

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  02/19/2025
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 0567</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 manage his or her financial affairs.</p> <p>19916</p> <p>Based on interview and record review, the facility failed to maintain authorization forms for three sampled residents (Residents #5, #2, and #39) out of four residents sampled for the resident trust review. The facility census was 55 residents.</p> <p>Review of the facility's policy entitled Resident Trust Policy and Procedures, dated March 2023, showed:</p> <ul style="list-style-type: none"> <li>-Purpose: Baptist Homes and Healthcare Ministries need to be good stewards of the money entrusted to us by our residents and their families.</li> <li>-This policy and procedures document outlines a general guide and specific steps on how to handle resident trust funds across the organization.</li> <li>-General Information regarding responsibilities of holding Resident Funds: <ul style="list-style-type: none"> <li>--Personal Funds of the resident shall be used exclusively for the resident, which must be authorized in writing. The individuals who can authorize such transactions may be the resident, his/her legal guardian, or a legal representative (who may not be an employee at the facility, including the Administrator). The facility is allowed to purchase a burial plan for the resident when written authorization is obtained.</li> </ul> </li> </ul> <ol style="list-style-type: none"> <li>1. Review of the Resident Fund records for Resident #5 showed the absence of signed authorization forms which allowed the facility to manage funds on behalf of the residents.</li> <li>2. Review of the Resident Fund records for Resident#2 showed the absence of signed authorization forms which allowed the facility to manage funds on behalf of the residents.</li> <li>3. Review of the Resident Fund records for Resident #39 showed the absence of signed authorization forms which allowed the facility to manage funds on behalf of the residents.</li> </ol> <p>During an interview on 1/23/25 at 3:31 P.M., the Business Office Manager (BOM) said:</p> <ul style="list-style-type: none"> <li>-The previous BOM did not keep track of the authorization forms, which were signed by the residents.</li> </ul> <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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she had only been in the position since December 17, 2024.</p>

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>19916</p> <p>Based on interview and record review, the facility failed to maintain records of reconciled (a process that takes place when the deposits, credits and interest that are on record but were not accounted for on the final bank statement; are added to the final amount on the bank statement, then checks and charges that are on record, but were not listed on the bank account statement, are subtracted from the adjusted final amount) banks statements dated January 2024 to September 2024; failed to maintain the monthly ending petty cash (small amount of discretionary funds in the form of cash used for small cash disbursements) amounts from January 2024 to December 2024; failed to maintain signatures or receipts of withdrawals from one sampled resident's (Resident #5's) account; failed to post (make a record of ) deposits into the resident trust fund accounts in a timely manner for two sampled residents (Resident#5 and #2) of four residents selected for resident trust fund review. This practice potentially affected 44 residents who allowed the facility to manage their resident trust funds. The facility census was 55 residents.</p> <p>Review of the facility's policy entitled Resident Trust Policy and Procedures, dated March 2023, showed:</p> <p>-Purpose: Baptist Homes and Healthcare Ministries need to be good stewards of the money entrusted to us by our residents and their families. This policy and procedures document outlines a general guide and specific steps on how to handle resident trust funds across the organization.</p> <p>-General Information regarding responsibilities off holding Resident Funds:</p> <p>--The facility shall keep an accurate, maintained accounting system for the residents that choose to have their personal funds managed. These funds shall be safeguarded by the facility, using complete and separate accounting principles, which precludes any commingling of resident funds with facility funds.</p> <p>--Personal Funds of the resident shall be used exclusively for the resident, which must be authorized in writing. The individuals who can authorize such transactions may be the resident, his/her legal guardian, or a legal representative (who may not be an employee at the facility, including the Administrator). The facility is allowed to purchase a burial plan for the resident when written authorization is obtained.</p> <p>--Records related to the resident funds shall be maintained in the facility or shall be made available for review and copying, in their entirety, within 24 hours of a request for access by the Social Security Administration, Missouri Department of Health and Senior Services or other Federal and State Agencies.</p> <p>--Social Security checks (SSA) that include both room and board and the monthly personal allowance should be deposited in the resident trust account and then the room and board amount is transferred to the site account.</p> <p>1. Review of the Reconciled Bank statements, dated January 2024 to December 2024, showed:</p> <p>(continued on next page)</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The absence of the bank statements from January 2024 to September 2024.</p> <p>-The absence of the monthly ending balances of petty cash dated January 2024 to December 2024.</p> <p>During an interview on 1/23/25 at 11:40 A.M., the Assistant Director said the reconciled bank statements should be uploaded to a file at the corporate level.</p> <p>During an interview on 1/23/25 at 11:44 A.M., the Business Office Manager (BOM) said there was no documentation of reconciled bank statements from January 2024 to September 2024.</p> <p>During an interview on 1/23/25 at 11:58 A.M., the BOM said the previous BOM has been gone since 11/5/24, and that BOM did not do reconciliations of the bank statements.</p> <p>During an interview on 1/23/25 at 3:17 P.M., the BOM said:</p> <p>-He/she was trying to figure out the record keeping processes of the facility.</p> <p>-The reconciliations from January 2024 to September 2024 should have been uploaded to the corporate file for the facility.</p> <p>2. Review of the Petty Cash Count Sheet (a one day accounting of how much money was actually in the petty cash box and added to the amount of money that had already been withdrawn over a certain time period) showed a difference of \$19.00 between the amount in the petty cash box and added to the amount that was already spent.</p> <p>-The beginning amount of the petty cash was \$500.00 on 12/18/24.</p> <p>-The amount in the petty cash box was \$180.00</p> <p>-The amount of money that was already spent, was \$301.00.</p> <p>-There was a difference of \$19.00 between what the amount should have been \$500.00 and the amount that was totaled on the Petty Cash Count sheet, which was \$481.00.</p> <p>During an interview on 1/23/25 at 12:07 P.M., the BOM said the facility had not tracked any petty cash in October 2024, November 2024, and December 2024.</p> <p>During an interview on 1/23/25 at 1:37 P.M., the BOM said:</p> <p>-He/she started on 12/17/24 and he/she may have missed recording cash withdrawals on 12/18/24 and 12/19/24 just a few days after he/she started.</p> <p>3. Review of Resident #5's Trust Statement showed:</p> <p>-A deposit of \$1,493.00 which was transferred into the resident's account in October 2024.</p> <p>-The absence of the amount being posted (properly accounted for) in that month.</p> <p>(continued on next page)</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The amount of \$1,493.00 was posted on 12/31/24, which caused the resident trust account to increase to \$6,789.79, which was above the Missouri (MO) Health Net limit of \$5,909.25.</p> <p>During an interview on 1/23/25 at 12:46 P.M., the BOM said:</p> <p>-There was a deposit for \$1,493.00 that originally came in October 2024, but was not posted by the previous BOM.</p> <p>-That amount did not get posted until 12/31/24 by the current BOM, which caused the resident's account balance to exceed the MO Healthnet limit.</p> <p>4. Review of Resident #2's Trust Statement showed:</p> <p>-A deposit of \$1,395.00 which was transferred into that resident's account in October 2024.</p> <p>-The absence of the amount being posted in that month.</p> <p>-The amount of \$1,395.00 was finally posted on 12/31/24 which caused the resident trust account to increase to \$5,921.88, which is above the MO Health Net limit of \$5,909.25.</p> <p>During an interview on 1/23/25 at 12:58 P.M., the BOM said:</p> <p>-There was a deposit of \$1,395.00 that came in October 2024, but was not posted in October 2024 by the previous BOM.</p> <p>-That amount did not get posted until 12/31/24 by the current BOM which caused the resident's account balance to exceed the MO Healthnet limit.</p> <p>5. Review of Resident #5's trust statement showed a withdrawal of \$100.00 on 9/10/24 and a withdrawal of \$50.00 on 10/10/24 with no receipt or signature for the withdrawals.</p> <p>During an interview on 1/23/25 at 12:51 P.M., the BOM said:</p> <p>-He/she started the position at the facility on 12/17/24.</p> <p>-There were no receipts or signatures for the withdrawals completed in September 2024 and October 2024.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39469</p> <p>Based on interview and record review, the facility failed to have a consistent code status (a medical directive that specifies the type of resuscitation and medical interventions a patient wishes to receive in the event of a cardiac or respiratory arrest) in the resident's medical record for one sampled resident, (Resident #54); and did not have a code status listed in the electronic health record for one sampled resident (Resident #209) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility's Code Status Designation policy, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-A code status would have been identified and supported by a physician's order to facilitate providing emergency care and services to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing in accordance with the comprehensive care plan.</li> <li>-Upon admission, the Social Worker, or designee would have reviewed the resident's Advanced Directive (a legal document that states a person's wishes for medical care if they were not able to communicate them) and initiate action to secure a code status order.</li> <li>-The code status order would have been signed by a physician.</li> <li>-Each facility would have a method for identifying resident code status.</li> </ul> <p>1. Review of Resident #54's face sheet showed:</p> <ul style="list-style-type: none"> <li>-A diagnosis of Cognitive Communication Deficit (a difficulty with communication caused by impairment in cognitive processes affecting how a person speaks, listens, reads, writes, and interacts socially).</li> <li>-There was no place for a code status to be listed.</li> <li>-There was no code status listed.</li> </ul> <p>Review of the resident's Physician's progress notes, dated [DATE], showed his/her code status was full code (if a person's heart stops they wish medical personal to perform life saving measures).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning), dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-He/She was able to understand others.</li> <li>-He/She was able to be understood.</li> </ul> <p>Review of the resident's Physician's progress notes, dated [DATE], showed his/her code status was full code.</p> <p>(continued on next page)</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>Review of the resident's Outside the Hospital DNR Order dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-The resident signed the document on [DATE].</li> <li>-The physician signed the document on [DATE].</li> <li>-The physician's name was not typed or printed.</li> <li>-The physician's license number was blank.</li> </ul> <p>Review of the resident's Physician's Progress notes, dated [DATE], showed his/her code status was full code.</p> <p>Review of the resident's care plan, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-The resident passed away on [DATE].</li> <li>-The resident's code status was revised, the resident was listed as a Do No Resuscitate (DNR not to perform cardiopulmonary resuscitation (CPR) if a patient's heart stops beating or breathing stops); dated [DATE].</li> <li>-If the resident was found with no pulse or respirations, no lifesaving interventions would be implemented, dated [DATE].</li> </ul> <p>During an interview on [DATE] at 9:10 A.M., Licensed Practical Nurse (LPN) C said:</p> <ul style="list-style-type: none"> <li>-There was a notebook at the nurses's station that had the resident's code status.</li> <li>-The resident was a DNR effective [DATE].</li> <li>-The resident passed away on [DATE].</li> <li>-The Social Service Designee (SSD) was responsible for ensuring residents wishes regarding code status were documented.</li> <li>-A resident's code status should have been on the DNR sheet, POS, and on the care plan.</li> <li>-The code status should have been the same throughout the chart.</li> <li>-If there was a change it should have been changed that day.</li> <li>-The DNR sheet should have been completed by the physician which would have included his/her signature, the physician's name typed or printed, and should have included the physician's number.</li> </ul> <p>During an interview on [DATE] at 9:50 A.M. Certified Medication Technician (CMT) C said:</p> <ul style="list-style-type: none"> <li>-A resident's code status should have been on the resident's face sheet.</li> </ul> <p>(continued on next page)</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>-This resident's code status was not on the face sheet.</p> <p>-They had a notebook at the nurses' station with the residents names who wished to have been a DNR.</p> <p>-The resident was a DNR.</p> <p>-The SSD or the nurses should have ensured the resident's code status was the same throughout the chart.</p> <p>37576</p> <p>2. Review of Resident #209's Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <p>-Heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).</p> <p>-Chronic (persisting for a long time or constantly recurring) kidney disease (CKD- is a condition characterized by a gradual loss of kidney function over time).</p> <p>Review of the resident's Admission MDS, dated [DATE], showed the resident admitted with the following diagnoses:</p> <p>-Atrial Fibrillation ( A-Fib a condition where the upper chambers of the heart (atria) beat irregularly and rapidly).</p> <p>-Heart failure.</p> <p>Review of the resident's Electronic Health Record (EHR) on [DATE] at 12:30 P.M., showed no documentation of advanced directives in his/her record.</p> <p>Review of the resident's EHR on [DATE] at 9:00 A.M., showed:</p> <p>-No advanced directives listed on the resident's POS.</p> <p>-No advanced directives listed on the resident's EHR's Miscellaneous tab.</p> <p>-No care plan with an advanced directive listed.</p> <p>During an interview on [DATE] at 12:54 P.M., Certified Nursing Assistants (CNA) A said:</p> <p>-He/She found information about the resident on their care plan.</p> <p>-The care plan would show if the resident was a full code or a DNR.</p> <p>-He/She did not know what this resident's code status was.</p> <p>During an interview on [DATE] at 1:12 P.M., CNA B said:</p> <p>(continued on next page)</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>-The resident's code status would be on his/her care plan.</p> <p>-Care plans were in the resident's medical record.</p> <p>-He/She was not sure what the resident's code status was.</p> <p>Review of the resident's EHR on [DATE] at 1:12 P.M., showed:</p> <p>-No advanced directives listed on the resident's POS.</p> <p>-No advanced directives listed on the resident's Medication Administration Record. (MAR).</p> <p>-No advanced directives listed on the resident's EHR's Miscellaneous tab.</p> <p>-No care plan with an advanced directive listed.</p> <p>During an interview on [DATE] at 1:30 P.M., the Assistant Director said the resident did have advanced directives and a care plan.</p> <p>Review of the resident's EHR on [DATE] at 1:30 P.M., showed:</p> <p>-The resident's code status on his/her profile page in the EHR was blank, there was no code status listed.</p> <p>-The resident's care plan indicated he/she was a full code dated [DATE].</p> <p>During an interview on [DATE] at 10:44 A.M., LPN C said:</p> <p>-The resident's code status should have been on his/her POS, MAR, and care plan.</p> <p>-Resident care plans should have current information including his/her code status.</p> <p>-The SSD was responsible for ensuring a residents wishes regarding code status were documented.</p> <p>-The resident was listed as a full code.</p> <p>3. During an interview on [DATE] at 3:30 P.M., the Director of Nursing (DON) Assistant Director, and the Executive Director said:</p> <p>-The SSD or designee was responsible for obtaining a code status from the resident or family.</p> <p>-The code status should have been on the resident's POS, and in the care plan.</p> <p>-The code status should match throughout the chart.</p> <p>-The Outside the Hospital Do Not Resuscitate sheet should have been complete.</p> <p>-There was a notebook at the nurses' station which showed which residents were a DNR.