised 3/15/24, showed:</p> <p>-He/She had a history of a traumatic event;</p> <p>-His/Her spouse was verbally and emotionally abusive to him/her with triggers of loud noises startling him/her;</p> <p>-Known triggers of potential trauma included loud noises;</p> <p>-No interventions identified for known triggers.</p> <p>During an interview on 9/16/24 at 6:40 P.M., the resident said:</p> <p>-His/Her ex-spouse choked him/her one time, went to jail, and was emotionally abusive;</p> <p>-The resident across the hall was throwing a fit of yelling and cussing which triggered him/her;</p> <p>-Loud noises trigger the resident to relive his/her abuse;</p> <p>-The resident across the hall was yelling the other morning so the resident started yelling back at the other resident;</p> <p>-Staff came and yelled at the resident for confronting the other resident.</p> <p>Review of facility electronic medical record showed:</p> <p>-On 5/1/22, resident had a trauma, abuse, neglect screening completed with a score of 4.0 which showed he/she had a history of abuse and/or neglect, increased vulnerability, psychiatric history and present mental health diagnosis, and had depressive illness including low self esteem, isolation, and withdrawn behaviors. His/Her spouse had physically and emotionally abused him/her.</p> <p>-On 1/1/23, the resident had a trauma informed care assessment completed and no trauma was noted;</p> <p>-On 11/8/23, the resident had a trauma informed care assessment completed and no trauma was noted;</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 4/22/24, the resident had a trauma informed care assessment completed and reported that his/her ex husband was verbally and emotionally abusive.</p> <p>-On 7/23/24, the resident had a trauma informed care assessment completed and reported that his/her ex husband was verbally and emotionally abusive;</p> <p>During an interview on 9/18/24 at 3:28 P.M., Certified Nurse Aide (CNA) A said he/she did not know this resident was triggered by hearing yelling.</p> <p>During an interview on 9/23/24 at 9:43 A.M., Certified Medication Technician (CMT) A said he/she was not aware of the resident having any triggers.</p> <p>During an interview on 9/23/24 at 10:05 A.M., Registered Nurse (RN) A said he/she was not aware of the resident having any trauma triggers.</p> <p>During an interview on 9/18/24 3:40 P.M., the Social Services Director said:</p> <p>-He/She was aware this resident was triggered by loud noises;</p> <p>-He/She was not aware the resident was triggered by other residents yelling on the hall, but was aware the resident's roommate would get upset and come out yelling at other residents across the hall;</p> <p>-The resident has a history of closing his/her door a lot, and likes to do arts and crafts as part of his/her coping strategies;</p> <p>-He/She communicates the resident's triggers directly with the charge nurse on the hall who then verbally communicates with the staff providing direct care.</p> <p>2. Review of Resident #87's quarterly MDS, dated [DATE], showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She had clear speech, was able to make self-understood, and understand others;</p> <p>-He/She had impairment on one side of upper extremity, and impairment on both sides of lower extremities;</p> <p>-He/She was dependent on a wheelchair;</p> <p>-Behaviors included hallucinations and delusions;</p> <p>-He/She had an an antipsychotic on routine basis;</p> <p>(continued on next page)</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnosis included central cord syndrome as a after affect at the cervical vertebra five level of the cervical spinal cord (type of incomplete spinal cord injury characterized by weakness, loss of sensation below injury site, loss of bladder control, pain such as tingling and burning), dementia (loss of cognitive function such as thinking, remembering, and reasoning), paraplegia (paralysis of legs and lower body caused by spinal injury), cognitive communication deficit, muscle weakness, and difficulty walking.</p> <p>Review of the resident's care plan, revised 8/9/24, directed staff of the following:</p> <p>-Resident had past trauma of being in a tornado, car accident that left him/her with a spinal cord injury, being jumped (assaulted or attacked), and homeless. Resident reported no triggers or distress related to traumas;</p> <p>-He/She had impaired cognitive function/dementia and impaired thought processes;</p> <p>-He/She stated on 1/26/24 that everyone was out to get him/her and he/she was tired of the witches in the place. He/She stated he knew for a fact that a CNA was casting spells with chicken bones and the constant laughter in the hallway and was always smiling about him/her;</p> <p>-He/She stated on 3/13/24 that therapy staff were making fun of him/her, and he/she knew people were making fun of him/her;</p> <p>-He/She stated on 6/5/24 that he/she knew when people were making fun of him/her and then refused his/her morning shower stating shower aide was a witch and that his/her potions and lotions cause him/her to burn and itch;</p> <p>-The care plan did not identify any resident triggers for prior trauma.</p> <p>Observation on 9/17/24 at 10:49 A.M., showed the resident came out of his/her room yelling at Resident #87 sitting in a wheelchair in the hallway.</p> <p>During an interview on 9/17/24 at 10:55 A.M., CNA A said:</p> <p>-The resident had specific behaviors targeting him/her and RN A;</p> <p>-The resident will state that he/she put stuff in the resident's soap to make him/her itch.</p> <p>During an interview on 9/23/24 at 9:43 A.M., CMT A said:</p> <p>-The resident was triggered by certain staff on the hall, specifically CNA A and RN A;</p> <p>-The resident gets agitated at others and call staff witches and a cuss word;</p> <p>-The resident will only accept his/her medication and treatments from CMT A, because he/she did not have a problem with him/her and he/she liked to interact with CMT A.</p> <p>During an interview on 9/23/24 at 10:05 A.M., RN A said:</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident was very delusional and paranoid;</p> <p>-The resident acts out every Friday afternoon;</p> <p>-He/she was aware the resident was best supported by staff praying with him/her as long as the person praying with him/her was not the person he/she was targeting;</p> <p>-He/she had learned the resident was best supported when the staff member he/she is targeting walks away. He/she had learned the more that staff members interact with the resident, the likelihood the resident will continue to escalate.</p> <p>During an interview on 9/18/24 at 3:40 P.M., the Social Services Director said:</p> <p>-The resident was triggered by any kind of mention of mental health around him/her;</p> <p>-The resident could be a difficult resident to identify his/her triggers, as he/she could be triggered by someone simply approaching him/her and feeling threatened and having severe paranoia;</p> <p>-The resident would start calling people witches and warlocks when he/she was triggered;</p> <p>-The resident seemed to be triggered very easily.</p> <p>3. Review of facility training logs for last year showed no trauma informed care training was provided to the facility staff.</p> <p>During an interview on 9/18/24 at 3:14 P.M., the MDS Coordinator said the social services director completed the trauma informed care section regarding care plans and the trauma informed care assessments.</p> <p>During an interview on 9/18/24 at 3:28 P.M., CNA A said:</p> <p>-He/She had not received any trauma informed care training;</p> <p>-He/She was not aware of any residents that were triggered from their past abusive relationship;</p> <p>-No one had conveyed any resident trauma triggers to him/her or methods of interventions;</p> <p>-He/She did know that some residents are triggered by yelling.</p> <p>During an interview on 9/23/24 at 9:43 A.M., CMT A said:</p> <p>-He/she received trauma informed care training a long time ago, but no training in the past year;</p> <p>-If he/she observed a resident was being triggered by another resident's yelling he/she would separate the residents and inform the nurse.</p> <p>During an interview on 9/23/24 at 10:05 A.M., RN A said:</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she had no trauma informed care training by the facility since starting three months ago;</p> <p>-He/she was not aware of trauma triggers for residents.</p> <p>During an interview on 9/18/24 3:40 P.M., the Social Services Director said:</p> <p>-He/She completed trauma assessments upon admission, every quarter, and annually;</p> <p>-He/She notified staff of trauma triggers directly by going to the charge nurse;</p> <p>-The charge nurse then filtered down the information to floor staff;</p> <p>-He/She was not aware of any trauma informed care training to staff at facility since he/she started the position in February;</p> <p>-If a resident was triggered due to a past abusive relationship/marriage by another resident who was yelling and cussing loudly then he/she would offer to look at moving the resident to create a calming environment, work to help resident identify and develop coping skills, and obtain noise canceling headphones;</p> <p>-The facility had purchased noise canceling headphones in the past for residents who were triggered by loud noises but not for Resident #49.</p> <p>During an interview on 9/23/24 at 3:33 P. M, the Administrator said:</p> <p>-He/She completed trauma informed training to staff in facility;</p> <p>-He/She trained on trauma two or three times;</p> <p>-He/She documented training in staff meeting notes.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to meet basic care needs for seven residents (Residents #13, #67, #80, #12, #49, #87, and #74) including assistance to reposition and incontinent care for two residents (Resident #13 and #80), failed to provide basic hygiene for one resident (Resident #67), and failed to provide assistance with bathing for three residents (Residents #12, #49 and #87) of 21 sampled residents. Additionally the facility failed to answer call lights timely for nine of 20 Resident Council attendees. The facility census was 104.</p> <p>Review of the facility provided policy Activities of Daily Living (ADLs: tasks completed in a day to care for oneself) dated 9/1/21 showed:</p> <p>-A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>Review of the facility provided policy Bathing a Resident dated 9/1/21 showed:</p> <p>-It is the practice of this facility to assist residents with bathing to maintain proper hygiene.</p> <p>Review of the facility provided policy Nursing Services and Sufficient staff dated 9/1/21 showed:</p> <p>-It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment;</p> <p>-The facility will supply services by sufficient numbers of each of the following personnel types on a 24 hour basis to provide nursing care to all residents in accordance with resident care plans;</p> <p>-Providing care includes, but not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>1. Review of Resident #13's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated, 6/20/24, showed:</p> <p>-Severe cognitive impairment;</p> <p>-Dependent on staff for Activities of ADLs;</p> <p>-Incontinent of bowel and bladder;</p> <p>-Diagnoses included, dementia, high blood pressure and anxiety.