

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE 17451 Medical Center Parkway Independence, MO 64057	

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 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37841</p> <p>Based on observation, interview and record review, the facility failed to provide care in a respectful and dignified manner when Certified Nursing Assistant A (CNA) forcefully pushed Resident #1 into his/her recliner out of three sampled residents. The facility census was 55 residents.</p> <p>On 4/22/24, the Administrator were notified of the past noncompliance (PNC) for an incident that occurred on 4/15/24. The facility administration had all staff in-serviced on abuse and neglect, customer services, resident rights and dignity. The deficiency was corrected on 4/15/24.</p> <p>Review of the facility policy titled Dignity, dated 2/2001 showed:</p> <ul style="list-style-type: none"> -Residents are treated with dignity and respect at all times. -The facility culture supports dignity and respect for residents by honoring resident goals, choices preferences, values and beliefs. -Individual needs and preferences of the resident are identified through the assessment process. -When assisting with care, residents are supported in exercising their rights, such as: <ul style="list-style-type: none"> --Groomed as they wish to be groomed (hair styles, nails, facial hair, etc). --Encouraged to attend the activities of their choice, including religious, political, civic, recreational or social activities. --Allowed to choose when to sleep, eat and conduct activities of daily living (ADL's - those activities that people perform every day, such as eating, dressing and hygiene). --Staff do not handle or move a resident's personal belongings with the resident's permission. -Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. -Demearing practices and standards of care that compromise dignity are prohibited. <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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff are expected to promote dignity and assist residents; for example:</p> <p>-Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example:</p> <p>--Addressing the underlying motives or root causes for behavior, and not challenging or contradicting the residents beliefs or statements.</p> <p>1. Review of Resident #1's facility face sheet showed the resident admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should).</p> <p>-Meniere's Disease (a disease of the inner ear that can cause a person to get dizzy and have trouble hearing).</p> <p>-Alzheimer's Dementia (a progressive disease that destroys memory and other important mental functions).</p> <p>-Pain.</p> <p>-Anxiety.</p> <p>-Age related Physical Debility.</p> <p>-Depression.</p> <p>-Mood Disturbance (a type of mental health condition where there is a disconnect between actual life circumstances and the persons state of mind or feeling).</p> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool that facilities use for care planning) dated 2/13/24 showed:</p> <p>-The resident has severe cognitive impairment.</p> <p>-He/she requires assist of one staff for all activities of daily living.</p> <p>Review of the resident's care plan dated 2/28/19 showed:</p> <p>-The resident is dependent on staff for meeting emotional, intellectual, physical and social needs.</p> <p>-The resident has an Activity of Daily Living (ADL) self-care performance deficit related to Alzheimer's dementia, limited mobility and pain.</p> <p>-The resident has impaired cognitive function/dementia or impaired thought processes related to diagnoses.</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident is high risk for falls related to deconditioning, incontinence, poor communication/comprehension, unaware of safety needs, leaves walker behind when ambulating.</p> <p>Review of the facility investigation dated 4/15/24 showed:</p> <p>-Persons involved in the incident were Resident #1 and CNA A.</p> <p>-Witnesses were the family via observation on video from video camera in the resident's room.</p> <p>-Family observed CNA A on video to be physically aggressive with the resident during cares.</p> <p>-CNA A rushed the resident into his/her recliner and appeared to push him/her into recliner with too much force.</p> <p>-The local police department was notified.</p> <p>During an interview on 4/17/24 at 10:00 A.M., Local Police Department said:</p> <p>-The CNA was assisting Resident #1 to his/her room and then the CNA backed up and shoved Resident #1 into his/her chair and closed the door and just left him/her in the room.</p> <p>-Resident #1 was turning around to sit down and was too slow and the CNA shoved him/her in the chair.</p> <p>-Family came to visit the resident, and resident was upset but couldn't vocalize the problem and the family watched the video and saw the incident.</p> <p>Observation of the video on 4/22/24 showed:</p> <p>-CNA A and Resident #1 entering the resident's room, with CNA A behind Resident #1, with his/her hand on the resident's back, while Resident #1 was walking with a walker.</p> <p>-CNA A was guiding the resident to the recliner in a rough manner, by pushing the resident forward.</p> <p>-When the resident reached the recliner, CNA A moved his/her hand to turn the resident around, while pushing the resident into the recliner.</p> <p>-The resident landed in the recliner with a hard landing.</p> <p>-The resident had a facial expression of confusion, while the CNA left the room.</p> <p>During an interview with Resident #1 on 4/22/24 at 11:45 A.M., he/she said:</p> <p>-He/she is fine, how are you?</p> <p>-Yes, everyone treats him/her very well here, thank you.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-No, he/she doesn't think anyone was every rough with him/her.</p> <p>-He/she shakes head no, when asked if he/she remembers the incident with CNA A.</p> <p>During an interview with the Administrator on 4/22/24 at 12:05 P.M., he/she said:</p> <p>-He/she doesn't want CNA A working here with the residents.</p> <p>-He/she plans on terminating the CNA regardless of the outcome of State Agency (SA) investigation.</p> <p>-He/she watched the video that the family of Resident #1 sent him via email, and thought what if that was his/her mother?</p> <p>-He/she couldn't tolerate having residents treated in that manner.</p> <p>During an interview with CNA A on 4/22/24 at 1:30 P.M., he/she said:</p> <p>-He/she doesn't remember the incident really at all.</p> <p>-He/she wouldn't ever want to hurt anyone, or cause them to feel bad.</p> <p>-He/she may have just been in a hurry, but doesn't really remember at all.</p> <p>During an interview on 4/23/24 at 9:20 A.M., Resident #1's Durable Power of Attorney (DPOA) said:</p> <p>-If he/she didn't have the diagnoses of Alzheimer's dementia, and could remember things, he/she would have been furious at that CNA treated him/her.</p> <p>-He/she has no doubt in his/her mind that the resident would have been very mad and very hurt by how the CNA treated him/her.</p> <p>-The family did make the decision to not press charges against the CNA.</p> <p>MO00234815</p>		