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37576</p> <p>Based on interview and record review, the facility failed to notify the resident's family for one sampled resident (Resident #35) of a change in condition out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility's Accidents and Incidents-Investigating and reporting policy, dated revised July 2017, showed:</p> <ul style="list-style-type: none"> <li>-All accidents or incidents involving residents shall be investigated and reported to the administrator.</li> <li>-The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.</li> <li>-The following data, as applicable, shall be included on the report of incident/accident form: <ul style="list-style-type: none"> <li>--The date and time the accident or incident took place.</li> <li>--The nature of the injury/illness (e.g., bruise, fall, nausea, etc.).</li> <li>--The circumstances surrounding the accident or incident.</li> <li>--Where the accident or incident took place.</li> <li>--The time the injured persons attending physician was notified.</li> <li>--The date/time the injured person's family was notified and by whom.</li> <li>--The disposition of the injured (i.e., transfer to hospital, put to bed).</li> <li>--Any corrective action taken.</li> <li>--Follow-up information.</li> <li>--Other pertinent data as necessary or required.</li> </ul> </li> </ul> <p>Review of the facility's policy and procedure- Incident and Accident Investigation, dated 1/1/2024, showed:</p> <ul style="list-style-type: none"> <li>-To ensure a safe environment that strives to eliminate hazards and to provide adequate care, supervision and assuasive devices to prevent incidents and accidents.</li> <li>-To this end, all occurrences or events regarding a resident injury, including unexplained injuries will be investigated and reported to facility administration.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An Incident/Event Report or Point Click Care (PCC, computer based) Risk Management Report shall be completed upon identification of any incident, accident, or injury of unknown source.</p> <p>-Completion of the report will include timely notification of the attending physician and the durable power of attorney/responsible party.</p> <p>-The administrator and/or director of nursing services will report incidences, accidents, injuries of unknown source to state and federal agencies in accordance with all applicable regulations and statutes.</p> <p>1. Review of Resident #35's Admission Record showed he/she admitted on [DATE] with the following diagnoses:</p> <p>-Dementia (a general term for a decline in mental ability resulting in memory loss, and other mental abilities severe enough to interfere with daily functioning).</p> <p>-Macular degeneration (deterioration of the macula, which is the small central area of the retina of the eye that controls visual acuity).</p> <p>-Poly osteoarthritis (five or more joints with inflammation of the of the bone with progressive cartilage deterioration).</p> <p>-Disorders of bone density (measurement of amount of minerals in bones, it helps determine risk of fractures and osteoporosis [bones become brittle and fragile from loss of tissue]).</p> <p>Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility staff for care planning), dated 1/20/25, showed his/her cognition was severely impaired.</p> <p>Review of the resident's Health Status Note, dated 1/3/25 at 1:26 P.M., showed:</p> <p>-The resident complained of pain to his/her left forearm in the morning when the day shift arrived.</p> <p>-Deformity noted to his/her left forearm.</p> <p>-Message left with the resident's Physician's answering service.</p> <p>-His/her left forearm X-ray ordered.</p> <p>-Administrator notified.</p> <p>Review of the resident's Radiology Results Report, dated 1/3/25 at 4:03 P.M., showed:</p> <p>-There was an acute (sudden onset) spiral fracture (occurs when a rotating force is applied along the axis [imaginary line running through the center of a bone] of a bone, often occurs when the body is in motion while one extremity is planted) of the distal (away from the point of attachment) diaphysis (the long tubular shaft of a bone) of the Ulnar bone (the longer bone in the forearm located on the side of the little finger and extended from the elbow to wrist).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical record showed no documentation the physician or family were notified until 1/8/25 when the physician was at the facility.</p> <p>Review of the resident's progress note, dated 1/8/25 at 4:39 P.M., showed:</p> <ul style="list-style-type: none"> <li>-The MDS Coordinator/Licensed Practical Nurse (LPN) rounded with the Physician who was seeing the resident for a fractured arm.</li> <li>-The Physician asked for results from the X-ray which had been sent to the nurses on 1/3/25.</li> <li>-The X-ray results reported the resident had a spiral fracture of arm.</li> <li>-The MDS Coordinator looked for a report of the fracture and none noted.</li> <li>-The MDS Coordinator reported to the Executive Director (ED) and the Director of Nursing (DON) the family had not been notified and the resident's arm was broken.</li> <li>-The ED reported the DON would call the family and that the resident should be sent out.</li> <li>-The Physician did see the resident and read the X-ray results.</li> <li>-The Physician gave orders for pain medication and for facility to contact family as what they would like to do about the resident's arm fracture.</li> </ul> <p>Review of the resident's Physicians Progress note, dated 1/8/25 no time listed, showed:</p> <ul style="list-style-type: none"> <li>-Chief complaint/Nature of presenting problem: follow-up x-ray/ new orders.</li> <li>-On 1/3/25 an X-ray of the resident's left forearm was obtained.</li> <li>-The X-ray report was received via fax and dated 1/6/2025 at 10:30:12 A.M.</li> <li>-The X-ray results were, acute spiral fracture of the distal diaphysis of the ulnar bone, with approximately 3.5 millimeter (mm) palmar displacement (where the fractured bone fragment is displaced towards the palm of the hand) of the distal fracture moiety (one of the portions into which something is divided). Severe diffuse osteopenia (condition characterized by a lower than normal bone mineral density). No joint subluxation (a partial dislocation or displacement of a joint) or dislocation was seen. No soft tissue emphysema (air trapped in tissues beneath the skin), radiodense soft tissue (a soft tissue within the body that appears denser on an x-ray image compared to other soft tissues) abnormality or foreign body was seen.</li> </ul> <p>-Overall Plan:</p> <ul style="list-style-type: none"> <li>--Follow-up in 4 weeks or sooner as deemed necessary.</li> <li>--Call if there was any significant changes in patient's medical condition.</li> </ul> <p>Review of the resident's Order Note, dated 1/8/25 at 4:52 P.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The Administrator spoke with a family member of the resident and informed them that on Friday 1/3/25 the facility got an X-ray because the resident was saying his/her left forearm was hurting.</p> <p>-The Administrator let the family member know the resident had a fracture to the left arm.</p> <p>-The DON was contacting the doctor and when he/she found out what the doctor wanted to do, he/she would call the family member back and let them know the Physician's decision.</p> <p>Review of the resident's Communication note, dated 1/8/25 at 5:41 P.M., showed:</p> <p>-The DON called the resident's family member and informed them, the Physician had seen the resident and X-ray report.</p> <p>-The Physician said the options were to consult with orthopedics, keep the resident's arm immobilized in a sling or send him/her to the emergency room (ER) to be evaluated and see what options they recommended.</p> <p>-The family member did not want to send the resident to the ER, they would contact other family members and call the DON back tomorrow as to what the family decided.</p> <p>Review of the resident's progress note, dated 1/10/25 at 1:23 P.M., showed:</p> <p>-The MDS Coordinator spoke with the resident's family member concerning his/her left arm fracture.</p> <p>-The family member was very upset that the resident had a fracture of the left arm and was not notified until six days later.</p> <p>-The MDS Coordinator had not been notified of a fall or an injury until 1/8/25 when rounding with the Physician for a follow-up for a fracture.</p> <p>-The MDS Coordinator looked for progress notes and there were no reports of the injury or notes that the family had been informed of the X-ray and break of the left arm.</p> <p>-The MDS Coordinator reported this to the Executive Director.</p> <p>-The Executive Director notified a family member of the fracture to the resident's left arm.</p> <p>-The family member agreed that if the resident was not able to get into orthopedics by Tuesday 1/14/25 then the resident would be sent out to the hospital for evaluation/treatment to help with stabilizing the arm to decrease pain.</p> <p>-The MDS Coordinator would notify the family member of orthopedic appointment or if sent out.</p> <p>Review of the resident's progress note, dated 1/10/25 at 3:55 P.M., showed:</p> <p>-The resident was sent to the hospital via Emergency Medical Services (EMS) transport.</p> <p>-The resident's family member followed in private car.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident was sent to be evaluated for fracture of his/her left forearm per portable x-ray, sling in place, pulse and motor sensory intact to left forearm/left hand.</p> <p>Review of the resident's progress note, dated 1/10/25 at 10:28 P.M., showed:</p> <p>-The resident returned to the facility with a diagnosis of a fractured left forearm.</p> <p>-Plaster splint placed in ER to his/her left forearm.</p> <p>-Splint to be kept dry at all times.</p> <p>-Skin around the splint should be inspected daily.</p> <p>-Sling was to be kept to shoulder level when sitting or standing, rest on chest or on a pillow when lying down to prevent swelling under the splint for the first 48 hours.</p> <p>-Certified Nursing Assistants (CNA)s instructed of resident's splint care.</p> <p>Review of the resident's progress note, dated 1/15/25 at 4:54 P.M., showed:</p> <p>-The resident's family member came to talk with the MDS Coordinator, the resident was to have a follow-up Orthopedic appointment.</p> <p>-A note was left for the receptionist, who made appointments, to get an appointment.</p> <p>-Family member had concerns of the resident's safety at the facility due to the break in arm and not being notified or resident sent out when it was found.</p> <p>-The MDS Coordinator informed family member that the resident was safe, and care would be given, staff was educated on notifying family of new issues and concerns right away.</p> <p>-The MDS Coordinator informed the ED of family concerns.</p> <p>During an interview on 1/22/25 at 12:35 P.M., the resident's family member said:</p> <p>-The resident had a spiral arm fracture and the facility did not know when or how it happened.</p> <p>-The facility found out the resident was having pain on 1/3/25 and did an X-ray on 1/3/25.</p> <p>-The family found out about the X-ray and the fracture on 1/8/25 from the Executive Director.</p> <p>-The Interim DON called the family member to see if the family wanted the resident to see the doctor or to send the resident to the ER.</p> <p>-The family member said to make a Doctor's appointment by Friday 1/10/25.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The family member talked to the MDS Coordinator on Friday 1/10/25 and found out the resident could not get a doctor appointment and to send the resident to the ER.</p> <p>-A splint was put on the resident's left arm in the ER and was to see an Orthopedic doctor on Friday 1/24/25.</p> <p>Review of the resident's progress note, dated 1/22/25 at 2:26 P.M., showed:</p> <p>-The resident had a care plan meeting today and the resident's family member was there.</p> <p>-The family member expressed that it was very discouraging that the resident had a broken arm and it was not reported to the family member.</p> <p>-The family member stated the resident's arm could have been treated if he/she had been sent out earlier.</p> <p>-The DON said he/she did not know why the x-ray was not read and reported to the family.</p> <p>During an interview on 1/28/25 at 12:28 P.M., the DON said:</p> <p>-He/She was told on 1/3/25 the resident had complained about arm pain.</p> <p>-He/She went to check out the resident's arm.</p> <p>-An X-ray was ordered by the resident's physician.</p> <p>-The X-ray was done in the afternoon and the report didn't come right away.</p> <p>-He/She let the night charge nurse know to notify the doctor about the report and to find out what orders he/she may have.</p> <p>-There was no documentation to show if the resident's physician was notified of the X-ray results.</p> <p>-He/She did not see the X-ray report until Tuesday 1/7/25, when he/she returned back to the facility.</p> <p>-He/She started making phone calls to see if family wanted the resident sent to the ER or an orthopedic appointment.</p> <p>-The family said if it would take a while to get an orthopedic appointment to go ahead and send the resident to the hospital.</p> <p>-He/She notified the facility doctor of the incident on Tuesday 1/7/25.</p> <p>-He/She did not hear back from the facility doctor and he/she did not call him/her back.</p> <p>-The resident went to the hospital per family request as the facility was not able to get an orthopedic appointment right away.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/30/25 at 1:59 P.M., LPN C said:</p> <ul style="list-style-type: none"> <li>-The resident's family was notified by the Assistant Director of the X-ray and the X-ray results.</li> <li>-The resident's family was contacted by the DON as a follow up to the physician's visit with the resident to determine the family's wishes regarding treatment.</li> </ul> <p>During an interview on 1/30/25 at 10:09 A.M., the Assistant Director said:</p> <ul style="list-style-type: none"> <li>-He/She was notified by the MDS Coordinator that the resident's family had not been notified of the injury, X-ray, or X-ray results.</li> <li>-He/She called the resident's family and informed them of the injury, X-ray, and X-ray results.</li> <li>-He/She informed the family the DON would follow up after the physician saw the resident to discuss treatment options available.</li> </ul> <p>During an interview on 1/31/25 at 3:25 P.M., the DON, Assistant Director and the Executive Director said:</p> <ul style="list-style-type: none"> <li>-When a resident had a change in condition the facility doctor and the resident's family member or representative should have been notified as soon as possible.</li> <li>-Waiting five days to notify the doctor or family member was not acceptable.</li> <li>-The doctor and the family should have been notified of the X-ray results by the nurse who took the report off of the copier.</li> <li>-X-ray reports should come back the same day or at least in 24 hours.</li> <li>-The doctor should have been notified of the X-ray results by faxing the report to him/her.</li> <li>-The nursing staff or DON should have sent the resident out to the hospital when they knew of the X-ray results.</li> <li>-The charge nurse should have made nursing notes of the resident's X-ray being done and who they notified of it.</li> </ul> <p>MO00247918</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</b></p> <p>Based on interview and record review, the facility failed to ensure a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN) (SNF/ABN-form Centers for Medicare and Medicaid Services (CMS)-10055) was provided to the resident or their representative for three sampled residents (Residents #41, #43, and #56) out of three sampled residents who were discharged from Medicare part A (insurance that covers inpatient hospital care, skilled nursing facility, lab tests, surgery, home health care for individuals who are [AGE] years of age and above or disabled). The facility census was 55 residents.</p> <p>Review of the facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notices policy, dated as revised September 2022, showed when Medicare A stops coverage of the resident's extended care items or services, the facility should issue a SNF/ABN before the extended care items or services are terminated.</p> <p>Review of the CMS memo (S&amp;C-09-20), dated 1/9/09, showed:</p> <p>-If the SNF believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled using the SNF/ABN (form CMS-10055).</p> <p>-The SNF/ABN provides an estimated cost of items or services in case the beneficiary had to pay for them him/herself or through other insurance they may have.</p> <p>Review of the CMS website, updated 8/28/24, showed SNFs use the SNF/ABN as the liability notice for Medicare Part A items and services.</p> <p>1. Review of the facility's Beneficiary Notice worksheet of residents discharged from Medicare Part A within the last six months form showed:</p> <p>-Resident #56 was discharged from Medicare A on 12/8/24.</p> <p>-Resident #41 was discharged from Medicare A on 11/13/24.</p> <p>-Resident #43 was discharged from Medicare A on 8/31/24.</p> <p>Review of Resident #56, #41, and #43's beneficiary notices showed none of the residents were provided with an SNF/ABN.</p> <p>During an interview on 1/27/25 at 1:44 P.M., the Social Services Director said he/she was told not to do the SNF/ABN on residents discharged off Medicare A services and to only provide the SNF/ABN when the resident was on Medicare B benefits that were ending.</p> <p>(continued on next page)</p>		

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F 0582  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	During an interview on 1/31/25 at 3:25 P.M., the Contract Administrator said the SNF/ABN should have been completed for Resident #56, #41, and #43.		