</p> <p>Review of the resident's care plan revised, 3/27/24, showed:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avalon View Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 West College Street Liberty, MO 64068	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident has an ADL self care performance deficit;</p> <p>-The resident is dependent on staff for toileting;</p> <p>-Clean peri-area after each incontinent episode;</p> <p>-The resident has the potential for pressure ulcer development related to incontinence;</p> <p>-The resident requires total assistance of one staff for transfers;</p> <p>-The resident has the right to be treated with dignity.</p> <p>Continuous observation of the resident beginning on 09/16/24 at 09:20 A.M., showed:</p> <p>-09:20 A.M., the resident was setting at the table in the dining room in his/her wheelchair;</p> <p>-10:13 A.M., the resident was setting at the table in the dining room in his/her wheelchair and no staff have offered to toilet the resident;</p> <p>-10:59 A.M., the resident still setting in his/her wheelchair at the table with his/her eyes closed;</p> <p>-11:03 A.M., the resident still setting in his/her wheelchair at the table and LPN B walked by and did not provide incontinent care for the resident;</p> <p>-11:25 A.M., CNA D walked by the resident setting in his/her wheelchair at the table and did not offer to provide incontinent care for the resident;</p> <p>-12:26 P.M., lunch was delivered to the memory care unit and was still setting in his/her wheelchair at the table with his/her eyes closed;</p> <p>-12:42 P.M., lunch was delivered to the resident and he/she was still at the table in his/her wheelchair;</p> <p>-12:46 P.M., no staff have repositioned or toileted the resident;</p> <p>- 01:01 P.M., the resident finished his/her lunch and was still setting in his/her wheelchair at the table and no staff have provided incontinent care for the resident;</p> <p>-01:25 P.M., the resident was setting at the table in his/her wheelchair and no staff have toileted the resident.</p> <p>Continuous observation of the resident beginning on 09/17/24 at 05:39 A.M., showed:</p> <p>-05:39 A.M., the resident was setting at the table in the dining room in his/her wheelchair;</p> <p>-06:15 A.M., the resident was setting at the table in the dining room in his/her wheelchair and no staff have offered to toilet the resident;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-07:30 A.M., the resident was still setting in his/her wheelchair at the table;</p> <p>-08:30 A.M., the resident was setting at the table in the dining room in his/her wheelchair;</p> <p>-09:30 A.M., the resident was setting at the table in the dining room in his/her wheelchair and no staff have offered to toilet the resident.</p> <p>2. Review of Resident #67's Annual MDS dated , 7/17/24, showed:</p> <p>-Moderate cognitive impairment;</p> <p>-Visual impairment;</p> <p>-Substantial assistance from staff for toileting;</p> <p>-Supervision of staff for dressing;</p> <p>-Incontinent of urine;</p> <p>-Diagnoses included, stroke, depression, high blood pressure and cataracts (a clouding of the eye's lens that can lead to vision loss).</p> <p>Review of resident's undated care plan showed:</p> <p>-The resident has an ADL self care performance deficit;</p> <p>-The resident requires supervision for dressing;</p> <p>-The resident requires supervision with personal hygiene;</p> <p>-The resident requires assistance with toileting;</p> <p>-The resident has the right to be treated with dignity.</p> <p>Observation on 09/16/24 at 09:50 A.M., showed:</p> <p>-The resident walking into the dining room;</p> <p>-The resident hair was unkempt and his/her glasses had white specks on the lenses;</p> <p>-The resident's pants and shirt had black stains on them.</p> <p>Observation on 09/16/24 at 12:24 P.M., showed:</p> <p>-The resident was setting in the dining room at a table;</p> <p>- The resident's glasses still had white specks on the lenses;</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident's hair was still unkempt and his/her clothes still had black stains on them.</p> <p>Observation on 09/17/24 at 08:01 A.M., showed:</p> <p>-The resident was setting in the dining room;</p> <p>-The resident was wearing the same clothes as yesterday;</p> <p>-The resident's pants and shirt still had black stains on them.</p> <p>-The resident's hair was unkempt and his/her glasses still had white specks on the lenses.</p> <p>3. Review of Resident #80's Quarterly MDS dated [DATE], showed:</p> <p>-Severe cognitive impairment;</p> <p>-Dependent on staff for ADLs;</p> <p>-Incontinent of bowel and bladder;</p> <p>-Diagnoses included, dementia, high blood pressure and anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues).</p> <p>Review of the resident's care plan revised, 6/13/24, showed:</p> <p>-The resident has an ADL self care performance deficit;</p> <p>-The resident requires total assistance of one to two staff for showers and toileting;</p> <p>-The resident requires total assistance of one to two staff for transfers;</p> <p>-The resident has impaired cognitive function related to dementia;</p> <p>-The resident has the right to be treated with dignity;</p> <p>-The resident has the right to privacy and confidentiality.</p> <p>Continuous observation of the resident beginning on 09/16/24 at 09:20 A.M., showed:</p> <p>-09:20 A.M., the resident was setting at the table in the dining room in his/her wheelchair;</p> <p>-10:13 A.M., the resident was setting at the table in the dining room in his/her wheelchair and no staff have offered to toilet the resident;</p> <p>-10:59 A.M., the resident was still setting in his/her wheelchair at the table with his/her eyes closed;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-11:03 A.M., the resident was still setting in his/her wheelchair at the table and LPN B walked by and did not provide incontinent care for the resident;</p> <p>-11:25 A.M., CNA D walked by the resident setting in his/her wheelchair at the table and did not offer to provide incontinent care for the resident;</p> <p>-12:26 P.M., lunch was delivered to the memory care unit and the resident was still setting in his/her wheelchair at the table with his/her eyes closed;</p> <p>-12:42 P.M., lunch was delivered to the resident and he/she was still at the table in his/her wheelchair;</p> <p>-12:46 P.M., no staff have repositioned or toileted the resident;</p> <p>- 01:01 P.M., the resident finished his/her lunch and was still setting in his/her wheelchair at the table and no staff have provided incontinent care for the resident;</p> <p>-01:25 P.M., the resident was setting at the table in his/her wheelchair with his/her eyes closed and no staff have toileted the resident.</p> <p>Continuous observation of the resident beginning on 09/17/24 at 05:39 A.M., showed:</p> <p>-05:39 A.M., the resident was setting at the table in the dining room in his/her wheelchair;</p> <p>-06:15 A.M., the resident was setting at the table in the dining room in his/her wheelchair and no staff have offered to toilet the resident;</p> <p>-07:30 A.M., the resident was still setting in his/her wheelchair at the table and the DON delivered breakfast to him/her and the DON did not offer to reposition or toilet the resident;</p> <p>-08:30 A.M., the resident was setting at the table in the dining room in his/her wheelchair;</p> <p>-09:30 A.M., LPN B said good morning to the resident and did not toilet the resident.</p> <p>During an interview on 9/18/24 at 1:14 P.M., CNA D said:</p> <p>-He/she tries to toilet Residents #13, #67 and # 80 at least every two hours, but he/she did not have enough time today;</p> <p>-It gets busy sometimes and he/she does not have time;</p> <p>-Incontinent residents should be toileted at least every two hours.</p> <p>During an interview on 9/18/24 at 1:28 P.M., LPN B said:</p> <p>-The CNAs usually toilet the residents;</p> <p>-He/she expects the residents to have incontinent care every two hours or as needed;</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she was not aware the incontinent residents had not been toileted for over two hours;</p> <p>-Incontinent residents should be toileted at least every two hours.</p> <p>During an interview on 9/18/24 at 1:42 P.M., the DON said</p> <p>-He/she expects residents to have incontinent care every two hours or as needed;</p> <p>-He/she was not aware the incontinent residents had not been toileted for over two hours;</p> <p>-He/she expects incontinent residents should be given pericare and changed at least every two hours.</p> <p>4. Review of Resident #12's Quarterly MDS) dated [DATE], showed:</p> <p>-He/She was cognitively impaired;</p> <p>-He/She had moderate difficulty with hearing, speaker has to increase volume and speak distinctly;</p> <p>-He/She had clear speech and was able to make self understood and understand others;</p> <p>-He/She had no impairment to upper or lower extremities;</p> <p>-He/She was dependent on a walker/wheelchair;</p> <p>-He/She required supervised or touching assistance with bathing, sit to stand and chair to bed transfers;</p> <p>-Diagnosis included lack of coordination, difficulty walking, muscle weakness, unsteadiness on feet, depression, bipolar disorder (mental illness that causes extreme mood swings).</p> <p>Review of the resident's care plan, revised 9/1/24, showed:</p> <p>-He/She had an ADL self-care performance deficit due to stroke and chronic obstructive pulmonary disease (COPD);</p> <p>-Resident required assistance from one staff with showering twice weekly and as necessary;</p> <p>-Check nail length and trim and clean on bath day and as necessary;</p> <p>Observation on 9/16/24 at 10:06 A.M. showed:</p> <p>-The resident's hair was greasy and had not been brushed;</p> <p>-He/She had long nails with black/brown color underneath his/her nail bed.</p> <p>During an interview on 9/16/24 at 10:06 A.M., Resident #12 said:</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She did not get showers or baths when he/she wanted them;</p> <p>-He/She had went 7-8 days without a shower;</p> <p>-He/She wanted a shower twice a week on Mondays and Fridays;</p> <p>-He/She had scheduled shower days, but he/she never got showers on his/her scheduled shower days;</p> <p>-He/She was lucky because he/she got one shower on Saturday during the past week;</p> <p>-During the night he/she could not find staff;</p> <p>-Call lights are on throughout the night and there was no staff to answer the lights;</p> <p>-Food was not served on time;</p> <p>-Staff do not pass ice water very often, he/she had to go after water themselves.</p> <p>Review of shower schedule, dated 4/30/24, in the shower book for Maple hall showed:</p> <p>-His/Her room number had shower days on Mondays and Thursdays.</p> <p>Review of Resident #12's shower sheets, dated 6/1/24 to 9/17/24 , showed:</p> <p>-He/She received one shower in September on 9/17 out of [NAME] scheduled opportunities, which was nineteen days from his/her last prior shower in August;</p> <p>-He/She received five showers in August on 8/1, 8/7, 8/13, 8/26, and 8/29 of nine schedule opportunities;</p> <p>-He/She received four showers in July on 7/2, 7/9, 7/19, and 7/23 of nine scheduled opportunities;</p> <p>-He/She received three showers in June on 6/17, 6/20, and 6/26 of eight scheduled opportunities.