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19916</p> <p>Based on observation and interview, the facility failed to maintain the ceiling vent in the dining room free of a heavy buildup of dust; failed to maintain the 80 Hall free of a persistent urine odor; failed to ensure the hot water in resident rooms 86, 84, 82 was at or above 105 F (degrees Fahrenheit); failed to ensure there was not a buildup of dust and debris on the floor in resident rooms [ROOM NUMBERS]; failed to prevent a heavy buildup of dust in the ceiling vents in 50 Hall Shower Room A, 20 Hall Shower Room A, and in the restroom of resident room [ROOM NUMBER]. This practice potentially affected at least 40 residents who resided in, or used those areas in the facility. The facility census was 55 residents.</p> <p>1. Observation on 1/28/25 at 11:45 A.M., with the Maintenance Director showed a heavy buildup of dust in the ceiling vent in the dining room.</p> <p>During an interview on 1/28/25 at 11:46 A. M, the Maintenance Director said the ceiling vent looked like it had not been cleaned in a while.</p> <p>2. Observations on 1/28/25 with the Maintenance Director showed the following rooms on the 80 Hall:</p> <ul style="list-style-type: none"> <li>-At 11:51 A.M. there was a strong urine odor in the hall in general.</li> <li>-At 11:53 A.M. there was a strong urine odor in resident room [ROOM NUMBER].</li> <li>-At 11:58 A.M. there was a strong urine odor in resident room [ROOM NUMBER]</li> <li>-At 11:59 A.M., there was a strong urine odor in resident room [ROOM NUMBER].</li> <li>-At 12:07 P.M., there was a string urine odor in resident room [ROOM NUMBER].</li> </ul> <p>Observation on 1/28/25 from 12:15 P.M. to 3:00 P.M., showed:</p> <ul style="list-style-type: none"> <li>-The 80 Hall in general had a strong urine odor.</li> <li>-room [ROOM NUMBER] had a strong urine odor.</li> <li>-room [ROOM NUMBER] had a strong urine odor.</li> <li>-room [ROOM NUMBER] had a strong urine odor.</li> <li>-room [ROOM NUMBER] had a strong urine odor.</li> </ul> <p>During an interview on 1/29/25 at 2:24 P.M., Housekeeper A said the following regarding the urine smell in the 80 Hall:</p> <ul style="list-style-type: none"> <li>-He/she did not think the cleaning agents were strong enough to get the smell out.</li> </ul> <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 sprayed the cleaning agent on the floor and mopped the floors in the restroom of those rooms where most of the urine odor originated.</p> <p>-He/she sprayed the cleaning agent on the toilets and wiped the toilets down.</p> <p>-Some of the residents have problems and urinate on the floor and the urine may soak into the floor.</p> <p>-The smell did not go away even after cleaning.</p> <p>Observation on 1/29/25 at 2:31 P.M., showed:</p> <p>-The floor of the shared restroom between resident rooms [ROOM NUMBERS] was very sticky.</p> <p>-Shoes stuck to the floor while walking in that restroom.</p> <p>-There was a urine odor in the shared restroom.</p> <p>Observation on 1/30/25 at 10:00 A.M., showed there was a urine odor in the 80 hall in general.</p> <p>During an interview on 1/30/25 at 12:04 P.M., the Executive Director said he/she smelled the urine odor in the 80 Hall.</p> <p>During an interview on 1/31/25 at 9:09 A.M., the Executive Director said:</p> <p>-He/she had smelled the persistent urine odor in the 80 Hall.</p> <p>-He/she spoke with the Maintenance Supervisor about creating a Lead Housekeeper and trying to deep clean all the rooms on the 80 Hall.</p> <p>3. Observation on 1/28/25 with the Maintenance Supervisor showed:</p> <p>-At 11:55 A.M., the hot water in resident room [ROOM NUMBER], was 81.3 F after the water was allowed to run for 2 or more minutes.</p> <p>-At 11:59 A.M., the hot water temperature in resident room [ROOM NUMBER], was 101.3 F</p> <p>-At 12:09 P.M., the hot water temperature in resident room [ROOM NUMBER] was 100 F.</p> <p>During an interview on 1/28/25 at 12:01 P.M., the Maintenance Director said:</p> <p>-He/she had only been working at the facility for a few weeks</p> <p>-He/she was not sure which hot water heater provided hot water to the resident rooms on the 80 Hall.</p> <p>4. Observations on 1/28/25 with the Maintenance Director, showed a buildup of dust and debris in the following rooms:</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>-At 12:24 P.M., there was a buildup of debris on the floor at the corner of the bed and the wall in resident room [ROOM NUMBER].</p> <p>-At 2:16 P.M., there was a heavy buildup of dust on the floor in Shower Room A on the 50 Hall.</p> <p>-At 2:26 P.M., there was a heavy buildup of dust in the restroom ceiling vent in resident room [ROOM NUMBER].</p> <p>-At 3:15 P.M., there was a buildup of cobwebs in the corner next to the bed on the floor in resident room [ROOM NUMBER].</p> <p>Observations on 1/29/25 with the Maintenance Director, showed a buildup of dust and debris in the following rooms:</p> <p>-At 11:24 A.M., there was a heavy buildup of cobwebs behind the bed on the floor in resident room [ROOM NUMBER].</p> <p>-At 11:31 A.M., there was a buildup of dust in the ceiling vent in Shower Room A of 20 Hall.</p> <p>During an interview on 1/29/25 at 11:35 A.M., the Maintenance Director said he/she expected housekeeping staff to clean the areas with the cobwebs and clean the areas behind the beds.</p> <p>During an interview on 1/29/25 at 2:32 P.M., Housekeeper B said:</p> <p>-His/her supervisors want the housekeepers to deep clean a couple rooms per day.</p> <p>-During a deep clean the housekeepers pull everything into the middle of the room.</p> <p>-During a regular clean, they dust the areas in the room they may spot clean.</p> <p>MO00247567</p>		

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  02/19/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37576</p> <p>Based on interview and record review, the facility failed to report an injury of unknown origin timely to the physician as per policy and to the State Agency for one sampled resident (Resident #35) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility policy titled: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, showed:</p> <ul style="list-style-type: none"> <li>-Investigate and report any allegations within time frames required by federal requirements.</li> </ul> <p>Review of the facility policy titled: Recognizing signs and symptoms of abuse/neglect dated April 2021 showed:</p> <ul style="list-style-type: none"> <li>-All personnel are expected to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing (DON).</li> <li>-The following are signs and symptoms of abuse/neglect that should be promptly reported.</li> <li>--Injuries that are non-accidental or unexplained.</li> <li>--Fractures, dislocations or sprains.</li> </ul> <p>Review of the facility policy titled: Abuse, neglect, exploitation or misappropriation reporting and investigating, dated September 2022, showed:</p> <ul style="list-style-type: none"> <li>-Reports of resident injuries of unknown source are reported to local, state and federal agencies.</li> <li>-If injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law.</li> <li>-The Administrator or the individual making the allegation immediately reports his/her suspicion to the following persons or agencies: <ul style="list-style-type: none"> <li>--The state licensing/certification agency responsible for surveying/licensing the facility.</li> <li>--The local/state Ombudsman.</li> <li>--The resident's representative.</li> <li>--The resident's attending physician.</li> <li>--The facility's medical director.</li> </ul> </li> </ul> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>---Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury.</p> <p>1. Review of Resident #35's quarterly Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning), dated 10/20/24, showed:</p> <ul style="list-style-type: none"> <li>-He/She was severely cognitively impaired.</li> <li>-Had a diagnosis of Dementia (a group of conditions that cause a progressive decline in cognitive function, memory, and behavior).</li> <li>-Required maximum assistance to total dependence with all aspects of activities of daily living.</li> </ul> <p>Review of the resident's Health Status Note, dated 1/3/25 at 1:26 P.M., showed:</p> <ul style="list-style-type: none"> <li>-The resident complained of pain to his/her left forearm when day shift arrived.</li> <li>-Deformity noted to the resident's left forearm.</li> <li>-A message was left with the resident's Physician's answering service.</li> <li>-A left forearm x-ray was ordered.</li> <li>-The Administrator was notified.</li> </ul> <p>Review of the resident's X-ray Results Report, dated 1/3/25 at 4:03 P.M., showed:</p> <p>-There was an acute (sudden onset) spiral fracture (occurs when a rotating force was applied along the axis [imaginary line running through the center of a bone] of a bone, often occurred when the body was in motion while one extremity was planted) of the distal (away from the point of attachment) diaphysis (the long tubular shaft of a bone) of the Ulnar bone (the longer bone in the forearm located on the side of the little finger and extends from the elbow to wrist).</p> <p>Review of the resident's Quarterly MDS dated [DATE], showed his/her cognition was severely impaired.</p> <p>During an interview on 1/22/25 12:35 P.M., the resident's family member said:</p> <ul style="list-style-type: none"> <li>-The resident had a spiral arm fracture and facility did not know when or how it happened.</li> <li>-The facility found out the resident was having pain on 1/3/25 and did an X-ray on 1/3/25.</li> <li>-The family found out about the X-ray and the fracture on 1/8/25 from the Executive Director.</li> </ul> <p>During an interview on 1/28/25 at 12:28 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-He/She was told on 1/3/25 that the resident had complained about arm pain.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She went to check out the resident's arm.</p> <p>-A X-ray was ordered.</p> <p>-He/She wrote a progress note concerning the incident.</p> <p>-The X-ray was done in the afternoon and the results didn't come right away.</p> <p>-He/She let the night charge nurse know to notify the doctor about the results and to find out what orders he/she may have as to sending the resident out to the hospital or other treatment.</p> <p>Review of the resident's EHR on 1/28/25 showed:</p> <p>-No documentation of an X-ray being done on 1/3/25.</p> <p>-No documentation of the X-ray results of a spiral fracture of the left forearm.</p> <p>-No documentation of the resident's physician being notified.</p> <p>-No documentation of the State Agency being notified.</p> <p>During an interview on 1/31/25 at 3:25 P.M., the DON, Assistant Director and the Executive Director said:</p> <p>-The Assistant Director was not aware that an injury of unknown origin needed to be reported to the state.</p> <p>-The DON was not aware that an injury of unknown origin needed to be reported to the state.</p> <p>Review of the resident's EHR on 2/14/25 showed:</p> <p>-No documentation of the State Agency being notified of the injury of unknown origin (fracture) on or around 1/3/25.</p> <p>During an interview on 2/14/25 at 5:45 P.M., the Assistant Director said:</p> <p>-He/She did not know the injury of unknown origin needed to be reported to the State Agency.</p> <p>During an interview on 2/14/25 at 7:04 P.M., the DON said:</p> <p>-The X-ray results were not reported to the physician timely.</p> <p>-The injury of unknown origin was not reported to the State Agency.</p> <p>-He/She did not know injury of unknown origin had to be reported to the State Agency.</p> <p>During an interview on 2/14/25 at 7:34 P.M., Physician A said:</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The facility should follow their policies and procedures and report incidents to the appropriate people.</p> <p>-The resident's injury of unknown origin should have been reported if the policy and procedure indicated it should have been reported.</p> <p>During an interview on 2/19/25 at 10:00 A.M. the Interim Administrator said:</p> <p>-The resident's physician should have been notified by the charge nurse on duty when the X-ray results were sent to the facility.</p> <p>-The DON or the Assistant Director should have followed up with the physician if there was no response documented by the charge nurse.</p> <p>-The Administrator of the facility at the time of the injury should have notified the state agency.</p> <p>MO00247918</p> <p>MO00248157</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576</b></p> <p>Based on interview and record review, the facility failed to follow the facility policy and procedure and investigate an injury of unknown origin of a fractured (broken) arm for one sampled resident (Resident #35); and failed to investigate the cause of skin tears and bruises for one sampled resident (Resident #30) out of 14 sampled residents. The facility census was 55 residents.</p> <p>The Administrator was notified on 2/14/25 at 9:00 P.M. of the Immediate Jeopardy (IJ) which began on 1/3/25. The IJ was removed on 2/18/25, as confirmed by surveyor onsite verification.</p> <p>Review of the facility policy titled: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, showed:</p> <ul style="list-style-type: none"> <li>-Residents had the right to be free from abuse, neglect, misappropriation of property and exploitation.</li> <li>-Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.</li> <li>-Investigate and report any allegations within time frames required by federal requirements.</li> <li>-Establish and implement a Quality Assurance and Performance Improvement (QAPI) review and analysis of reports, allegations or findings of abuse, neglect, mistreatment or misappropriation of property.</li> </ul> <p>Review of the facility policy titled: Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating, dated September 2022, showed:</p> <ul style="list-style-type: none"> <li>-If resident abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law.</li> <li>-All allegations are thoroughly investigated. The Administrator initiates investigations.</li> <li>-Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations.</li> <li>-The Administrator is responsible for keeping the resident and his/her representative informed of the progress of the investigation.</li> <li>-The investigator consults daily with the Administrator concerning the progress/findings of the investigation.</li> <li>-Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the Administrator.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Within five business days of the incident, the Administrator will provide a follow-up investigation report.</p> <p>-The follow up investigation report will provide sufficient information to describe the results of the investigation and indicate any corrective actions taken if the allegation was verified.</p> <p>-The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.</p> <p>1. Review of the Resident #35's Admission Record showed he/she admitted on [DATE] with a diagnosis of Dementia (a general term for a decline in mental ability resulting in memory loss, and other mental abilities severe enough to interfere with daily functioning).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning), dated 10/20/24, showed:</p> <p>-He/She was severely cognitively impaired.</p> <p>-Had a diagnosis of Dementia.</p> <p>-Required maximum assistance to total dependence with all aspects of activities of daily living.