</p> <p>5. Review of Resident #49's Quarterly MDS, dated [DATE], showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She had clear speech, and was able to make self-understood and understand others;</p> <p>-He/She felt down, depressed or hopeless half or more days;</p> <p>-He/She had no behavioral symptoms or rejection of care;</p> <p>-He/She had impairment on one side of upper and lower extremities;</p> <p>-He/She was dependent on walker and wheelchair;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She required substantial/maximal assistance with bathing;</p> <p>-He/She was frequently incontinent;</p> <p>-Diagnoses included: stroke (condition causing damage to the brain from an interruption of its blood supply), hemiplegia (condition causing weakness on one side of the body), heart failure, high blood pressure, diabetes (too much sugar in the blood), depression, post traumatic stress disorder (PTSD) (a mental health condition that can develop after a person experiences a traumatic event), unsteadiness on feet, lack of coordination, pain in left shoulder, need for assistance with personal care, osteoarthritis of the right shoulder (a chronic joint disease that causes the cartilage in one or more joints to break down over time).</p> <p>Review of the resident's care plan, revised 7/30/24, showed:</p> <p>-He/She had an ADL self-care performance deficit due to hemiplegia;</p> <p>-He/She required extensive assistance with one person assist for shower twice weekly and as necessary;</p> <p>-He/She required assistance washing under his/her arm, abdominal folds, and lower body;</p> <p>-He/She had a rash under breast and pannus due to moisture;</p> <p>-Preventive skin care as ordered, keep area under breast and pannus clean and dry.</p> <p>During an interview on 9/16/24 at 6:24 P.M., Resident #49 said:</p> <p>-Showers were very infrequent;</p> <p>-The last shower he/she had was less than a week ago and the shower prior to that was about 2 weeks in between showers;</p> <p>-Not having showers regularly made him/her feel dirty and disgusting;</p> <p>-Prior to his/her stroke he/she was taking two or three showers a day;</p> <p>-He/She would like to receive at minimum of two showers a week;</p> <p>-He/She was scheduled to have showers on Tuesdays and Fridays, but he/she rarely received showers as scheduled;</p> <p>-A lot of times there was not any pads or sheets available;</p> <p>-Staff do not keep beds made as there was not enough sheets to put back on the beds;</p> <p>-He/She had to sleep on a bare mattress due to facility not having any clean sheets;</p> <p>-Water is only passed one time a day;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The facility had never changed out his/her water cup since he/she had been there;</p> <p>-Call light response time is slow;</p> <p>-He/She had to wait thirty minutes or more for his/her call light to be answered.</p> <p>Review of shower schedule, dated 4/30/24, in shower book on Maple hall showed:</p> <p>-His/Her room number was assigned shower days on Mondays and Thursdays.</p> <p>Review of shower sheets, dated 6/1/24 to 9/17/24 , showed:</p> <p>-He/She received one shower in September on 9/5 out of five scheduled opportunities;</p> <p>-He/She received two showers in August on 8/6 and 8/21 out of nine scheduled opportunities;</p> <p>-He/She received two showers in July on 7/9 and 7/21 out of nine scheduled opportunities;</p> <p>-He/She received two showers in June on 6/15 and 6/25 out of eight scheduled opportunities;</p> <p>-He/She received only 7 out of 31 shower opportunities from June to September.</p> <p>6. Review of Resident #87's Quarterly MDS, dated [DATE], showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She had clear speech, was able to make self-understood, and understand others;</p> <p>-He/She had impairment on one side of upper extremity, and impairment on both sides of lower extremities;</p> <p>-He/She was dependent on a wheelchair;</p> <p>-He/She was dependent for bathing and tub transfers;</p> <p>-Diagnosis included traumatic spinal cord dysfunction, central cord syndrome as an after effect of disease, condition, or injury at the fifth cervical vertebra level of the cervical spinal cord (type of incomplete spinal cord injury characterized by weakness, loss of sensation below injury site, loss of bladder control, pain such as tingling and burning), paraplegia (paralysis of legs and lower body caused by spinal injury), spinal stenosis in cervical region (a chronic condition that occurs when spinal canal narrows, putting pressure on spinal cord and nerve roots), muscle weakness, and difficulty walking.</p> <p>Review of the resident's care plan, revised 1/31/24, showed:</p> <p>-Resident had an ADL self-care performance deficit;</p> <p>-He/She was dependent on two staff for transfers from chair to bed, and shower;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She required set up, supervision, and physical assistance to maintain personal hygiene;</p> <p>-Revision 7/5/24 showed patient refused shower that morning because he/she said shower aide was a witch and that his/her potions and lotions cause him/her to burn and itch.</p> <p>During an interview on 9/16/24 at 10:40 A.M., Resident #87 said:</p> <p>-He/She received a shower one time every two weeks;</p> <p>-He/She felt like garbage when he/she had to go so long without showers;</p> <p>-He/She had a shower on 9/14, prior to that his/her last shower was two weeks prior;</p> <p>-He/She would like to have a shower every day;</p> <p>-His/Her bedding is only changed every two weeks;</p> <p>-Water is not passed to his/her room everyday.</p> <p>Review of shower schedule, dated 4/30/24, in shower book for Maple hall showed:</p> <p>-His/Her room number was assigned shower days on Wednesdays and Saturdays.</p> <p>Review of shower sheets, dated 6/1/24 to 9/17/24 , showed:</p> <p>-He/She had no documented showers in September out of four opportunities, and he/she had one documented refusal on 9/17/24;</p> <p>-He/She received three showers in August on 8/7, 8/17, and 8/31 out of nine scheduled opportunities, with no documented refusals;</p> <p>-He/She received two showers in July on 7/3 and 7/7 out of nine opportunities with 2 refusals on 7/19 and 7/24;</p> <p>-He/She received three showers in June on 6/5, 6/19, and 6/26 out of nine scheduled opportunities, no documented refusals;</p> <p>-He/She received 8 out of 31 opportunities for showers, and 3 refusals out of 31 scheduled opportunities for showers.</p> <p>During an interview on 9/16/24 at 12:11 P.M., Certified Nurse Aide (CNA) A said:</p> <p>-He/She was only aide scheduled to work Maple hall most of the time;</p> <p>-He/She was a shower aide, but he/she was pulled from completing showers to work the floor all the time;</p> <p>-Residents go without showers for much longer than a week at time due to staffing shortages;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She had given showers and the white towels will be black;</p> <p>-He/She did not have time to do all patient care needs due to staffing;</p> <p>-He/She had three residents on Maple hall that required feeding assistance and there was insufficient staff to feed the residents in timely manner;</p> <p>-Laundry staff do not stock linens;</p> <p>-He/She had to go to laundry to obtain linens because linens were not restocked on halls.</p> <p>During an interview on 9/16/24 at 7:48 P.M., Certified Medication Technician (CMT) A said:</p> <p>-Insufficient staff working the facility was an issue that affected patient care;</p> <p>-He/She had to work late because he/she had to help the CNAs work the floor and had to stop passing medications;</p> <p>-He/She had to stop medication passes to assist with passing food trays on the floor;</p> <p>-Showers were not getting done;</p> <p>-The hall had only one CNA scheduled, but needed two to meet resident cares due to transfers, incontinence, and Hoyer's;</p> <p>-Staffing is an issue which has resulted in patient care not getting done;</p> <p>-Showers were not being completed due to staffing shortages;</p> <p>-The shower aide was constantly pulled to floor to work as a CNA so showers were not getting completed.</p> <p>During an interview on 9/17/24 at 5:18 A.M., Licensed Practical Nurse (LPN) A said:</p> <p>-Biggest issue in the facility was staffing;</p> <p>-He/She had been asked to cover multiple halls due to staffing shortages;</p> <p>-He/She was not comfortable covering multiple halls due to residents with tracheotomies that needed to be checked more frequently;</p> <p>-He/She found that it was hard to hold CNAs accountable when that CNA was the only CNA working the floor;</p> <p>-Patient care needs were not being met with just one aide covering a hall.</p> <p>During an interview on 9/17/24 at 5:48 A.M., CNA B said:</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Avalon View Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 West College Street Liberty, MO 64068	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Staffing was an issue in facility;</p> <p>-Residents did not receive adequate pericare, toileting, transfers, feeding assistance, and showers as a result of staffing shortages;</p> <p>-There had been shortage of bed pads and sheets;</p> <p>-Laundry staff was short for time period;</p> <p>-He/She had to go to other halls to track down bed pads and sheets;</p> <p>-Facility has ran out of sheets and bed pads.</p> <p>During an interview on 9/23/24 at 10:05 A.M., Registered Nurse (RN) A said:</p> <p>-There was never enough staff;</p> <p>-Staff do the best they can to meet resident needs but there was never enough staff to go around;</p> <p>-Resident care suffered as a result of short staffing;</p> <p>-One CNA was assigned thirty residents and half of the residents on the hall were incontinent;</p> <p>-The CNA was also expected to pass drinks and meal trays;</p> <p>-The CMT had to stop passing medications and assist at meal times;</p> <p>-Showers are a problem throughout the facility, not just on one hall;</p> <p>-Showers are not done due to not having sufficient staff.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Director of Nursing said:</p> <p>-The facility was doing the best it could with staffing;</p> <p>-He/She could not control staff call ins.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said:</p> <p>-Showers had not been completed twice weekly due to staffing;</p> <p>-His/Her goal was to have two CNAs, a CMT, and a nurse working on each hall;</p> <p>-Time goal had not been met due to staffing in facility.</p> <p>7. During a group interview of the Resident Council on 9/18/24 at 10:00 A.M., eight of 20 residents (Residents #13, #67, #80, #12, #49, #87, #74, and #12) said:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Call times take a long time and can be an hour or longer;</p> <p>-Delays for call lights to be answered is due to the staff being overworked and short-handed;</p> <p>-At night there is not enough staff to take care of the residents;</p> <p>-On the weekends staffing is very low.</p> <p>8. Review of Resident #74's Admission assessment, completed by facility staff, dated 9/10/24, showed:</p> <p>-He/She was cognitively intact;</p> <p>-Incontinent of both bowel and bladder;</p> <p>-Diagnoses included brain disease; shortness of breath; urinary tract infection; kidney disease; asthma; heart disease; depression; osteoarthritis; malnutrition.</p> <p>Review of the resident's undated care plan, showed:</p> <p>-Resident's autonomy and dignity will be honored in the personal choices they make;</p> <p>-Resident had an ADL performance deficit;</p> <p>-Resident was at risk for falls.</p> <p>Review of progress notes dated 9/14 showed:</p> <p>-Resident continued ABT (antibiotic therapy) for UTI (urinary tract infection) with no adverse reactions. Fluids encouraged while awake.</p> <p>Review of progress notes dated 9/15 showed:</p> <p>-Resident remained on ABT/UTI without any adverse reaction.</p> <p>Review of Progress notes dated 9/16 showed:</p> <p>-Resident continued ABT/UTI with no adverse reaction. Resident was incontinent with some control. Assist of one with toileting and cares. Fluids encouraged while awake.</p> <p>Review of progress notes, dated 9/17, showed:</p> <p>-Continued Cipro (antibiotic) for UTI; encouraged to increase water intake.</p> <p>Observation and interview on 09/16/24 09:59 A.M. showed:</p> <p>-The resident was observed sitting on bed in a hospital gown. The resident said he/she had been waiting since 8:30 A.M. and expressed frustration that he/she was not dressed yet.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident said he/she often doesn't get help to the bathroom in time and sometimes soils themselves while waiting for assistance.</p> <p>During an interview on 09/17/24 at 11:19 A.M., the resident's daughter said:</p> <p>-She is concerned the resident has not had a bath since he/she has been here (admitted : 9/08/24) and said the resident has started scratching at his/her head due to his/her hair and scalp being dirty.</p> <p>Observation and interview on 09/23/24 at 09:13 A.M., showed:</p> <p>-The resident was unshaven and resident said he/she asked several days ago for assistance. He/she said there is not enough staff at the facility to help resident shave.</p> <p>During an interview on 09/18/24 at 03:35 P.M., Nurse B said:</p> <p>-The resident's shaving/shower schedule depends on resident preference vs. resident schedule and there are residents that are scheduled for twice a week.</p> <p>During an interview on 09/19/24 at 07:08 A.M., CNA B said:</p> <p>-He/she checks on the resident to see if he/she needs to use the bathroom and the resident uses a urinal.</p> <p>During an interview on 09/23/24 at 10:16 AM , CNA A said:</p> <p>-There is not enough staff in general, but especially the CNAs. It makes employees and residents on edge because residents do not get changed or put down for a nap in a timely manner.</p> <p>-He/she is working alone on the floor on average, 3-4 times per week and does not always get breaks.</p> <p>During an interview on 09/23/24 at 03:36 PM, the Administrator said:</p> <p>-Most of the time the facility has enough staff to meet the residents needs. The goal is to have two CNAs per hall, but it does not always happen due to staff calls out.</p> <p>MO#241353</p> <p>MO#241172</p> <p>MO#241807</p> <p>46706</p> <p>47195</p> <p>50980</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706</p> <p>Based on observation, interview and record review, the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles for five (Resident #12,#15, #69, #77 and #154) out of 23 sampled residents when the facility failed to store medications in a locked storage area for Resident #12 and Resident #154 and failed to ensure medications were inaccessible to unauthorized staff and residents when the medication cart was left unlocked and unattended. Additionally, the facility failed to ensure staff were able to read the pharmacy label for Resident #69, failed to destroy expired medications for Resident #69 and Resident #77, and failed to destroy expired house stock medications. The facility census was 104.</p> <p>Review of the facility's Medication Storage Policy, revised, 9/1/21, showed in part:</p> <ul style="list-style-type: none"> - It is the policy of this facility to ensure all medications will be stored according to the manufacturers recommendation and securely; - All drugs and biologicals will be stored in locked medication rooms or carts; - Only authorized personnel will have access to medications; - Medication that is outdated, discontinued or with missing or illegible labels will be destroyed. <p>1. Observation on 09/18/24, at 11:58 P.M., of the medication cart showed:</p> <ul style="list-style-type: none"> -The second, third and fourth drawers of the medication cart had multiple loose pills, dirt and debris in the bottom of the drawer; - The fourth drawer had a white liquid spilled in the bottom of the drawer; - A bottle of house stock Milk of Magnesia (used to treat constipation) with an expiration date of April 2024; - A bottle of Flonase Nose Spray (used to treat allergies) for Resident #15 with an expiration date of July 2024; - A bottle of Haldol (used to treat certain types of mental disorders) for Resident #77 with an expiration date of July 2024; - A bottle of Valproic Acid (used treat seizures and bipolar disorder) for Resident #69 with the label covered with sticky liquid and illegible. <p>During an interview on 9/18/14, at 12:08 P.M., Certified Medication Technician (CMT) B said:</p> <ul style="list-style-type: none"> -Expired medications should be removed from the medication cart daily; <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The CMTs are responsible for making sure the expired medications are taken out of the medication cart;</p> <p>-He/she was not sure who was responsible for making sure the there were no loose pills in the bottom of the medication cart and that the medication cart was clean;</p> <p>-There should not be loose pills, dirt and debris in the bottom of the medication cart;</p> <p>-Any labels that are damaged or unreadable should be replaced;</p> <p>-The nurses get replacement labels for medications if needed;</p> <p>-The nurse takes care of destroying expired medications.</p> <p>During an interview on 09/18/24, at 12:16 P.M., Licensed Practical Nurse (LPN) B said:</p> <p>-Expired medications should be removed from the medication cart at least every week;</p> <p>-The CMTs are responsible for removing the expired medications from the medication cart;</p> <p>-The nurses should ensure the expired medications are removed from the medication cart by the CMTs and that the cart is clean and good order;</p> <p>-He/she does not have time to ensure this gets done;</p> <p>-There should not be loose pills, dirt and debris in the bottom of the drawers of the medication cart;</p> <p>-The nurses take care of destroying the medications.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Director of Nursing (DON) said:</p> <p>-He/she expects the CMTs to monitor the medication carts for expired medications, labels that are not readable, and general cleanliness of the medication cart;</p> <p>-He/she expects the nurses to check the medication carts as well as the CMTs to ensure there are no expired medications, the medication labels are readable and the medication carts are clean;</p> <p>-The DON should monitor at least every month.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator concurred with the DON.</p> <p>47195</p> <p>2. Review of Resident #12's, quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 9/6/24, showed:</p> <p>-He/She was cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She had clear speech and was able to make self understood and understand others;</p> <p>-He/She had no impairment to upper or lower extremities;</p> <p>Diagnosis included breathing abnormality, asthma (a lung disease that affects the airways, making it difficult to breathe), cognitive communication deficit (difficulty with communication that's caused by disruption in cognitive processes such as attention, memory, or problem solving, emphysema (a lung condition that causes shortness of breath), chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe).</p> <p>Review of the resident's care plan, revised 9/1/24, dated:</p> <p>-He/She had emphysema, chronic obstructive pulmonary disorder due to smoking;</p> <p>-Give aerosol or bronchodialator as ordered. Monitor/document any side effects and effectiveness;</p> <p>-Head of bed elevated to or out of bed upright in a chair;</p> <p>-Monitor for difficulty breathing (dyspnea) or exertion. Remind resident not to push beyond endurance;</p> <p>-Monitor for signs and symptoms of impending asthma attack: coughing spells, decreased energy, rapid breathing, complaint of chest tightness or hurting, wheezing, shortness of breath, tightness of neck or chest muscles, malaise or fatigue;</p> <p>-Monitor for anxiety. Offer support, encourage resident to vent frustrations, fears. Reassurance. Give as needed medications for anxiety as ordered.</p> <p>-Monitor/document/report as needed any signs and symptoms of respiratory infection.</p> <p>-Occupational therapy consult for energy conservation recommendations.</p> <p>Review of the physician's orders, dated 9/17/24, showed:</p> <p>-Order started 5/16/23, Preventil HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate), 2 puffs inhale orally every 4 hours as needed for shortness of breath related to chronic obstructive pulmonary disease, unspecified, emphysema, unspecified, shortness of breath or wheezing;</p> <p>-No orders to self administer medications.</p> <p>Review of the electronic medical record showed:</p> <p>-No self-administration of medications assessment completed.</p> <p>Observation on 9/16/24 at 10:06 A.M., showed an albuterol sulfate inhaler on the bedside table beside the resident's bed. The inhaler showed 50 on the side of inhaler dispenser.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 9/19/24 at 5:24 P.M., showed two inhalers laying on the bedside table in the resident's room. The ventolin inhaler at bedside with 000 showing in dispenser and albuterol sulfate inhaler with no visible number on the inhaler unit.</p> <p>Observation on 9/23/24 at 9:54 A.M., showed an albuterol inhaler labeled and dated as filled on 9/19/24. Number displaying on inhaler showed 180/16.</p> <p>During an interview on 9/23/24 at 9:43 A.M., Certified Medication Technician (CMT) A said:</p> <ul style="list-style-type: none"> -He/She was not sure if resident was allowed to keep his/her inhaler at bedside; -The inhaler is administered by the nurse; -The other nurse kept the inhaler in his/her medication cart. <p>During an interview on 9/23/24 11:19 A.M., Registered Nurse A said:</p> <ul style="list-style-type: none"> -He/She had only one resident on the Maple hall that self administered medications; -Resident #12 was not able to self administer his/her medications; -Resident #12 should not have his/her inhaler at bedside; -Residents must have physician's orders and self-administration of medications assessment completed prior to being able to self-administer medications. <p>During an interview on 9/23/24 at 3:33 P.M., the DON said residents who have medications at bedside should have a physician's order and self-administration of medication assessment.