</p> <p>Review of the resident's Health Status Note, dated 1/3/25 at 1:26 P.M., showed:</p> <p>-The resident complained of pain to his/her left forearm when day shift arrived.</p> <p>-Deformity noted to his/her left forearm.</p> <p>-A message was left with the resident's Physician's answering service.</p> <p>-A left forearm x-ray was ordered.</p> <p>-The Administrator was notified.</p> <p>Review of the resident's X-ray Results Report, dated 1/3/25 at 4:03 P.M., showed:</p> <p>-There was an acute (sudden onset) spiral fracture (occurs when a rotating force was applied along the axis [imaginary line running through the center of a bone] of a bone, often occurred when the body was in motion while one extremity was planted) of the distal (away from the point of attachment) diaphysis (the long tubular shaft of a bone) of the Ulnar bone (the longer bone in the forearm located on the side of the little finger and extends from the elbow to wrist).</p> <p>Review of the resident's progress note, dated 1/8/25 at 4:39 P.M., showed:</p> <p>-The MDS Coordinator rounded with the Physician who was seeing the resident for a fractured arm.</p> <p>-The MDS Coordinator asked for results from the X-ray which had been sent to nurses on 1/3/25.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The X-ray results showed a spiral fracture of the resident's left arm.</p> <p>-The MDS Coordinator looked for a report of the fracture and none was noted.</p> <p>-The MDS Coordinator reported to the Executive Director and the Director of Nursing (DON) the family had not been notified and the resident's arm was broken.</p> <p>Review of the resident's progress note, dated 1/10/25 at 1:23 P.M., showed:</p> <p>-The MDS Coordinator spoke with the resident's family member concerning the resident's left arm fracture.</p> <p>-The family member was very upset the resident had a fracture of the left arm and was not notified until six days later.</p> <p>-The MDS Coordinator had not been notified of a fall or an injury until 1/8/25 when rounding with the Physician for a follow-up for a fracture.</p> <p>-The MDS Coordinator looked for additional progress notes and there were no reports of the injury or that the family had been informed of the X-ray and break of the left arm.</p> <p>Review of the resident's Quarterly MDS, dated [DATE], showed his/her cognition was severely impaired.</p> <p>During an interview on 1/22/25 12:35 P.M., the resident's family member said:</p> <p>-The resident had a spiral arm fracture and the facility did not know when or how it happened.</p> <p>-The facility found out the resident was having pain on 1/3/25 and did an X-ray on 1/3/25.</p> <p>-The family found out about the X-ray and the fracture on 1/8/25 from the Executive Director.</p> <p>-The DON called the family member to see if the family wanted the resident to see the doctor or be sent to the emergency room (ER).</p> <p>-The family member said to make a doctor's appointment by Friday 1/10/25.</p> <p>-The family member talked to the MDS Coordinator on Friday 1/10/25 and found out the resident could not get a doctor appointment and to send the resident to the ER.</p> <p>-While in the ER the resident had a splint put on his/her left arm and was to see an Orthopedic doctor on Friday 1/24/25.</p> <p>-The family member wanted to know what happened.</p> <p>Review of the resident's Electronic Health Record (EHR) showed:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-No nursing documentation of the resident complaining of pain.</p> <p>-No incident report for an injury of unknown origin for a spiral fracture of the left forearm.</p> <p>-No documentation of an investigation of the cause of an injury of unknown origin.</p> <p>During an interview on 1/28/25 at 12:28 P.M., the DON said:</p> <p>-There was no incident report written regarding the resident's pain, X-ray, and X-ray results.</p> <p>-There was no investigation done to determine the cause of the resident's injury of unknown origin that resulted in a fractured arm.</p> <p>During an interview on 1/31/25 at 3:25 P.M., the DON, Assistant Director and the Executive Director said:</p> <p>-The Assistant Director was not aware an incident report needed to be made with an injury of unknown origin.</p> <p>-The Assistant Director did not investigate the cause of the resident's injury of unknown origin.</p> <p>-The DON was not aware an incident report needed to be made with an injury of unknown origin.</p> <p>-The DON did not investigate the cause of the resident's injury of unknown origin.</p> <p>During an interview on 2/14/25 at 6:30 P.M., Certified Nurse Aide (CNA) T said:</p> <p>-The resident had not complained of pain in his/her arm or anywhere else on the night shift 1/2/25 into 1/3/25.</p> <p>During an interview on 2/14/25 at 6:48 P.M., CNA S said:</p> <p>-While he/she was putting the resident to bed on 1/2/25 the resident complained of pain in his/her left arm.</p> <p>-The resident was still swinging both arms at the CNA as he/she always did.</p> <p>-He/She told Licensed Practical Nurse (LPN) G about the resident complaining of pain.</p> <p>-No one thought anything about it, as the resident was still swinging his/her arms at anyone who did anything to help him/her.</p> <p>-When he/she got the resident up on the morning of 1/3/25 for breakfast the resident said his/her arm still hurt, but he/she was still swinging both arms around.</p> <p>-He/She again told LPN G the the resident was complaining of pain.</p> <p>-LPN G went to the dining room to look at the resident's arm.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-LPN G touched the resident's arm and the resident said ouch, but was swinging his/her arms at LPN G.</p> <p>-He/She and LPN G both thought if the resident's arm was hurt, the resident wouldn't be swinging/swatting at the staff with his/her arms.</p> <p>During an interview on 2/14/25 at 7:19 P.M., LPN G said:</p> <p>-CNA S did report the resident was complaining of pain, but did not remember what day or time it was.</p> <p>-CNA S told him/her the resident was in the dining room and was complaining of pain in the right arm.</p> <p>-He/She looked at the resident's right arm and did not see any swelling or discoloration.</p> <p>-He/She did not look at the resident's left arm at that time.</p> <p>-The resident was swinging both arms and swatting at him/her.</p> <p>-The resident did not complain of pain at that time.</p> <p>During an interview on 2/14/25 at 7:06 P.M., CNA C said:</p> <p>-The resident did not complaint of pain during day shift on 1/2/24 or day shift 1/3/25 to him/her.</p> <p>-The licensed nurse gave residents pain medication.</p> <p>-He/She did not help get the resident up on 1/2/25 or 1/3/25.</p> <p>During an interview on 2/14/25 at 7:57 P.M. CNA D said:</p> <p>-He/she worked day shift on 1/3/25.</p> <p>-He/she went to the resident's room to provide care for the resident and the resident said don't touch my arm, it's broken and then pointed to his/her left arm.</p> <p>-The resident did not complain of pain in his/her left arm at that time.</p> <p>-The resident had a long sleeve shirt on, and when the sleeve was moved the resident winced, but did not say it hurt.</p> <p>-The resident's upper left forearm looked swollen and appeared light reddish in color.</p> <p>-He/She went to tell the nurse, but could not find the nurse so he/she told the Assistant Director.</p> <p>-The Assistant Director looked at the resident's arm and told CNA D to find the nurse and have an x-ray ordered.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/14/25 at 7:04 P.M. the Assistant Director said:</p> <ul style="list-style-type: none"> <li>-When he/she arrived to work on 1/3/25 a day shift employee informed him/her of the resident complaining of left arm pain.</li> <li>-He/She went to look at the resident's left arm.</li> <li>-He/She could see something wasn't right with the resident's left arm, but did not have clinical experience and told staff to notify the DON when he/she arrived.</li> <li>-He/She did not start a risk management form.</li> <li>-A risk management form should have been started.</li> <li>-He/She did not start an incident report.</li> <li>-An incident report should have been done.</li> <li>-He/She did not start an investigation.</li> <li>-An investigation should have been done.</li> <li>-As of February 14, 2025 no incident report or investigation had been done.</li> </ul> <p>During an interview on 2/14/25 at 7:04 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-He/She did not start a risk management form.</li> <li>-He/She asked the 1/2/25 night shift staff if they knew what happened to the resident's arm.</li> <li>-There was no documentation of the staff interviews.</li> <li>-He/She asked the 1/3/25 day shift staff if they knew what happened to the resident's arm.</li> <li>-There was no documentation of the staff interviews.</li> <li>-He/She did not start an incident report.</li> <li>-He/She did not know an incident report needed to be done.</li> <li>-He/She did not start an investigation.</li> <li>-He/She did not know an investigation needed to be done.</li> </ul> <p>During a phone interview on 2/14/25 at 7:34 P.M., Physician A said:</p> <ul style="list-style-type: none"> <li>-The staff should have called and discussed possible causes of the fracture during the investigation of the injury.</li> </ul> <p>(continued on next page)</p>

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  02/19/2025
NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The staff should have followed their policy and procedures following an incident.</p> <p>-If the policy and procedures said to complete a risk management report, an incident report and/or an investigation, the reports should have been done.</p> <p>-There should be some written record of an incident report and investigation.</p> <p>22727</p> <p>2. Review of Resident #30's Admission MDS dated [DATE] showed:</p> <p>-He/She was severely cognitively impaired.</p> <p>-Was dependent on staff for most of cares.</p> <p>-Had a diagnosis of Cancer.</p> <p>Review of the resident's health status note, dated 5/23/24 at 5:19 P.M., showed:</p> <p>-A small, open area was noted to the resident's right shin.</p> <p>-The area appeared to be the result of ruptured bruise.</p> <p>Review of the resident's electronic health record, health status notes dates 5/24/24 to 8/14/24 showed:</p> <p>-The resident had no skin issues documented.</p> <p>-The resident had no bruises documented.</p> <p>-The resident had not skin tears documented.</p> <p>Review of the resident's most recent skin assessment, dated 8/14/24, showed:</p> <p>-The resident had no skin issues.</p> <p>-The resident had no bruises.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following staff assessment of the resident:</p> <p>-Moderately cognitively impaired.</p> <p>-Had no functional limitation in range of motion in any extremities.</p> <p>-Required maximum assistance with toileting hygiene, dressing, and personal hygiene.</p> <p>-Required moderate assistance with bathing and going from sitting to standing.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Used a manual wheelchair.</p> <p>-Did not stand.</p> <p>-Was always incontinent of bowel and bladder.</p> <p>-Some of his/her diagnoses included cancer and high blood pressure.</p> <p>-Had a skin tear.</p> <p>Review of the resident's care plan, dated 11/18/24 (the last time the resident's care plan was updated), showed it did not include anything about skin injuries including skin tears or bruises.</p> <p>Review of the resident's nurse's note, dated 1/26/25 at 4:31 A.M. showed:</p> <p>-The resident was noted to have a small skin tear to his/her right ankle approximately 0.2 centimeters (cm) round with a small amount of red drainage.</p> <p>-No information regarding how the skin tear happened.</p> <p>During an interview on 1/30/25 at 9:08 A.M., the MDS Coordinator said:</p> <p>-He/She had not noticed the resident having any wounds, bruises, skin tears or scratches.</p> <p>-The resident usually turned on his/her call light and didn't usually try to get up on his/her own.</p> <p>-The resident would yell out for help if his/her call light wasn't in reach.</p> <p>During an interview on 1/30/25 at 11:26 A.M., the DON said:</p> <p>-He/She didn't know any cause of the resident's bruise or skin tears.</p> <p>-He/She did not know an investigation was required when a resident had a skin injury, or bruise to determine the root cause or contributing factors of the injury.</p> <p>During an interview on 1/30/25 11:50 A.M., the DON said:</p> <p>-There was a risk management form they could enter, but he/she could not open it.</p> <p>-There were no incident reports or investigations on the any of the resident's bruises or skin tears.</p> <p>Observation on 1/30/25 at 2:09 P.M., showed the resident was in his/her room in his/her wheelchair asleep and had a large bruise that was dark purple, yellow, and green on the right side of his/her face that covered his/her forehead, was around the resident's right eye and down to his/her cheek.</p> <p>During an interview on 1/31/25 at 3:25 P.M., the DON said:</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The nurses should have documented and started a risk management form after finding the skin tears and/or bruises.</p> <p>-He/She did not know he/she was responsible to investigate skin tears and/or bruises for a reason or contributing factor of the injury.</p> <p>NOTE: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).</p> <p>MO00247918</p> <p>MO00248157</p> <p>MO00249755</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</b></p> <p>Based on observation, interview, and record review, the facility failed to accurately reflect the resident's status on Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) assessments for three sampled residents (Resident #9, #40, and #3) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility MDS 3.0 Process policy, dated 1/1/24, showed:</p> <ul style="list-style-type: none"> <li>-The facility should complete an accurate MDS.</li> <li>-The MDS should be signed by everyone completing any portions of the assessment to certify the accuracy of the portion of the assessment he/she completed.</li> </ul> <p>1. Review of Resident #9's care plan, dated 7/25/23, showed the resident had a pressure ulcer (any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s)) that was a Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) to his/her right face cheek related to heart disease, right sided weakness, chronic pain, incontinence, and weight loss.</p> <p>Review of the resident's Treatment Administration Record (TAR), dated November 2024, showed:</p> <ul style="list-style-type: none"> <li>-Treatment orders for the resident's coccyx wound dated 2/9/24.</li> <li>-Treatment orders for the resident's face cheek wound dated 7/3/24.</li> </ul> <p>Review of the resident's Physician's Order Sheet (POS), dated January 2025, showed:</p> <ul style="list-style-type: none"> <li>-A physician's order for hospice dated 7/28/23.</li> <li>-A physician's order for a wound treatment for the resident's coccyx dated 2/9/24 .</li> <li>-A physician's order for a wound treatment for the resident's right cheek dated 12/23/24.</li> </ul> <p>Review of the resident's quarterly MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-The resident was not on hospice (end of life care).</li> <li>-The skin section was marked as not assessed.</li> <li>-Section GG (functional abilities): The resident was dependent on staff for all cares.</li> </ul> <p>Review of the resident's care plan, dated January 2025, showed the resident had a Stage IV pressure ulcer on his/her right cheek.</p> <p>Review of the resident's hospice nurse's note, dated 1/15/25, showed the hospice nurse documented that he/she completed the treatments on the resident's coccyx and cheek wounds.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan, updated 1/24/25, showed:</p> <ul style="list-style-type: none"> <li>-The resident had a venous/stasis ulcer (open lesion caused by poor circulation) of the coccyx treatment in place.</li> <li>-No care plan for the resident's cheek wound.</li> </ul> <p>Observation on 1/27/25 at 3:06 P.M. with Licensed Practical Nurse (LPN) E showed:</p> <ul style="list-style-type: none"> <li>-The resident had a wound on his/her coccyx and a wound on his/her face on the right cheek.</li> <li>-LPN completed the wound treatments on both wounds.</li> </ul> <p>During an interview on 1/30/25 at 9:08 A.M., the MDS Coordinator said:</p> <ul style="list-style-type: none"> <li>-Not marking the resident for hospice was a mistake.</li> <li>-The resident had been on hospice for a long time.</li> <li>-He/She started doing wound rounds with the wound doctor two weeks ago since no one else was doing it.</li> <li>-He/She rounded with the wound doctor, entered in wound treatment orders, and did not have time to do care plans or MDSs.</li> <li>-He/She was also assigned additional duties at times such as working as a floor nurse and giving showers so he/she was not able to update the MDS.</li> <li>-The MDS should be accurate.</li> </ul> <p>During an interview on 1/31/25 at 3:25 P.M., with the Director of Nursing (DON) present, the Executive Director said:</p> <ul style="list-style-type: none"> <li>-Hospice should have been marked yes.</li> <li>-The MDS Coordinator and the DON were supposed to complete the wounds section.</li> <li>-The MDS Coordinator had been pulled to other duties so he/she didn't have time to update the MDS.</li> <li>-The MDS should be complete and accurate.</li> </ul> <p>2. Review of Resident #40's quarterly MDS dated [DATE] showed the resident was on an anticoagulant medication.</p> <p>Review of the resident's Medication Administration Record (MAR), dated November 2024, showed:</p> <ul style="list-style-type: none"> <li>-No orders for an anticoagulant (medication used to slow down the process of making blood clots) medication.</li> </ul> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-A physician's order, dated 9/27/24, for aspirin which was an antiplatelet (prevent blood cells called platelets from clumping together to form a clot) medication.</p> <p>During an interview on 1/30/25 at 9:08 A.M., the MDS Coordinator said he/she accidentally marked anticoagulant medication when antiplatelet medication should have been marked.</p> <p>During an interview on 1/31/25 at 3:25 P.M., with the DON present, the Executive Director said:</p> <ul style="list-style-type: none"> <li>-The charge nurse and the DON were responsible for completing the medication section.</li> <li>-The MDS should have reflected the correct medication classification.</li> <li>-The MDS should be complete and accurate.</li> </ul> <p>39469</p> <p>3. Review of Resident #3's face sheet, undated, showed the resident was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Chronic Obstructive Pulmonary Disease (COPD-a condition causing constriction of the airways and difficulty or discomfort in breathing).</li> <li>-Bipolar disorder (mental health condition that caused extreme mood swings).</li> <li>-Vascular dementia (impaired supply of blood to the brain).</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the cognitive status section of the MDS was not completed.</p> <p>Review of the resident's care plan, dated 11/5/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident had potential impairment to skin integrity and received wound management.</li> <li>-The resident had a peg tube (a thin, flexible tube inserted through the skin of the abdomen directly into the stomach) in place.</li> <li>-The resident had a suprapubic catheter (a medical device that drained urine from the bladder through a small incision in the abdomen).</li> </ul> <p>Review of the resident's Physician Order Summary, dated January 2025, showed:</p> <ul style="list-style-type: none"> <li>-The resident had a peg tube.</li> <li>-The resident had a urinary catheter (a tube placed in the body to drain and collect urine from the bladder).</li> <li>-The resident had a pressure ulcer on his/her coccyx (small bone at the end of the spine).</li> </ul> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-The resident's cognitive status section of the MDS was not completed.</li> <li>-The resident showed no skin conditions present at time of assessment.</li> <li>--The resident had a pressure ulcer at the time of the assessment.</li> </ul> <p>-NOTE: The resident had a peg tube and a urinary catheter in place at the time of the assessment that were not identified on the assessment.</p> <p>Observation on 1/22/25 at 10:44 A.M., showed:</p> <ul style="list-style-type: none"> <li>-The resident had a wound on his/her coccyx.</li> </ul> <p>4. During an interview on 1/23/25 at 10:09 A.M., the MDS Coordinator said:</p> <ul style="list-style-type: none"> <li>-He/She was called in to work the floor a lot and his/her MDS updates didn't always get done.</li> <li>-He/She had not been able to complete care plans.</li> <li>-Residents were assessed when they were admitted and again quarterly, or as needed with changes in the resident's condition.</li> <li>-Resident #3's peg tube should have been identified on the MDS.</li> <li>-Resident #3's urinary catheter should have been identified on the MDS.</li> </ul> <p>During an interview on 1/29/25 at 10:32 P.M., LPN A, said:</p> <ul style="list-style-type: none"> <li>-The MDS Coordinator completed the resident's MDSs.</li> <li>-Nurses did not complete the resident MDSs.</li> <li>-Nurses told the MDS Coordinator when something changed with the resident.</li> </ul> <p>During an interview on 1/31/25 at 4:44 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-Residents with pressure ulcer should have those reflected in the MDS.</li> <li>-He/She would expect to see peg tube and urinary catheter on the MDS.</li> <li>-He/She expected the MDS to reflect current and up to date resident information.</li> </ul>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37576</p> <p>Based on interview and record review, the facility failed to create a baseline care plan within 48 hours of admission for one sampled resident (Resident #209) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility's Care Plans, Baseline policy, dated March 2022, showed:</p> <ul style="list-style-type: none"> <li>-A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission.</li> <li>-The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: <ul style="list-style-type: none"> <li>--Initial goals based on admission orders and discussion with the resident/representative.</li> <li>--Physician orders.</li> <li>--Dietary orders.</li> <li>--Therapy services.</li> <li>--Social services.</li> </ul> </li> <li>-The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than two days after admission).</li> <li>-The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: <ul style="list-style-type: none"> <li>--The stated goals and objectives of the resident/</li> <li>--a summary of the resident's medications and dietary instructions.</li> <li>--Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</li> <li>-Provision of the summary to the resident and/or resident representative is documented in the medical record.</li> </ul> </li> </ul> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #209's Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).</li> <li>-Chronic (persisting for a long time or constantly recurring) kidney disease (CKD- is a condition characterized by a gradual loss of kidney function over time).</li> </ul> <p>During an interview on 1/24/25 at 10:26 A.M., the resident said:</p> <ul style="list-style-type: none"> <li>-He/She wasn't sure if he/she had a care plan.</li> <li>-He/She signed something when he/she first came in.</li> <li>-He/She wasn't given a copy of what he/she had signed.</li> </ul> <p>Review of the resident's Electronic Health Record (EHR) baseline care plan on 1/24/25, 1/27/25, and 1/28/25 showed no data available, no record found.</p> <p>During an interview on 1/27/25 at 12:54 P.M., Certified Nurses Aide (CNA) A said:</p> <ul style="list-style-type: none"> <li>-He/She found information about residents on their care plan.</li> <li>-He/She did not know anything about base line care plans.</li> </ul> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said:</p> <ul style="list-style-type: none"> <li>-Care plans could be seen on the resident's medical record.</li> <li>-Care plans should be up to date.</li> <li>-The nurses took care of care plans.</li> <li>-He/She did not know anything about base line care plans.</li> </ul> <p>On 1/28/25 at 9:00 A.M., a copy of the resident's care plan was requested from the Director of Nursing (DON) and was not received by the end of survey.</p> <p>Review of the resident's paperwork handed to the surveyor on 1/28/25 at 2:42 P.M. by the DON showed the resident's care plan was initiated on 1/27/25 and updated on 1/28/25.</p> <p>Review of the resident's EHR care plan on 1/28/25 at 2:45 P.M., showed:</p> <ul style="list-style-type: none"> <li>-The care plan was dated as initiated on 1/2/25.</li> <li>--There was no data.</li> <li>---It showed no record found.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/29/25 at 10:00 A.M., the MDS Coordinator said:</p> <ul style="list-style-type: none"> <li>-He/She had not completed or updated all the care plans.</li> <li>-He/She was called to work the floor a lot.</li> <li>-He/She had been in the position for two weeks and the MDS Coordinator before him/her was not doing the care plans correctly.</li> <li>-He/She said a baseline care plan should be done upon admission and the completed care plan should be within two weeks.</li> <li>--He/She did not do base line care plans as he/she did not have time.</li> </ul> <p>During an interview on 1/29/25 at 10:32 A.M., Licensed Practical Nurse A said:</p> <ul style="list-style-type: none"> <li>-The MDS Coordinator did the initial care plans.</li> </ul> <p>During an interview on 1/31/25 at 3:25 P.M., the DON, Assistant Director, and the Executive Director said:</p> <ul style="list-style-type: none"> <li>-A baseline care plan should be done within 72 hours of admission.</li> <li>-The MDS Coordinator was responsible for initiating the base line care plan.</li> </ul>		

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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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42955</p> <p>Based on interview and record review, the facility failed to provide continuity of resident care by not developing and implementing resident comprehensive care plans for one sampled resident (Resident #109) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility's Care Plans, Comprehensive Person-Centered policy, dated March 2022, showed:</p> <ul style="list-style-type: none"> <li>-A comprehensive care plan was developed for each resident.</li> <li>-The care plan was developed within seven days of the completion of the resident's required Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) and no more that 21 days after admission.</li> <li>-Each resident and/or their representative had the right to participate in care plan development.</li> <li>-Each care plan included: <ul style="list-style-type: none"> <li>--Measurable objectives and time frames.</li> <li>--Description of services to be provided.</li> <li>--Resident's goals.</li> </ul> </li> </ul> <p>1. Review of the Resident #109's face sheet, undated, showed the resident admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Dependence on supplemental oxygen.</li> <li>-Muscle weakness.</li> <li>-Heart failure.</li> </ul> <p>Review of the resident's Admission MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>During an interview on 1/22/25 at 9:32 A.M., the resident said:</p> <ul style="list-style-type: none"> <li>-He/She did not remember having a care plan meeting when he/she was admitted to the facility.</li> <li>-He/She did not express familiarity with the care process when it was explained to him/her.</li> </ul> <p>During an interview on 1/23/24 at 10:09 A.M., the MDS Coordinator said:</p> <ul style="list-style-type: none"> <li>-He/She was called to work the floor a lot.</li> </ul> <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 had not completed all the care plans.</p> <p>-He/She had been in the position for two weeks and the MDS Coordinator before him/her was not doing the care plans correctly.</p> <p>-The comprehensive care plan should be completed within two weeks.</p> <p>-The resident's comprehensive care plan was not completed.</p> <p>Review of the resident's Electronic Health Record (EHR) on 1/24/25, 1/25/25, and 1/27/25 showed no base line or comprehensive care plan had been developed for the resident.</p> <p>During an interview on 1/27/25 at 12:54 P.M., Certified Nursing Assistant (CNA) A said:</p> <p>-He/She found information about the resident on their care plan.</p> <p>-He/She was unaware if the resident had a care plan completed.</p> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said:</p> <p>-Care plans can be seen on the resident's medical record.</p> <p>-He/She was unsure if the resident had a care plan.</p> <p>Review of the resident's EHR on 1/28/25 showed no care plan had been developed for the resident.</p> <p>During an interview on 1/28/25 at 9:30 A.M., Licensed Practical Nurse (LPN) A said:</p> <p>-Care plans were completed when the resident's MDSs were done.</p> <p>-The resident should have a care plan.</p> <p>-He/She had not looked for a care plan for the resident.</p> <p>Review of the resident's comprehensive care plan showed:</p> <p>-It was initiated on 12/31/24.</p> <p>-It was not completed until 1/28/25.</p> <p>During an interview on 1/29/25 at 10:32 A.M., LPN A said:</p> <p>-The MDS Coordinator was responsible for creating the care plans.</p> <p>-Nurses told the MDS Coordinator when something needed updated.</p> <p>-The MDS Coordinator then updated the care plans.</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>During an interview on 1/31/25 at 3:25 P.M., the DON, Assistant Director, and the Executive Director said:</p> <ul style="list-style-type: none"> <li>-It was the responsibility of the MDS Coordinator to create all resident care plans.</li> <li>-It was the responsibility of the MDS Coordinator to keep all care plans accurate with current information.</li> </ul>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42955</p> <p>Based on observation, interview, and record review, the facility failed to provide continuity of resident care by not reviewing and revising resident comprehensive care plans for four sampled residents (Resident #15, #28, #39, and #9) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility's Care Plans, Comprehensive Person-Centered policy, dated March 2022, showed:</p> <ul style="list-style-type: none"> <li>-A comprehensive care plan was developed for each resident.