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -Residents who self-administer medications should have physician's orders; -Residents who self-administer medications should have a self-administration of medication assessment completed. <p>3. Observation on 9/16/24 at 9:08 A.M., showed the medication cart on the [NAME] hall was unlocked and unattended. The treatment cart on the Maple hall was unlocked and unattended.</p> <p>Observation on 9/16/24 at 9:33 A.M., showed the treatment cart on the Maple hallway was unlocked and unattended.</p> <p>Observation on 9/16/24 at 7:39 P.M., showed the medication cart on the [NAME] hall was unlocked and unattended in hallway outside of rooms B18 and B19. Staff was not in line of sight of the cart. Drawers to the cart were facing the middle of the hall.</p> <p>Observation on 9/16/24 at 7:46 P.M., showed the treatment cart was unlocked on the Maple hall.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 9/17/24 at 5:06 A.M., showed the medication cart on the Maple hall was left unlocked and unattended. Licensed Practical Nurse (LPN) A was observed coming out of room A-25 at the end of the hall while the medication cart was up at the nurses station.</p> <p>Observation on 9/23/24 at 8:57 A.M., showed the treatment cart was unlocked on the Maple Hall.</p> <p>Observation on 09/23/24 08:57 AM, showed the treatment cart unlocked on the Maple hall.</p> <p>During an interview on 9/23/24 at 9:43 A.M., CMT A said:</p> <ul style="list-style-type: none"> -Medication carts should be locked all the time; -He/She has observed residents come by the medication cart and grab at things on the medication cart; -The medication treatment cart should be locked, but staff sometimes forget. <p>During an interview on 9/23/24 11:19 A.M., RN A said:</p> <ul style="list-style-type: none"> -Medication carts should be locked at all times. -Medication and treatment carts should not be left unattended and unlocked. <p>During an interview on 9/23/24 at 3:33 P.M., the DON said medication carts should be locked when not attended.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said medication carts should be locked when staff are not present.</p> <p>44395</p> <p>4. Review of Resident #154 Admission MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) of 7; indicated moderate cognitive loss -Able to make self understood and understands others -Ability to make daily decisions safely is not addressed -Supervision of staff to maximum assistance of staff for ADLs. <p>-Diagnoses of Chronic Obstructive Pulmonary Disease (COPD: A group of lung diseases that block airflow and make it difficult to breathe), Chronic Kidney Disease (a condition that occurs when the kidneys are damaged and cannot filter blood properly), Post Traumatic Stress Disorder (PTSD: a mental health condition that can develop after a person experiences or witnesses a traumatic event), Tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe (trachea) to allow air to flow into the lungs), and Barrett's Esophagus (a condition that occurs when the lining of the lower esophagus changes due to stomach acid damage).</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's undated care plan showed:</p> <ul style="list-style-type: none"> -The resident had a self care deficit; -No care plan for self administration of medication or storage of medication at bedside. <p>Review of the physician orders for September 2024 showed:</p> <ul style="list-style-type: none"> -Gabapentin Oral Solution (an anticonvulsant and nerve pain medication that can have a sedative effect) give 6 milliliters by mouth three times a day for pain. Ordered 9/12/24; -Nystatin powder, apply to groin topically three times a day for yeast. Ordered 9/12/24 -No order for resident to keep medications at bedside. <p>Review of the resident's medical record showed:</p> <ul style="list-style-type: none"> -No assessment for self administration of medication. <p>Observation on 09/16/24 at 1:05 P.M. showed:</p> <ul style="list-style-type: none"> -Nystatin powder sitting in the resident's window sill. -Gabapentin liquid 250 milligram(mg)/5 ml sitting in the resident's windowsill. -The resident was not in the room <p>During an interview on 9/23/24 11:19 A.M., RN A said:</p> <ul style="list-style-type: none"> -He/She had only one resident that self administered medications; -Resident #154 should not have his/her medications at bedside; -Residents must have physician's orders and self-administration of medications assessment completed prior to being able to self-administer their own medications. <p>During an interview with the DON and the Administrator on 9/23/24 at 3:33 P. M.,</p> <ul style="list-style-type: none"> -The DON said, medications cannot be left at bedside without an order. He/She was not aware a resident had Gabapentin, a sedative medication, at bedside. -The Administrator said, she would not expect medication to be left at bedside without a physicians order and proper assessments. 		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>50980</p> <p>Based on observation, interview and record review, the facility failed to adequately staff the kitchen with enough dietary staff to ensure meals were served to residents in a timely manner. This has the potential to affect all residents of the facility. The facility census was 104.</p> <p>1. Review of facility's meal serving policy, dated 12/2/22, showed:</p> <ul style="list-style-type: none"> -Check on the resident's at regular intervals; -Offer additional fluids and water with the meal when there are no fluid restrictions; <p>Facility did not provide a policy regarding dietary staffing.</p> <p>Review of the facility's planned meal time schedule dated 9/15-9/28/24, showed:</p> <ul style="list-style-type: none"> -Breakfast 7:30 A.M. -Lunch 11:30 A.M. -Dinner 5:00 P.M. <p>Observations on 9/16/24 showed the following:</p> <ul style="list-style-type: none"> -11:47 A.M., 19 residents assembled in the dining room for the lunch meal; The dining room had only a few chairs, no place settings, no condiments, no silverware, or centerpieces to indicate a home like environment for the meal time dining experience; -12:10 P.M., Residents received packets of cream and sugar from staff eight minutes after being served coffee, no utensils were provided to the residents to stir the coffee; -12:17 P.M., Some residents received metal silverware, some received plastic utensils; -12:27 P.M., Meals service started in the dining room; -12:30 P.M., The Administrator from a sister facility assisted with passing drinks in the dining room; -12:41 P.M., Meal service was completed in the dining room; -12:50 P.M., The food cart arrived at [NAME] hall; Corporate staff helped to serve the residents noon meal hall trays; -12:58 P.M., Food cart arrived at Maple hall; Corporate RN staff assisted with meal tray pass; <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-1:00 P.M., Environmental Services staff helped pass out trays;</p> <p>-1:04 P.M., The last tray was served for lunch time service.</p> <p>Observations on 9/17/24 showed the following:</p> <p>-8:18 A.M., During breakfast service nothing was provided for residents to use to stir beverages;</p> <p>-12:04 P.M., 14 residents were sitting in the dining room, no drinks were available and no staff members were in the dining room;</p> <p>-12:08 P.M., The Activities Director started passing drinks in the dining room. The residents at the first table received one drink cup Kool-Aide which was half full. The residents at the second table received two cups of drinks iced tea and juice;</p> <p>-12:13 P.M., Residents who requested coffee did not get any;</p> <p>-12:19 P.M., The Activities Director started passing coffee and creamers, but did not provide any spoons for the residents to stir in the condiments;</p> <p>-12:31 P.M., The hall meal trays were sent to the dementia unit;</p> <p>-12:46 P.M., The first meal tray was served in the dining room;</p> <p>-12:51 P.M., Most residents' drink cups were empty in the dining room, the majority of the residents had not been served lunch and drink refills had not been offered;</p> <p>-12:59 P.M., No drink refills were offered n the dining room;</p> <p>-1:12 P.M., Hall trays delivered to [NAME] Hall. The staff were passing out meal trays, but were unfamiliar where each resident was located;</p> <p>-1:18 P.M., The last meal tray was passed out on [NAME] Hall;</p> <p>-1:30 P.M., Hall meal trays were delivered to Maple Hall.</p> <p>Observations on 9/18/24 showed at:</p> <p>-12:10 P.M., Residents were sitting in the dining room with no drinks or meals;</p> <p>-12:19 P.M., Hall meal trays were starting to go out, no change in the dining room;</p> <p>-12:43 P.M., The drinks were being served to the dining room;</p> <p>-12:45 P.M., Meals were being served in the dining room for lunch service.</p> <p>Observation of posted meal service times showed:</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Meal times were not posted anywhere in the facility;</p> <p>-Three lunch services observed, on average the first meal served to the dining room was 69 minutes late.</p> <p>During an interview on 9/23/24 at 3:30 P.M., the Administrator said:</p> <p>-Dining room meals times are 7:00 A.M. - 9:00 A.M. Breakfast, 11:30 A.M. - 1:30 P.M. Lunch, and 5:00 P.M. - 6:30 P.M. Dinner;</p> <p>-She would expect residents to have condiments and utensils readily available for each resident for their coffee.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980</p> <p>Based on observation, interview, and record review, the facility failed to ensure the food served to the residents was palatable, attractive, and at a safe and appetizing temperature when staff did not temperature check cooked foods and recipes were not followed for five (#27, #49, #90, #91, and #96) of 21 sampled residents. In addition, 15 of 20 residents from the resident council group interview said the food was cold and recipes were not followed. The facility census was 104.</p> <p>1. Review of the facility policy, on Palatability and Nutritive Value, dated 6/27/23, showed:</p> <ul style="list-style-type: none"> - Hot foods will be held at temperature 135 degrees or above and cold foods will be held at 41 degrees or below prior to serving to maintain food safety; - Best efforts will be made to present hot food hot and cold foods cold at point of service by using thermal lids and bases, heated or chilled plates and thermal pellets as necessary; - Food service staff will monitor palatability of food at point of service by periodic test tray evaluation and review of resident council concerns. <p>Review of the facility policy on Recording of Food Temperatures, dated 9/1/21 showed:</p> <ul style="list-style-type: none"> - It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled; - Hot foods will be held at 135 degrees Fahrenheit or greater; - Hot foods will be stirred during holding to redistribute heat throughout the food product; - If the food temperature falls into an unsafe range, immediately follow procedures for reheating previously cooked food; - No food will be served that does not meet the food code standard temperatures. <p>Review of the facility policy on Food Safety and Sanitation, undated, showed:</p> <ul style="list-style-type: none"> -There was no guidance on how to prepare, distribute, and serve food in accordance with professional standards for food safety. <p>Review of the facility policy on Assistance with Meals, revised September 2013, showed:</p> <ul style="list-style-type: none"> -For all residents, hot foods shall be held at a temperature of 136 degrees or above until served. Cold foods shall be held at 40 degrees or below until served. Nursing and Dietary Services will establish procedures such that delivery of food to serving areas accommodates this requirement. <p>Review of the 9/17/24 lunch menu showed, beef taco with chopped lettuce and tomato, Spanish rice, and chocolate brownie.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the beef taco recipe card, dated 9/17/24, showed:</p> <ul style="list-style-type: none"> -Brown beef in skillet until the internal temperature reaches 160 F; -Drain off fat. Add onions and cook until softened; -Combine cornstarch and seasonings in a bowl. Add to ground beef and onions. Mix well; -Add 3 quarts of water to meat mixture. Mix. Simmer for 45 minutes, stirring frequently; -Place soft taco shells in counter pans. Warm in oven; -To serve, fill each taco shell with No. 16 dipper of meat mixture; -Cover meat mixture with lettuce, then tomato, and top with shredded cheese. <p>Observation of the Beef Taco preparation on 9/17/24 showed:</p> <p>Cook A completed all the below tasks:</p> <ul style="list-style-type: none"> -9:30 A.M., Removed the defrosted beef from the refrigerator, removed packaging, and placed the beef into a large pot. -9:37 A.M., Added water to the pot with the beef and placed it on a heated stove; -9:38 A.M., Broke up the beef with a spoon while stirring the water mixture; -9:42 A.M., Added two containers of unmeasured hot water to the beef/water mixture; -9:52 A.M., Stirred the beef/water mixture on the stove; -10:03 A.M., Removed the beef mixture from the stove and poured the liquid into containers sitting on the counter. No temperature checks were taken; No strainer was used. -10:05 A.M., The pot was placed back on the stove and the beef, with remaining liquid, was stirred; -10:22 A.M., One spice was added to the beef mixture on the stove and was stirred; -10:28 -10:32 A.M., Six more seasoning ingredients were added and stirred one at a time into the mixture, the pot was covered with tin foil and placed into a heated oven. No temperature checks or taste testing was done on the mixture. -10:53 A.M., The taco meat was removed from the oven, an initial temperature check was done which read<160 F -11:30 A.M., The taco meat container was observed on the serving line covered in foil. The temperature log showed>160 F when placed on the line. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Spanish Rice recipe card, dated 9/17/24, showed:</p> <ul style="list-style-type: none"> -Cook rice according to directions; -Saute onion, peppers, and celery, cook about 10 minutes; -Add remaining ingredients (diced tomatoes, Chile sauce, tomato paste, seasonings, 1 quart water) to Sauteed vegetables; -Combine with cooked rice; -Place in oven for 1 hour in 12x20 2 pans. <p>Observation of the Spanish Rice preparation on 9/17/24 showed:</p> <p>Cook A completed the below tasks:</p> <ul style="list-style-type: none"> -10:07 A.M., Water was poured into a pot and placed on the stove under heat; -10:12 A.M., Diced celery was added to the hot water on the stove; -10:15 A.M., Diced onions were added to the hot water on the stove; -10:35 A.M., A block of butter without measurement was added to the boiling water containing celery and onions. (The recipe did not have butter as an ingredient but did have vegetable oil for the saute process which was not followed); -10:40 A.M., Uncooked rice was added to the boiling water with butter and vegetables; -10:46 A.M., Diced tomatoes, chile sauce, tomato paste and seasonings were added to boiling rice mixture; -10:49 A.M., [NAME] A said he/she will know the rice is cooked when it starts to swell up; -10:56 A.M., Temperature check of the Spanish rice showed 175 F. The mixture was placed into a heated oven to harden up. It was in a soupy state; -11:13 A.M., The Spanish rice was starting to harden up and lose the watery consistency, temperature check was 180 F, placed on the steam line, and no taste test of the product was completed. <p>Observation of meal service 9/17/24 showed:</p> <ul style="list-style-type: none"> -12:05 P.M., The meal service started, no food items were taste tested and no temperature checks were done from the steam line prior to serving residents. -12:06 P.M., Tacos are filled with a No. 16 dipper with meat into soft taco shells which were directly taken from plastic storage bag (room temperature), topped with lettuce, and tomatoes. The recipe card called for cheese, but none was added; <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The taco meat appeared watery with a pale grayish white color;</p> <p>-The Spanish Rice showed the correct consistency, however, no taste test or temperature check was done prior to serving;</p> <p>-Residents were provided rough paper towels for napkins wrapped around the silverware tightly and were wet due to sitting in semi-wet trays on the serving line before being passed to the residents.</p> <p>Observations of the Test Tray from lunch on 9/17/24 received directly after the last resident was served at 1:31 P.M., showed:</p> <p>-Taco meat temperature was 105.8 F. The meat was bland, no taste of spices, and watery.</p> <p>-The taco shell was room temperature, the shell broke apart immediately upon picking it up. The taco, lettuce and tomatoes could only be eaten with a spoon.</p> <p>2. Review of Resident #27's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/12/24 showed:</p> <p>-Resident is cognitively intact;</p> <p>-Diagnoses of heart failure, hypertension (high blood pressure), diabetes (disease of the pancreas), hyperlipidemia (high cholesterol), anxiety disorder, depression, asthma (inflammation of lung airways);</p> <p>During an interview on 9/16/24 at 10:16 A.M., the resident said the food is inedible most of the time. He/She has been served moldy hamburger buns, unidentifiable menu items, and bad quality meals with no consistency. The substitutes for hamburgers and hot dogs are equally bad. He/She takes meals in their room and the presentation of the meals is poor.</p> <p>Review of Resident #49's Quarterly MDS, dated [DATE] showed:</p> <p>-Resident is cognitively intact.</p> <p>-Diagnoses of stroke (brain damage), heart failure, hypertension (high blood pressure); diabetes (disease of the pancreas), hyperlipidemia (high cholesterol), hemiplegia (paralysis of one side of the body), depression, and PTSD (fear from a traumatic event or situation).</p> <p>During an interview on 9/16/24 at 6:30 P.M., the resident said the food is always cold and he/she is not able to chew the food very well. He/She prefers to eat in his/her own room.</p> <p>Review of Resident #90's Quarterly MDS, dated [DATE] showed:</p> <p>-Resident is moderately cognitively impaired;</p> <p>-Diagnoses of stroke (brain damage), hypertension (high blood pressure), hyperlipidemia (high cholesterol), hemiplegia (paralysis of one side of the body);</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #90's undated care plan showed:</p> <ul style="list-style-type: none"> -Resident has difficulty performing ADLs (activities of daily living) and required substantial assistance with eating. -Resident had dehydration related to poor intake of fluids. <p>Review of resident's orders, dated 7/10/24, showed:</p> <ul style="list-style-type: none"> -Regular diet, mechanical soft texture, nectar thick liquids consistency. <p>During an interview on 09/16/24 03:58 PM, the resident said:</p> <ul style="list-style-type: none"> -The food does not taste good and is so salty that he/she cannot eat it; He/She eats in his/her room; -The resident's family member said the resident eats in his/her room and is on a mechanical soft diet. The resident's family member said the food is served clumped together, which made it difficult for the resident to get a bite size. <p>Review of Resident #91's Admission MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> -Resident is cognitively intact; -Diagnoses of anemia (lack of healthy red blood cells), deep venous thrombosis (blood clots), heart failure; hypertension (high blood pressure), renal insufficiency (poor kidney function), obstructive uropathy (urinary tract issues), hip fracture, malnutrition, and asthma (inflammation of lung airways); <p>During an interview on 9/16/24 10:36 A.M., the resident said the food is often cold and difficult to chew.</p> <p>Review of Resident #96's Quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> -Resident is cognitively intact; -Diagnoses of Debility Cardio-respiratory, heart failure, hypertension (high blood pressure), diabetes (disease of the pancreas), hyperlipidemia (high cholesterol), anxiety disorder, depression, asthma (inflammation of lung airways); <p>During an interview on 9/16/24 at 11:47 A.M., the resident said the food preparation quality is done poorly, tastes bad as a result, and often times it is served very late. He/She has been living here for five months and the food has always been this way. Instead of a napkin to use with his/her meal they are given soggy paper towels. Sometimes he/she does not get the items that are listed on the menu.</p> <p>During a group interview of the Resident Council on 9/18/24 at 10:00 A.M., The residents said:</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Food service was their number one complaint at the facility;</p> <p>-Meals are not served on time and are cold or sometimes burnt;</p> <p>-Meal tickets are not followed consistently;</p> <p>-Food service is getting worse;</p> <p>-They must bring their own spoon if they want to stir cream and sugar into their coffee before it gets cold because utensils take so long to get passed out;</p> <p>-Some meals are just a clump of food that is unrecognizable.</p> <p>During an interview on 9/17/24 at 2:00 P.M., the Dietary Manager said:</p> <p>-She would expect temperature checks to be done as the recipe requires;</p> <p>-She would expect the recipe followed per the recipe card when preparing meals.</p> <p>During an interview on 9/23/24 at 9:55 A.M., the Registered Dietician said:</p> <p>-She would expect food temperatures checked on the steam line right before beginning meal service;</p> <p>-She would expect temperature checks to be done per the recipe card if it's called for;</p> <p>-Taco shells should be heated up per the recipe card for the beef taco menu;</p> <p>-She would not expect hot foods to be held at 135 F when serving hall trays to residents, it's fine as long as it's above 120 F;</p> <p>-The difference between the serving line of 135 F and the 120 F serving hall requirement is because you're always going to lose heat between serving and getting the trays to the residents, it must be over 120 F.