</li> <li>-The care plan was developed within seven days of the completion of the resident's required Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) and no more than 21 days after admission.</li> <li>-Assessments of residents were ongoing and care plans were reviewed and revised as information about the resident and resident's conditions change.</li> <li>-The interdisciplinary team (facility staff and health care professionals who work together to manage the physical, psychological, and spiritual needs of the resident) reviewed and updated care plans at least quarterly.</li> </ul> <p>Review of the facility's MDS Coordinator Job Description, dated March 2023, showed:</p> <ul style="list-style-type: none"> <li>-To ensure timely, accurate, and complete assessment of the resident's health and functional status during the entire assessment period.</li> <li>-Participate in the interdisciplinary team process to communicate opportunities, facilitate efficient and effective care plan development and management.</li> <li>-Communicate with care team regarding practitioner orders, care plans, and changes in condition.</li> </ul> <p>1. Review of Resident #15's face sheet, undated, showed the resident admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Otalgia (a condition which caused discomfort, aching, or sharp pain in one or both ears).</li> <li>-Unspecified hearing loss.</li> <li>-Anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress).</li> </ul> <p>Review of the resident's Hearing Aid Purchase Agreement, dated 7/3/24, showed the resident received a new hearing aid for his/her left ear.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-The resident had minimal difficulty hearing.</li> <li>-The resident did not have hearing aids.</li> </ul> <p>During an interview on 1/24/25 at 8:57 A.M., the resident said:</p> <ul style="list-style-type: none"> <li>-He/She needed batteries for his/her hearing aid.</li> <li>-He/She asked staff to replace them.</li> </ul> <p>Observation on 1/24/25 at 8:57 A.M., showed:</p> <ul style="list-style-type: none"> <li>-The resident was speaking to the surveyor.</li> <li>-The surveyor had to speak loudly for the resident to understand what was being said.</li> <li>-The resident was fidgeting with his/her hearing aid and a pack of unused hearing aid batteries.</li> </ul> <p>During an interview on 1/27/25 at 12:54 P.M., Certified Nursing Assistant (CNA) A said:</p> <ul style="list-style-type: none"> <li>-He/She did not remember the resident having a hearing aid.</li> <li>-The resident had not asked him/her for batteries.</li> </ul> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said he/she was unaware if the resident had hearing aids.</p> <p>During an interview on 1/28/25 at 9:30 A.M., Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> <li>-He/She had never seen the resident with hearing aids.</li> <li>-If a resident did wear hearing aids it should be on the resident's care plan so staff were aware of the use of hearing aids.</li> </ul> <p>During an interview on 1/30/25 at 10:44 A.M., LPN C said:</p> <ul style="list-style-type: none"> <li>-Resident care plans should have current information.</li> <li>-Hearing aids should be in the care plan.</li> <li>-Resident #15 had a hearing aid in his/her left ear.</li> <li>-He/She checked the EHR and did not see hearing aids on the care plan.</li> </ul> <p>During an interview on 1/31/25 at 3:25 P.M., with the Director of Nursing (DON) present, the Executive Director said:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #15 had a hearing aid.</p> <p>-The hearing aid should have been addressed in the resident's care plan.</p> <p>2. Review of Resident #28's face sheet, undated, showed the resident was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Alzheimer's Disease (a brain disorder that included loss of memory, confusion, difficulty thinking, and changes in language, behavior, and personality).</p> <p>-Age related physical debility.</p> <p>-Anxiety.</p> <p>Review of the resident's Hospice (end of life care) contract, dated 8/27/24, showed the resident entered Hospice care on 8/27/24.</p> <p>Review of the resident's care plan, dated 11/13/24, showed no documentation of the resident receiving Hospice care.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-The resident was severely cognitively impaired.</p> <p>-The resident was on Hospice.</p> <p>Review of the resident's Hospice Book, undated showed the resident had received visits from Hospice personnel throughout the months of December 2024 and January 2025.</p> <p>During an interview on 1/22/25 at 9:37 A.M., the resident's family member said the resident was on Hospice.</p> <p>During an interview on 1/30/25 at 10:44 A.M., LPN C said:</p> <p>-The resident care plans should have current information.</p> <p>-Hospice care should be in the care plan.</p> <p>-Resident #28 was on Hospice.</p> <p>-He/She checked the EHR and did not see Hospice on the care plan.</p> <p>During an interview on 1/31/25 at 3:25 P.M., with the Director of Nursing (DON) present, the Executive Director said:</p> <p>-Resident #28 was receiving Hospice services.</p> <p>-Hospice should have been addressed in the resident's care plan.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of Resident #39's Admission MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-He/She was cognitively intact.</li> <li>-The resident was dependent on staff for feeding assistance.</li> </ul> <p>Review of the resident's electronic care plan, dated 11/15/24, showed:</p> <ul style="list-style-type: none"> <li>-No goals or interventions regarding feeding assistance was addressed.</li> <li>-NOTE: a paper copy of the care plan was requested and not received</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact.</li> <li>-The resident was at risk for malnutrition.</li> <li>-The resident was dependent on staff for feeding assistance.</li> <li>-He/She was diagnosed with muscle weakness.</li> </ul> <p>During an interview on 1/22/25 at 8:30 A.M. the resident's family member said:</p> <ul style="list-style-type: none"> <li>-The resident needed feeding assistance.</li> <li>-The staff were not feeding the resident.</li> </ul> <p>During an interview on 1/29/25 at 10:32 A.M., LPN A said:</p> <ul style="list-style-type: none"> <li>-The resident required total assistance from staff with feeding.</li> </ul> <p>During an interview on 1/30/25 at 10:44 A.M., LPN C said:</p> <ul style="list-style-type: none"> <li>-The resident was totally dependant on staff for feeding.</li> </ul> <p>During an interview on 1/31/25 at 3:25 P.M., with the Director of Nursing (DON) present, the Executive Director said:</p> <ul style="list-style-type: none"> <li>-The resident was dependent on staff for feeding assistance.</li> <li>-The resident's care plan should have reflected the total dependence on staff for feeding assistance.</li> </ul> <p>22727</p> <p>4. Review of Resident #9's significant change MDS, dated [DATE], showed the resident had no wounds.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan, dated 7/25/23, showed:</p> <ul style="list-style-type: none"> <li>-The resident had a stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear) to his/her face on the right cheek.</li> <li>-The resident had a venous/stasis ulcer (open lesion caused by poor circulation) of the coccyx with a treatment in place.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident had one stage III (full thickness tissue loss; subcutaneous fat may be visible, but bone, tendon or muscle is not exposed) pressure ulcer.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident had four stage IV pressure ulcers.</p> <p>Review of the resident's care plan, updated 1/24/25, (third day of the survey) showed:</p> <ul style="list-style-type: none"> <li>-The resident had a venous/stasis ulcer of the coccyx with treatment in place.</li> <li>-The care plan did not include the resident's facial wound on his/her cheek.</li> </ul> <p>Review of the resident's Physician's Order Sheet (POS) dated January 2025 showed:</p> <ul style="list-style-type: none"> <li>-Physician's orders for a treatment to the resident's coccyx dated 2/7/24.</li> <li>-Physician's orders for a treatment to the resident's face on the right cheek dated 12/23/24.</li> </ul> <p>Observation on 1/27/25 at 3:06 P.M., with LPN E showed:</p> <ul style="list-style-type: none"> <li>-The resident had a wound on his/her coccyx and a wound on his/her face on the right cheek.</li> <li>-LPN E completed the wound treatments on both wounds.</li> </ul> <p>During an interview on 1/29/25 at 10:32 A.M., LPN A said:</p> <ul style="list-style-type: none"> <li>-The MDS Coordinator developed the care plans.</li> <li>-The nurses told the MDS Coordinator of any changes with the residents and then the MDS Coordinator was responsible for updating the care plan.</li> </ul> <p>During an interview on 1/30/25 at 9:08 A.M., the MDS Coordinator said:</p> <ul style="list-style-type: none"> <li>-The family told him/her they weren't aware of the wound on the resident's cheek.</li> <li>-He/She read somewhere that the resident had the cheek wound when he/she admitted to the facility.</li> <li>-He/She was told the resident's cheek wound was cut off.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She was responsible for developing the care plans.</p> <p>-He/She was assigned other duties such as working as a floor nurse and doing baths so sometimes he/she didn't have time to do care plans.</p> <p>5. During an interview on 1/23/25 at 10:09 A.M., the MDS Coordinator said:</p> <p>-He/She was called to work the floor a lot.</p> <p>-He/She had not completed or updated all the care plans.</p> <p>-He/She had been in the position for two weeks and the MDS Coordinator before him/her was not doing the care plans correctly.</p> <p>-Care plan changes need to be updated quarterly and with any changes in resident's condition.</p> <p>During an interview on 1/27/25 at 12:54 P.M., CNA A said:</p> <p>-He/She found information about residents on their care plan.</p> <p>-He/She was unaware of when care plan updates were completed.</p> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said:</p> <p>-Care plans could be seen on the resident's medical record.</p> <p>-Care plans should be up to date.</p> <p>During an interview on 1/29/25 at 10:32 A.M., LPN A said:</p> <p>-Nurses do not update care plans.</p> <p>-Nurses told the MDS Coordinator when something needed updated.</p> <p>-The MDS Coordinator then updated the care plans.</p> <p>During an interview on 1/31/25 at 3:25 P.M., with the Director of Nursing (DON) present, the Executive Director said:</p> <p>-Any wounds that were present upon admission should be in the care plan.</p> <p>-Updates to care plans should stem from communication between the DON and the MDS Coordinator.</p> <p>MO00247435</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>22727</p> <p>Based on interview and record review, the facility failed to ensure physician orders were changed and transcribed correctly when the physician agreed with the pharmacists review for changes for two sampled residents (Resident #40 and #29 ) out of 14 sampled residents. The facility census was 55 residents.</p> <p>1. Review of Resident #40's Medication Regimen Review (MRR) by the pharmacist, dated 12/2/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident had an order for Fluticasone 110 microgram (mcg) inhaler one puff every six hours as needed for shortness of breath.</li> <li>-The pharmacist documented that Fluticasone was not a rescue medication to be used as needed and that having it scheduled would decrease the inflammation and help with breathing.</li> <li>-The pharmacist documented that the usual dosage for Fluticasone was one to two inhalations twice a day and recommended that the Fluticasone order be changed from as needed to twice a day.</li> <li>-The resident's primary care physician marked that he/she agreed with the recommendation and wrote an order to change the order to two puffs twice a day.</li> </ul> <p>Review of the resident's Physician's Order Sheet (POS) dated January 2025 showed a physician's order dated 12/12/24 for Fluticasone 110 mcg inhaler, two puffs every six hours as needed for shortness of breath.</p> <p>37576</p> <p>2. Review of Resident #29's MRR notes, dated 4/4/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident was on Digoxin (a medication to treat Congestive Heart Failure) and had not had a Digoxin level lab drawn since February 2023.</li> <li>-Please order these labs on the next convenient lab date and annually if they are due.</li> <li>--The physician agreed on 5/1/24.</li> </ul> <p>Review of the resident's MRR notes, dated 5/1/24, showed:</p> <ul style="list-style-type: none"> <li>-Digoxin levels were not included in lab results from 4/10/24.</li> <li>-Digoxin levels were not included in lab results in May 2024.</li> <li>-Please make sure labs were being done as ordered.</li> <li>--The physician agreed on 6/6/24.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's POS dated January 2025 showed:</p> <ul style="list-style-type: none"> <li>-Digoxin level to be drawn annually in May.</li> <li>-The date of the order was 10/23/24.</li> <li>--NOTE: The date of the order was five months after the original recommendation from the pharmacist.</li> </ul> <p>Review of the resident's medical record lab results showed:</p> <ul style="list-style-type: none"> <li>-The digoxin level results were not documented as being drawn on 10/23/24.</li> <li>-The staff were not able to locate the digoxin level results ordered on 10/23/24.</li> </ul> <p>3. During an interview on 1/29/25 at 10:32 A.M., Licensed Practical Nurse (LPN A) said:</p> <ul style="list-style-type: none"> <li>-The MRRs go to the Director of Nursing (DON).</li> <li>-He/She had not been given any MRR responses to enter medication order changes for any residents.</li> </ul> <p>During an interview on 1/31/25 at 12:05 P.M. with the DON and the Executive Director:</p> <ul style="list-style-type: none"> <li>-The Executive Director said:</li> <li>--The orders should have been transcribed correctly.</li> <li>-The DON said:</li> <li>--The charge nurse should have ensured the orders were transcribed correctly.</li> <li>--He/She had not checked to make sure the orders were transcribed correctly.</li> </ul>		

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  02/19/2025