</p> <p>51166</p> <p>During an interview on 9/23/14 at 3:30 P.M., the Administrator said:</p> <p>-She would expect residents served coffee to have cream and sugar readily available and utensils for stirring their coffee;</p> <p>-Would expect residents to have access to clean napkins for each meal;</p> <p>-She expects that recipes can be done in any order and that the staff are fully competent to add ingredients in any order they choose;</p> <p>-She expects temperature checks to be done when required;</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She would expect food temperatures checked on the serving line prior to serving the first meals to residents.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50980</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, and serve food in accordance with professional standards of food service safety when staff failed to manually clean and sanitize kitchen equipment, failed to maintain a clean and sanitary kitchen, failed to wash hands, failed to date and label foods, and failed to wear hair and beard coverings. This had the potential to affect all residents in the facility. The facility census was 104.</p> <p>1. Review of the facility's policy on three compartment sinks, undated, showed:</p> <ul style="list-style-type: none"> - Dishes and cookware will be cleaned and sanitized after each meal; - Check sanitation sink frequently using a test strip to ensure the level of sanitizing solution is appropriate; - Sink One Wash: Prepare the clean sink by measuring the appropriate amount of water into the sink and marking the sink with a water line. Determine the appropriate amount of detergent to be used. Water should be 110 F. Change water frequently to ensure effective cleaning of dishes; - Sink Two Rinse: Prepare the clean sink with hot water; - Sink Three Sanitize: Measure the appropriate amount of sanitizing chemical into the water. It should be 75 to 100 F. Test the sanitizing solution using test strips. Sanitize according to chart time (not provided). <p>Review of the facility's policy on sanitizer buckets, undated, showed:</p> <ul style="list-style-type: none"> - Sanitation solution will be used on items too large to immerse in sink and areas of production; - Sanitation buckets are changed as often as necessary, but not to exceed longer than 4 hours. <p>Observation on 9/16/24 9:00 A.M. showed, the three sink manual washing temperature log was missing for the month of August.</p> <p>Observation on 9/16/24 at 9:24 A.M. showed, no sanitizing buckets were visible in the kitchen.</p> <p>Observation on 9/17/24 at 9:12 A.M. showed:</p> <ul style="list-style-type: none"> -No temperature checks were documented on the log book for the three compartment sink for September 16th; -Dietary [NAME] B was observed filling the three compartment sinks and pre-washing cookware without taking any temperatures or testing the sanitizing solution concentration. <p>Observation on 09/17/24 at 9:23 A.M. showed:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cook A washed the cookware in sink one, moved them to sink two, rinsed off the cookware in hot water in sink two, and transferred to sink three.</p> <p>- 45 seconds later [NAME] A removed the items from the sanitizer sink and placed them on the sink counter to dry. No temperature or sanitizing solution checks were done.</p> <p>Continuous observation on 9/17/24 from 9:30 A.M. through 1:15 P.M. showed:</p> <ul style="list-style-type: none"> - Sanitizing buckets were not changed out after over four hours of use; - No temperature or sanitizing concentration checks were done over the last four hours. The water was not changed out in any of the sinks. <p>During an interview on 9/18/24 at 2:15 P.M., the Dietary Manager said:</p> <ul style="list-style-type: none"> - She would expect temperature checks for the three-sink manual wash station are taken morning, lunch, and dinner and for each use; - She would expect the sanitizing buckets to be visible in the kitchen during meal service times. <p>During an interview on 9/23/24 at 9:55 A.M., the Registered Dietician said:</p> <ul style="list-style-type: none"> - She would expect temperatures to be checked prior to washing dishes manually; - She would expect sanitizing buckets to be stationed throughout the kitchen for all meals. <p>2. Review of the facility's policy on sanitation inspections, dated 9/1/21, showed:</p> <ul style="list-style-type: none"> - All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. - Daily food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher temperatures daily. - Weekly, the dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations. - Inspections will be conducted but not limited to the following areas: Dry storage, freezer, refrigerator, dish room, pot wash, main production area, food preparation area, general dietary observations. <p>Observation on 09/16/24 08:59 AM, in the kitchen showed:</p> <ul style="list-style-type: none"> - Excessive dust and dirt on the ventilation ducts; - Floors were sticky throughout the kitchen, storage areas and cleaning stations; - Accumulation of dust/dirt on the wall next to the refrigerator; <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Avalon View Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 West College Street Liberty, MO 64068	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Accumulation of dust, dirt, screws, and lint on top of the freezer; - Vent duct overhead had an accumulation of lint; - Two ovens had old burned food debris inside; - Behind the stove there was a dirty oven shelf grate lying on the floor; - Behind the stove there was a large quantity of food and grease build up; - Vents behind the stove were covered in exhaust dust; - Food splatter on the slicer; - The microwave had old food splattered inside; - Paint was missing and debris and dirt build up near the 3 three compartment sink; - Surface area, where plates were staged at the steam line for serving, were noted to have visible old food debris; - Walls were dirty throughout the kitchen area, with dried food on the walls and ceiling surfaces; - The top of the tea machine had sticky dried liquid and debris; - The juice machine had dust on the exhaust fans; - Liquid had dripped onto the floor below the tea station; - Cut off plastic ties were lying on the kitchen floor. <p>Observation on 09/16/24 09:15 A.M., of the dry storage room showed:</p> <ul style="list-style-type: none"> - Loose ceiling material was hanging, a potential contamination risk; - Dust build up on the walls. <p>Observation on 09/16/24 09:22 A.M., of the cleaning closet showed:</p> <ul style="list-style-type: none"> - Cluttered floor with dust pans and tools, a possible harbinger for rodents and insects; - Sink was rusted; - Shelves had visible debris on top of them and an accumulation of dust; - Lint and dust were on the vents and walls. <p>Observation on 9/16/24 10:25 A.M., in the dining room showed:</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Orange substance build up over the internal metal lip right above the ice dispensing chute inside the ice machine; - Trash can without a lid, stored in the dining room containing food debris and trash; - Floor going into the kitchen had visible dirt and grime build up. <p>Observation on 09/17/24 at 12:22 P.M. showed:</p> <ul style="list-style-type: none"> -Cook C emptied cut up tomatoes directly into a container on the steam line from a large cutting board. The bottom surface of the cutting board made contact with the inside of the food serving container as the food transfer was made causing potential cross contamination. <p>During an interview on 9/18/24 at 2:15 P.M., the Dietary Manager said:</p> <ul style="list-style-type: none"> - The floors are sticky because they needed to be waxed; - Dust and dirt on the ventilation ducts should be cleaned; - The top of the freezer surface area should be free of dust, dirt, screws and lint; - The kitchen in its current state is clean and up to their standards; - He/She would not expect ovens to have old food debris; - He/She would not expect the cleaning closet to be cluttered and strewn with cleaning tools on the floor; - He/She would expect the ice machine to be free of dirt buildup inside the machine; - He/She would expect lids on all trash cans. <p>During an interview on 9/23/24 at 9:55 A.M., Registered Dietician said:</p> <ul style="list-style-type: none"> - She would expect deep cleaning around equipment and kitchen surfaces to be done weekly and that there is a cleaning schedule posted; - She would expect ventilation openings to be free of dirt and dust build up. <p>3. Review of the facility's policy on handwashing guidelines for dietary employees, 9/1/2021, showed:</p> <ul style="list-style-type: none"> - The facility shall provide a handwashing sink(s), with supply of hand cleaning solutions, in a location that is convenient for use by employees in food preparation, food dispensing, ware washing areas and in or immediately adjacent to toilet rooms. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Frequency of Handwashing: (a) After hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, (b) after hands have touched bare human body parts other than clean hands (such as face, nose, hair), (c) while preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, (d) before donning (applying) gloves for working with food, (e) after engaging in any activity that may contaminate the hands.</p> <p>- Handwashing procedure: turn on water to a comfortable warm temperature, rinse thoroughly under clean, running warm water.</p> <p>Observation on 9/16/24 at 9:00 A.M., showed, the cold-water faucet did not work and only hot water came out at the sink.</p> <p>Observation on 9/17/24 at 9:28 A.M., showed [NAME] A did not wash his/her hands after working in the sink area before applying gloves and working with meat.</p> <p>Observation on 9/17/24 at 9:30 A.M. showed:</p> <p>- [NAME] A moved beef from the defrosting stage in the refrigerator to the prep area and opened all beef packages, disposed of trash, put utensils into wash sink, and removed gloves;</p> <p>- [NAME] A added water to the pan with meat, and had not washed his/her hands since working with raw meat and removing gloves.</p> <p>Observation on 09/17/24 at 10:08 A.M. showed, [NAME] A did not wash hands before applying gloves after working at stove area, and then went to the prep area and chopped up green peppers.</p> <p>Observation on 09/17/24 at 12:27 P.M. showed:</p> <p>- [NAME] C chopped and prepared a hot dog by wrapping it in tin foil while wearing gloves;</p> <p>- [NAME] C wiped his/her gloved hands off on their apron so he/she could use a pen to write on the product wrapping;</p> <p>- [NAME] C then started preparing a 2nd hot dog with the same gloves, pulled out a bun and filled it with a hot dog with the gloved hands then changed the gloves.