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42955</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary services to maintain personal hygiene by not helping residents complete Activities of Daily Living (ADL), bathing/showering, causing poor hygiene and physical discomfort for six sampled dependent residents (Resident #12, #44, #109, #3, #39, and #50) out of 14 sampled residents. The facility census was 55 residents.</p> <p>A policy regarding ADLs was requested but not provided.</p> <p>Review of the facility's Bath, Shower/Tub policy, undated, showed:</p> <p>-The purpose of the policy was to provide a step-by-step procedure that promoted cleanliness, provided comfort to the resident and to observe the condition of the resident's skin</p> <p>-Document the date and time the shower/tub bath was performed with the name, title of the individual who assisted the resident.</p> <p>-Document all assessment data regarding skin condition.</p> <p>-Document if the resident refused.</p> <p>1. Review of Resident #12's face sheet, undated, showed the resident was admitted to the facility with the following diagnoses:</p> <p>-Unsteadiness on his/her feet.</p> <p>-Polyosteoarthritis (a degenerative joint disease that affected five or more joints at the same time).</p> <p>Review of the resident's care plan, dated 7/22/24, showed:</p> <p>-The resident had an ADL self-care performance deficit related to contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that caused the joints to be very stiff) of right and left knee with pain.</p> <p>-Interventions included:</p> <p>--Provide sponge bath if full bath/shower was not available.</p> <p>--The resident was totally dependent on one staff to provide bath/shower twice weekly on Tuesday and Friday.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated 10/21/24, 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>-The resident was cognitively intact.</p> <p>-The resident was dependent on staff for showering/bathing.</p> <p>-The resident used a wheelchair for mobility.</p> <p>Review of the resident's Skin Monitoring Comprehensive Certified Nursing Assistant (CNA) Shower Reviews (Shower Sheets), dated December 2024 and January 2025, showed:</p> <p>-The resident did not receive a bath/shower eight out of nine opportunities in December 2024.</p> <p>-The resident did not receive a bath/shower eight out of nine opportunities in January 2025.</p> <p>During an interview on 1/22/25 at 10:28 A.M., the resident said:</p> <p>-He/She had trouble getting showers on his/her scheduled shower days of Tuesday and Friday.</p> <p>-There was a bath aide that worked on his/her unit, but the bath aide missed a lot of work and when the bath aide didn't come in on his/her bath days then he/she missed his/her bath.</p> <p>-It had been about two weeks since his/her last bath.</p> <p>-He/She did not like missing showers as he/she felt dirty after missing so many.</p> <p>During an interview on 1/27/25 at 12:54 P.M., CNA A said:</p> <p>-He/She was unsure of the resident's bath days.</p> <p>-He/She had given a bath to the resident, but it had been a while.</p> <p>-The resident had not asked for a bath.</p> <p>-If there was no bath aide, the CNAs were supposed to do the baths.</p> <p>-The baths did not always get done if there was no bath aide.</p> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said:</p> <p>-He/She had not done any bathing with the resident.</p> <p>-He/She thought there was a sheet the aides were supposed to fill when baths were given.</p> <p>-He/She thought the bath sheets were at the nurses station.</p> <p>-He/she couldn't remember specific dates, but the resident had complained about not getting baths.</p> <p>-He/She was unaware of what the resident's shower days were.</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 unsure if there was a bath aide working on the unit.</p> <p>-If there was no bath aide, the CNAs were supposed to do the baths.</p> <p>-The baths did not always get done if there was no bath aide.</p> <p>2. Review of Resident #44's face sheet, undated, showed the resident was admitted to the facility with the following diagnoses:</p> <p>-Unspecified dementia (the loss of cognitive functioning, thinking, remembering, and reasoning that interferes with daily life and activities).</p> <p>-Weakness.</p> <p>-History of falling.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-The resident was severely cognitively impaired.</p> <p>-The resident required substantial/maximal assistance (helper did more than half of the effort) with showering/bathing.</p> <p>-The resident used a wheelchair for mobility.</p> <p>Review of the resident's care plan, dated 10/11/24, showed:</p> <p>-The resident had an ADL self-care performance deficit related to dementia.</p> <p>-The resident required physical assistance from one staff member for showering.</p> <p>Review of the resident's Shower Sheets, dated December 2024 and January 2025, showed:</p> <p>-The resident did not have a shower eight out of nine opportunities in December 2024.</p> <p>-The resident did not have a shower eight out of nine opportunities in January 2025.</p> <p>During an interview on 1/22/25 at 1:06 P.M., the resident's family member said:</p> <p>-The resident was not getting baths from facility staff.</p> <p>-The resident was on Hospice (end of life care) and they had been providing supplemental baths when they came to the facility.</p> <p>-The facility was supposed to provide baths.</p> <p>During an interview on 1/27/25 at 12:54 P.M., CNA A said:</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>-The resident was getting baths, probably from Hospice.</p> <p>-He/She documented bathing on shower sheets and charted it in the electronic health record (EHR).</p> <p>-He/She did not forget to chart bathing.</p> <p>-He/She ensured to chart so he/she knew it was done.</p> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said:</p> <p>-He/She never had to shower the resident.</p> <p>-The unit had a bath aide, but they put their notice in and had not worked since last week.</p> <p>-The resident was on Hospice, and they were here regularly.</p> <p>-The resident got baths from Hospice.</p> <p>-They came twice a week.</p> <p>-The resident had not asked him/her for baths or showers.</p> <p>3. Review of Resident #109's face sheet, undated, showed the resident was admitted to the facility with the following diagnoses:</p> <p>-Dependence on supplemental oxygen.</p> <p>-Muscle weakness.</p> <p>-Heart failure.</p> <p>Review of the resident's baseline care plan, dated 12/31/24, showed:</p> <p>-The resident required assistance with bathing.</p> <p>-The resident had limited physical mobility related to morbid obesity.</p> <p>-The resident was weight bearing.</p> <p>Review of the resident's Shower Sheets dated January 2025 showed:</p> <p>-The resident did not receive a bath/shower six out of nine opportunities.</p> <p>During an interview on 1/22/25 at 9:32 A.M., the resident said:</p> <p>-He/She arrived right before New Year's Day.</p> <p>-His/Her first bath was on 1/15/25.</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>-His/Her bath days were supposed to be Wednesdays and Saturdays.</p> <p>-He/She mentioned getting a bath or shower to the staff, but did not get one.</p> <p>-Staff say they would get the help they need and be right back and never come back.</p> <p>Observation on 1/22/25 at 9:32 A.M., showed the resident:</p> <p>-Was in bed.</p> <p>-Had a slight body odor.</p> <p>-Was in a gown and not dressed in street clothes.</p> <p>During an interview on 1/27/25 at 12:54 P.M., CNA A said:</p> <p>-He/She had been in the resident's room several times.</p> <p>-The resident did not get out of bed.</p> <p>-The resident needed a mechanical lift to get in and out of bed.</p> <p>-There was a shower aide on the unit.</p> <p>-If the shower aide missed work, then the day shift aides did half of the residents baths and the night shift did the other half of baths.</p> <p>-He/She did not always have time to bathe residents with his/her other responsibilities.</p> <p>-He/She was unaware if the resident preferred bed baths or full showers.</p> <p>-He/She could not recall the last time he/she gave a bath to the resident.</p> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said:</p> <p>-He/She was unsure if the resident refused baths.</p> <p>-He/She did not know the resident's bath preferences.</p> <p>-He/She would find the resident's preference in the care plan.</p> <p>-The resident had at least one bath since he/she had admitted to the facility.</p> <p>-He/She thought the resident was admitted around the first of the month.</p> <p>39469</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>4. Review of Resident #3's face sheet showed he/she was admitted to the facility with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Cerebrovascular disease (a group of conditions that impact the brain's blood vessels and blood supply).</li> <li>-Muscle weakness.</li> <li>-Hemiplegia (muscle weakness or partial paralysis on one side of the body).</li> </ul> <p>Review of the resident's MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-The cognitive section was not completed.</li> <li>-The ADL section was not completed.</li> <li>-The resident did not refuse cares.</li> </ul> <p>Review of the resident's shower sheets, dated December 2024, showed:</p> <ul style="list-style-type: none"> <li>-The resident did not receive a shower on seven out of eight opportunities.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-There was no cognitive score.</li> <li>-He/She needed assistance with bathing.</li> <li>-He/She had Hemiplegia.</li> </ul> <p>Review of the resident's care plan, dated 1/27/25, showed:</p> <ul style="list-style-type: none"> <li>-The resident was totally dependent on one staff to provide a bath/shower twice a week and as necessary, dated 8/25/24.</li> </ul> <p>Review of the resident's shower sheets, dated January 2025, showed:</p> <ul style="list-style-type: none"> <li>-The resident did not receive a shower on seven out of eight opportunities.</li> </ul> <p>During an interview on 1/30/25 at 1:25 P.M. Licensed Practical Nurse (LPN) C said:</p> <ul style="list-style-type: none"> <li>-The CNAs should have provided the resident with a bath or shower if there was no bath aide.</li> </ul> <p>5. Review of Resident #39's Admission MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-The ADL section was not completed.</li> <li>-The resident did not refuse cares.</li> </ul> <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>Review of Resident #39's shower sheets, dated November 2024 and December 2024, showed:</p> <ul style="list-style-type: none"> <li>-The resident did not receive a shower five out of five opportunities from 11/21/24 to 12/5/24.</li> <li>-The resident did not receive a shower seven out of seven opportunities from 12/10/24 to 12/31.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-There were no neurological problems.</li> <li>-He/She had limited range of motion on both sides, upper and lower extremities.</li> <li>-He/She was dependent on staff for bathing.</li> <li>-He/She was cognitively intact.</li> </ul> <p>Review of the resident's shower sheets, dated January 2025, showed:</p> <ul style="list-style-type: none"> <li>-The resident did not receive a shower seven out of seven opportunities from 1/1/25 to 1/21/25.</li> </ul> <p>During an interview on 1/27/25 at 3:30 P.M., the resident's family member said:</p> <ul style="list-style-type: none"> <li>-The resident had not been offered a bath or shower weekly.</li> <li>-Once the resident went three weeks without a shower.</li> <li>-The family had complained to the facility Administration and was told they were trying to hire more staff.</li> </ul> <p>Observation on 1/27/25 at 3:40 P.M., showed the resident:</p> <ul style="list-style-type: none"> <li>-Was not able to use his/her hands.</li> <li>-Needed assistance with all cares.</li> <li>-Had a slight body odor, and looked unkept.</li> </ul> <p>During an interview on 1/27/25 at 3:40 P.M., the resident said:</p> <ul style="list-style-type: none"> <li>-He/She wanted baths.</li> <li>-He/She felt dirty after going days or weeks without a bath.</li> <li>-He/She had told staff he/she wanted a bath.</li> </ul> <p>During an interview on 1/28/25 at 1:00 P.M., LPN A said the resident never refused a shower.</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 1/30/25 at 10:00 A.M., LPN C said the resident never refused to take a shower.</p> <p>37576</p> <p>6. Review of Resident #50's Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Seborrheic Dermatitis (a skin condition causing scaly patches and red shin, mainly on scalp, but can occur on oily areas of body), 9/6/23.</li> <li>-Need for assistance with personal care, 2/1/24.</li> </ul> <p>Review of the resident's Quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-No speech-absence of spoken words.</li> <li>-Frequently incontinent of bladder and always incontinent of bowel.</li> <li>-Aphasia (loss of ability to understand or express speech, usually caused by brain damage).</li> <li>-Needed assistance with bathing.</li> </ul> <p>Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review, dated December 2024 and January 2025, showed:</p> <ul style="list-style-type: none"> <li>-The resident did not receive a shower seven out of nine opportunities in December 2024.</li> <li>-The resident did not receive a shower five out of 10 opportunities in January 2025.</li> </ul> <p>During an interview on 1/23/25 at 1:25 P.M., the resident's spouse said:</p> <ul style="list-style-type: none"> <li>-The resident did not speak, he/she would shake his/her head for yes and no questions, or point to an item.</li> <li>-The resident did not get a shower twice a week sometimes he/she had gone more than a week without a shower.</li> <li>-The resident was sometimes incontinent.</li> <li>-He/She tried to come every other day and sometimes the resident had the same clothes on from the last time he/she was there.</li> <li>-He/she would clean the resident up and put on clean clothes.</li> <li>-The resident was a very clean person and would not miss a shower if it was offered.</li> </ul> <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>-The resident wanted to feel clean and when he/she did not have a shower he/she did not feel clean.</p> <p>Observation on 1/24/25 at 10:45 A.M., showed the resident:</p> <p>-Had dirty/greasy hair.</p> <p>-Had many flakes of dry scalp on his/her shirt.</p> <p>-Was wearing two shirts and both collars were soiled.</p> <p>During an interview on 1/28/25 at 1:00 P.M., LPN A said:</p> <p>-The resident was non-verbal, but was easily directed to get things done.</p> <p>During an interview on 1/29/25 at 10:30 A.M., Certified Medication Technician (CMT) C said:</p> <p>-He/She was working as a CNA.</p> <p>-CNA C was usually the bath aide for this wing, he/she did not come in today.</p> <p>-He/She was not sure if the CNA's were responsible for giving showers when the bath aide was not at work.</p> <p>-He/She was not sure if the resident received showers twice a week or not or if he/she refused showers.</p> <p>Observation on 1/29/25 at 11:45 A.M., showed the resident:</p> <p>-Had dirty/greasy hair.</p> <p>-Had many flakes of dry scalp on his/her shirt.</p> <p>-Had on a shirt that had a soiled collar.</p> <p>During an interview on 1/30/25 at 10:00 A.M., LPN C said if the resident had been given a bed bath it was not documented.</p> <p>7. During an interview on 1/27/25 at 1:40 P.M., CNA C said:</p> <p>-One of the bath aides had quit.</p> <p>-CNAs that worked were supposed to pick up the baths that were scheduled.</p> <p>-He/She was unsure if that was happening.</p> <p>-Residents told him/her they had not had 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>-Aides documented in the EHR under bath and showers when they were completed.</p> <p>-If the resident refused, he/she gave them time and then went back later to ask again.</p> <p>-If the residents still refused, he/she let the charge nurse know.</p> <p>-He/She completed bath sheets and gave them to the charge nurse to sign and she gave them to the Director of Nursing (DON).</p> <p>-There was a bath schedule: Monday/Thursday, Tuesday/Friday, and Wednesday/Saturday.</p> <p>-If there were not enough aides then residents didn't get their baths.</p> <p>During an interview on 1/28/25 at 9:30 A.M., LPN A said:</p> <p>-Residents were not getting consistent baths.</p> <p>-There were ten to 11 baths/showers scheduled each day.</p> <p>-CNA's were getting maybe two baths/showers done per day.</p> <p>-CNA's documented on shower sheets and gave them to the charge nurse.