</p> <p>Observation on 09/17/24 12:45 P.M. showed, [NAME] C stopped cutting tomatoes and went to the back office with gloves on and picked up and delivered a box of tea to a staff member at the kitchen door. [NAME] C then removed both gloves, put on new gloves, did not wash hands, and went back to the food prep area to prepare a hamburger. [NAME] C used a gloved hand to catch burger grease/water as he/she walked the item across the kitchen then started working on dicing tomatoes with the same gloved hands.</p> <p>During an interview on 9/23/24 at 9:55 A.M., the Registered Dietician said, he/she would expect hot and cold water at the handwashing station.</p> <p>4. No policy on the requirement for hair and beard coverings was provided.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 09/17/24 at 12:04 P.M. showed:</p> <ul style="list-style-type: none"> - Dishwashing Aide A not wearing a beard covering over moustache; - Maintenance staff entered the kitchen without a hairnet covering. <p>Observation on 09/17/24 at 1:12 P.M. showed:</p> <ul style="list-style-type: none"> - [NAME] A wore a beard covering below the chin while working with food in the kitchen. <p>5. Review of facility's policy on food storage, undated, showed:</p> <ul style="list-style-type: none"> - All food stock and products are stored in approved sanitary storage containers, of food quality plastic bags, covered, labeled as to contents, and dated. <p>Review of facility policy, food storage (dry, refrigerated, and frozen), undated, showed:</p> <ul style="list-style-type: none"> - Goods that have been opened with no date, left on the floor, or not properly sealed will be discarded; - Dry goods: food stored in bins are removed from original packaging. Bins are labeled and dated. All open products are sealed, labeled, and dated; - Refrigerated foods: open products are sealed, labeled, and dated; - Frozen foods that are taken out of original packaging, product is labeled and dated. <p>Observation on 09/16/24 at 0910 A.M. showed:</p> <ul style="list-style-type: none"> - Loose frozen hash browns in a plastic bag in the freezer with no date or label; - Loose pie shell in a plastic bag in the freezer with no date or label; - One shelf of bread not labeled with a date; - No date or label on raw onion bin; - No date on an oatmeal pie box opened. <p>During an interview on 9/18/24 at 2:15 P.M., the Dietary Manager said:</p> <ul style="list-style-type: none"> - Unlabeled bags in the freezer should be labeled and have a date written on them with a magic marker but the marker wears off. They are looking for other solutions; - Vegetables such as red onions kept in a bin should have a sticker with a date on it which is their normal process. 		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>44395</p> <p>Based on observation, record review, and interview, the facility failed to maintain all areas of the facility in a safe, functional, sanitary and comfortable environment for visitors, staff and residents. The facility census was 104.</p> <p>Review of the facility provided policy Routine Cleaning and Disinfection dated 9/1/21 showed:</p> <ul style="list-style-type: none"> -It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment. -Cleaning refers to the removal of visible soil from objects and surfaces. -Horizontal surfaces with infrequent hand contact (window sills and hard surface flooring) in routine areas should be cleaned on a regular basis; when soiling or spills occur; when a resident is discharged . -Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. <p>Review of the facility provided, undated, policy Safe and Homelike Environment included, in accordance with resident rights the facility will provide a safe, clean, comfortable and homelike environment.</p> <p>Observations beginning on 09/16/24 at 12:58 P.M. on [NAME] Hall showed:</p> <ul style="list-style-type: none"> -Large cobwebs with dead bugs at the corner of the exit door; -Wall paper trim was bubbled and coming off the walls; -The exit door was rusted in multiple places with visible daylight at the bottom on the latch side; -Multiple gouges and nicks in the wallpaper on the upper 2/3 of the hallway, with spackle over them; -Cobwebs on the air vent; -Multiple light fixtures with dead bugs and debris; -Multiple ceiling tiles surrounding air vent, with brown water stains, outside room B9; -Multiple mechanical hand sanitizer drip trays with dirt, debris and dead bugs. <p>Observation of the Director of Nursing Office showed:</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> -Light fixtures with dead bugs and debris; -Cobwebs in the corners with dead bugs and debris; -Gouges and scrapes in the sheet rock. <p>Observation on 09/18/24 at 12:33 P.M. showed on the Special Care Unit:</p> <ul style="list-style-type: none"> -Entry door push bar was loose from the door panel on both sides of the door; -Entry door was scuffed with black scuff marks; -Tiled floor had multiple scratches and black scuff marks; -Baseboards in the dining area had thick black debris along the floor line; -The dining room window blinds were broken and jagged, with zip ties holding them to the window sill; -The air conditioning units, in the dining room, were loose from the wall; -The ceiling vent was covered with dirt, dust and black debris; -The wallpaper was peeled and bubbled away from the wall; -The ceiling vent outside room E25 was coated with dirt and dust; -The ceiling above the nurses station had 2 lights burned out, both had dirt and debris; -The nurses station desk was chipped in eight places; - The outlet cover was broken and the floor in that area was dirty with dirt and debris; - The shower room curtain had dirt, debris and black mold like substance on both sides; -The baseboards were warped and curved away from the wall, had dirt and debris at edges, and were missing at the nurses station; -No window screen in Room E1. <p>During an interview on 09/23/24 at 7:33 A.M., Housekeeper A said:</p> <ul style="list-style-type: none"> -He/She completed daily cleaning of the resident bathrooms, and mops the floor; -One person cannot complete everything that needed to be completed; -There is a floor technician in the evening to buff floors; <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-There was no check off list for completed tasks.</p> <p>During an interview on 09/23/24 at 8:17 A.M., the Housekeeping Supervisor said:</p> <p>-The Administrator expects the facility to be clean and odor free;</p> <p>-Cleaning is completed daily by a list;</p> <p>-He/She expects the facility to be clean, odor free and floors and ceilings to be free of dirt and debris.</p> <p>During an interview on 9/23/24 at 9:11 A.M., the Maintenance Director said:</p> <p>-He had been employed in the facility four months;</p> <p>-Morning meetings are where he finds out repairs that are needed, or staff can fill out a work order;</p> <p>-He knew of the broken window a few days ago;</p> <p>-He completed weekly walk through inspections with Administration;</p> <p>-He tried to paint over some of the water damage after walk through with investors;</p> <p>-He tried to find leaks and fix them as he can;</p> <p>-He expects things to be in good repair;</p> <p>-The baseboards are paint stained. Housekeeping is responsible for cleaning baseboards;</p> <p>-Repairs are prioritized by need;</p> <p>-Housekeeping is responsible for all floors, dusting and baseboard cleaning;</p> <p>-Maintenance is responsible for light fixture cleaning, and repair;</p> <p>-Vents are maintenance responsibility; he has not seen anything that looks like mold; filters are changed once a month;</p> <p>-He used a log book to know what needs fixed. If it was not on the log then it would not be fixed;</p> <p>-Log books were at each nurses station and any staff can write in them.</p> <p>During an interview on 9/23/24 at 3:33 P.M., the Administrator said:</p> <p>-Housekeeping was to complete daily cleaning to include dusting and high dusting;</p> <p>-She expected the facility to attempt to be odor free as much as possible;</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Vents, floors and ceilings should be cleaned by housekeeping and maintenance as a collaborative effort;</p> <p>-Anyone can put a work order in if something is broken;</p> <p>-Each Department Head completes weekly rounds and would make a note of any issues that need addressed by a different department;</p> <p>-She would expect work orders to be completed if the department head found a concern for maintenance;</p> <p>-They have made progress in the cleanliness of the building but had more to go.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>44395</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to prevent flies and roaches. The facility census was 114.</p> <p>Review of the facility provided Pest Control Policy dated 9/1/22 showed:</p> <ul style="list-style-type: none"> -It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents -The facility will utilize a variety of methods in controlling certain seasonal pests, i.e. flies. These will involve indoor and outdoor methods that are deemed appropriate by the pest service and state and federal regulations. <p>Observations beginning on 09/16/24 at 12:58 P.M. on [NAME] Hall showed:</p> <ul style="list-style-type: none"> -Large cobwebs with dead bugs at the corner of the exit door. -Multiple flies in room B1. <p>Review of Resident #52's admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 7/26/24, showed:</p> <ul style="list-style-type: none"> -His/Her cognitive ability was not testable; -He/She had no speech; -He/She rarely or never understand others; -He/She had limited range of motion in upper and lower extremities on both sides; -He/She was dependent on a wheelchair for mobility; -He/She was dependent for all cares and mobility; <p>-Diagnoses included: aphasia (a language disorder that affects a person's ability to understand and express language), muscle weakness, lack of coordination, epilepsy (a chronic brain disorder that causes seizures, which are brief episodes of involuntary movement or altered consciousness), and Retts syndrome (a rare genetic disorder that affects the brain and causes a loss of skills and abilities).</p> <p>Observation on 9/16/24 at 7:26 P.M. showed:</p> <ul style="list-style-type: none"> -He/She had flies flying around his/her room; -There were two sticky fly traps hanging on the wall above resident's bed. <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/16/24 at 7:26 P.M. the resident representative said:</p> <ul style="list-style-type: none"> -The resident had excessive flies in his/her room; -The flies would land on the resident's face and he/she could not swat them away; -Flies in the room have been a problem since admission; -He/She purchased fly strips to hang in the resident's room to combat the problem. <p>During an interview on 9/23/24 at 9:11 A.M. the Maintenance Director said:</p> <ul style="list-style-type: none"> -Pest control is completed by an outside company. <p>During an interview on 9/23/24 at 3:33 P.M. the Administrator said:</p> <ul style="list-style-type: none"> -He/She was aware there were flies in the facility. -He/She expected the facility to be as free of pests as possible. -There is an outside company for pest control. -The outside company comes monthly to check and spray for pests. <p>The facility did not provide pest control invoices.</p>		