</p> <p>-There was no bath aide on Wednesday and the CNAs may have gotten four done.</p> <p>-Bathing was a huge issue.</p> <p>-He/She stepped in and gave baths when there was time.</p> <p>During an interview on 1/28/25 at 1:00 P.M., LPN A said:</p> <p>-The residents were not getting showers as they should have.</p> <p>-Many times, the shower aide did not show up for work.</p> <p>-They should have made out a shower sheet for all showers.</p> <p>-If the resident refused the shower, the shower aide should have offered to give the resident a shower a second time.</p> <p>-If the resident refused the shower both times, the resident and charge nurse should have signed the shower sheet indicating the showered had been refused.</p> <p>-The residents should have been offered two showers a week.</p> <p>During an interview on 1/29/25 at 10:00 A.M., the MDS Coordinator said:</p> <p>-The residents were not getting showers like they should have maybe once every two weeks.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-If a person had any preferences it should have been care planned.</p> <p>-If a resident needed assistance with ADLs it should have been care planned.</p> <p>-He/She was now responsible for the care plans.</p> <p>During an interview on 1/30/25 at 10:00 A.M., LPN C said:</p> <p>-The residents should have been offered two showers a week.</p> <p>-The residents usually get one shower a week.</p> <p>-Sometimes the shower aides did not show up.</p> <p>-The CNA's should give the residents a shower if there was no shower aide.</p> <p>-If the resident refused a shower, it should have been on the shower sheet that they had refused.</p> <p>During an interview on 1/31/25 at 4:55 P.M., the Assistant Director said:</p> <p>-Each resident had a scheduled bath two times a week.</p> <p>-Normally there was a bath aide for each unit who was responsible for giving baths.</p> <p>-The bath aide on one unit quit last week.</p> <p>-CNA's were expected to provide showers when bath aides were not scheduled on the shift.</p> <p>-Nurses were expected to step in to give baths when aides could not.</p> <p>-If residents were unable to get baths/showers then they should have received a bed bath.</p> <p>-He/She would not expect a resident to go two weeks without a bath/shower.</p> <p>-The DON was responsible to ensure residents were getting two showers a week.</p> <p>During an interview on 1/31/25 at 3:30 P.M., the DON said:</p> <p>-The residents should have been offered a shower twice a week.</p> <p>-They currently only had one shower aide.</p> <p>-The CNA's should have offered a shower to the resident if there was no shower aide.</p> <p>-Who ever offered the shower should have documented on the shower sheet if a shower or a bed bath was given or if the resident refused.</p> <p>-The DON was ultimately responsible for ensuring the residents were getting their showers.</p> <p>(continued on next page)</p>

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F 0677  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	-He/She would not have expected a resident to go more than a week without a shower.  MO00247435  MO00247567  MO00247918

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>42955</p> <p>Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities to meet the interests as well as the physical, mental, and psychosocial well-being for one sampled resident (Residents #109) out of 14 sampled residents. The facility census was 55 residents.</p> <p>A policy regarding resident activities was requested and not received.</p> <p>1. Review of Resident #109's face sheet, undated, showed the resident was admitted to the facility 12/31/21 with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Muscle weakness.</li> <li>-Morbid (severely overweight) obesity.</li> <li>-Heart failure.</li> </ul> <p>Review of the facility activity log dated October 2024 showed:</p> <ul style="list-style-type: none"> <li>-On 10/8/24, 10/9/24, 10/16/24,10/17/24, 10/22/24, 10/23/24, 10/24/24,10/25/24, 10/28/24, and 10/31/24 the resident did not attend activities.</li> </ul> <p>Review of the facility activity log dated November 2024 showed:</p> <ul style="list-style-type: none"> <li>-On 11/5/24, 11/6/24, 11/8/24, 11/12/24, 11/14/24, 11/15/24, 11/18/24, 11/19/24, 11/21/24, 11/22/24, 11/26/24, 11/27/24, and 11/29/24 the resident did not attend activities.</li> </ul> <p>Review of the facility activity log dated December 2024 showed:</p> <ul style="list-style-type: none"> <li>-On 12/2/24, 12/3/24, 12/4/24, 12/5/24, 12/6/24, 12/9/24, 12/10/24, 12/11/24, 12/12/24, 12/16/24, 12/17/24, 12/18/24, 12/19/24, 12/20/24, and 12/24/24 the resident did not attend activities.</li> </ul> <p>Review of the resident's Initial Activities Review, dated 1/2/25, showed:</p> <ul style="list-style-type: none"> <li>-The resident expressed he/she would like to go to activities.</li> <li>-He/She needed assistance to get to activities.</li> <li>-Assistance should be provided to get the resident to the activity.</li> </ul> <p>Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated 1/6/25, showed:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact.</li> </ul> <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 - Few</p>	<p>-It was very important to the resident to do his/her favorite activities.</p> <p>Review of the resident's care plan, dated 1/28/25, showed:</p> <ul style="list-style-type: none"> <li>-The resident would express satisfaction with type of activities and level of activity involvement when asked.</li> <li>-Invite and encourage the resident to attend activities.</li> <li>-Modify daily schedule to accommodate activity participation.</li> <li>-The resident needed a variety of activity types and locations to maintain interests.</li> <li>-The resident needed assistance/escort to activity functions.</li> </ul> <p>During an interview on 1/22/25 at 9:32 A.M., the resident said:</p> <ul style="list-style-type: none"> <li>-There was an activities calendar on the wall across the room.</li> <li>-It was too far away to read so he/she asked for a copy to keep at bedside and never received one.</li> <li>-He/she would like to go to activities.</li> <li>-The staff do not like to get him/her out of bed as he/she needed a mechanical lift for transfers.</li> <li>-He/She was not able to go to activities because staff did not get him/her up.</li> </ul> <p>During an interview on 1/27/25 at 12:54 P.M., Certified Nursing Assistant (CNA) A said:</p> <ul style="list-style-type: none"> <li>-The resident never asked to go to activities.</li> <li>-The resident did not want to get out of bed.</li> <li>-He/She needed a mechanical lift and the lift required two CNAs to use.</li> <li>-There were not always two CNAs available at the time the resident needed it.</li> <li>-He/She was unaware if the resident requested a calendar to keep at bedside.</li> </ul> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said:</p> <ul style="list-style-type: none"> <li>-The Life Enrichment Coordinator (Activities Director) or his/her assistant handed out activity calendars.</li> <li>-He/She did not know if the resident wanted to go to activities.</li> <li>-He/She did not ask the resident if he/she wanted to go to activities.</li> </ul> <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 - Few</p>	<p>During an interview on 1/28/25 at 9:30 A.M., Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> <li>-The resident did not ask for a lot and was very timid about asking for things.</li> <li>-When he/she offered to get the resident up for meals or activities then the resident got up.</li> <li>-He/She did not know if the resident wanted to go to activities, he/she did not ask the resident about going to activities.</li> </ul> <p>During an interview on 1/28/25 at 1:22 P.M., the Activities Director said:</p> <ul style="list-style-type: none"> <li>-The resident did not go to activities.</li> <li>-The resident had one-on-one activities in his/her room.</li> <li>-He/She had been in the resident's room a few times.</li> <li>-Residents who needed mechanical lifts did not come to activities.</li> <li>-The CNAs refused to get the residents up.</li> <li>-He/She had not told the Director of Nursing (DON) about staff not getting the resident up for activities.</li> <li>-The resident would enjoy the group activities and would come with encouragement.</li> <li>-The resident had a calendar at bedside.</li> </ul> <p>During an interview on 1/29/25 at 8:54 A.M., the resident said:</p> <ul style="list-style-type: none"> <li>-He/She was told by the CNAs they needed a days notice if he/she wanted to do something that required a mechanical lift (bathing, meals in the dining room, activities).</li> <li>-He/She was told by the CNAs he/she couldn't go to activities due to not enough staff to use the mechanical lift.</li> <li>-He/She did not remember when he/she was told he/she couldn't go to activities because of staffing.</li> <li>-He/She would really like to go to some activities, but there seemed to be an excuse every time for why staff couldn't get him/her out of bed to go.</li> </ul> <p>Observation on 1/29/25 at 8:54 A.M., showed:</p> <ul style="list-style-type: none"> <li>-There was no sling (device that covers and supports the shoulders, back and hips) under the resident.</li> <li>-The resident was in bed.</li> </ul> <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 - Few</p>	<p>During an interview on 1/31/25 at 4:55 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-The CNAs were responsible for getting resident's up using the mechanical lift.</li> <li>-Residents complained about the CNAs not wanting to get resident's up using the lift.</li> <li>-He/She expected the CNAs to comply with resident requests when a lift was needed.</li> <li>-He/She expected staff to offer to take residents to activities.</li> </ul>		

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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>42955</p> <p>Based on interview and record review, the facility failed to ensure the activities program was directed by a qualified professional when the staff person identified as the Life Enrichment Coordinator reported he/she did not complete the state approved training course. The facility census was 55 residents.</p> <p>An Activities policy was requested and not received.</p> <p>1. During an interview on 1/28/25 at 1:22 P.M., the Life Enrichment Coordinator said:</p> <p>-He/She did not complete the state approved training course.</p> <p>-He/She started it but with the changes in facility Administration it just didn't get done.</p> <p>-The previous Administrator was going to help pay for the course, but it was not paid for before he/she left the facility.</p> <p>During an interview on 1/28/25 at 1:42 P.M., the Human Resources (HR) Director said:</p> <p>-He/She thought the Administrator would be responsible for following up with the Life Enrichment Coordinator's certificate.</p> <p>-He/She was unaware if the Life Enrichment Coordinator was certified or not.</p> <p>-He/She assumed they were.</p> <p>During an interview on 1/31/25 at 4:55 P.M., the Executive Director said:</p> <p>-The Life Enrichment Coordinator was responsible for providing the activities program.</p> <p>-He/She did not know the Life Enrichment Coordinators education background.</p> <p>-He/She would expect the Life Enrichment Coordinator to have their certificate for the state approved training course.</p> <p>-He/She was not aware the Life Enrichment Coordinator did not have his/her certificate.</p> <p>-The facility should pay for the state approved course for the Life Enrichment Coordinator.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</b></p> <p>Based on observation, interview, and record review, the facility failed to complete and document weekly wound assessments that described the type and characteristics of the resident's coccyx wound (documented as non pressure) and face wound on the cheek, failed to complete wound treatments as ordered, failed to have a system in place to review the progress of wounds, and failed to keep the resident's cheek, neck, and chest free of dried drainage from the resident's facial wound for one sampled resident (Resident #9), and failed to ensure a follow-up surgical appointment was made per discharge orders to remove surgical staples for one sampled resident (Resident #29) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility wound care policy, dated 1/1/24, showed:</p> <ul style="list-style-type: none"> <li>-Any skin impairments should be assessed and documented weekly by the wound nurse or designee on the wound evaluation flow sheet or the weekly wound assessment in the Electronic Health Record (EHR).</li> <li>-Documentation of wounds should cover all pertinent characteristics of existing ulcers, including location, size, depth, maceration (the softening and breaking down of skin resulting from prolonged exposure to moisture), color of the ulcer and surrounding tissues, and a description of any drainage, eschar (dead tissue that falls off (sheds) from healthy skin), necrosis (relating to localized death of living cells as from interruption of blood supply or infection), odor, tunneling or undermining (the destruction of tissue or ulceration extending under the skin edges so that the pressure is larger at its base than at the skin surface. Undermining often develops from shearing forces and is differentiated from tunneling by the larger extent of the wound edge involved in undermining and the absence of a channel or tract extending from the pressure ulcer under the adjacent intact skin).</li> <li>-The wound nurse or designee should maintain and update a list of residents who have been identified to be at high risk and an assessment and documentation schedule.</li> <li>-Residents with wounds should be reviewed during weekly risk management committee meetings for progress, interventions, and care plan revision as appropriate.</li> </ul> <p>1. Review of Resident #9's EHR showed no skin assessments for the resident since 1/21/24.</p> <p>Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 7/18/24, showed the resident had one Stage 1 pressure ulcer (a persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved) and one skin tear.</p> <p>Review of the resident's care plan, dated 7/23/24, showed:</p> <ul style="list-style-type: none"> <li>-Pressure ulcer will show signs of healing and remain free from infection by/through review date.</li> <li>-Administer treatments as ordered and monitor for effectiveness.</li> <li>-Assess and treat for pain.</li> </ul> <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>-Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD.</p> <p>-Change treatment plan if no progress in 2-3 weeks as indicated.</p> <p>-Local wound care company to follow.</p> <p>Review of the resident's EHR showed there were no facility skin assessments dated 7/18/24 to 10/18/24.</p> <p>Review of the resident's EHR showed there were no progress notes that addressed the resident's skin issues dated 7/19/24 to 10/18/24.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-The skin section was not assessed.</p> <p>-The resident was dependent on staff for all cares.</p> <p>Review of the resident's Physician's Order Sheet (POS), dated November 2024, showed the following orders:</p> <p>-Cleanse the right facial cheek with normal saline, pat dry, apply skin prep to whole area, cover with Xeroform (cut to fit), sprinkle with pixie dust, secure with mepilex, change weekly and as needed for soiled until healed.</p> <p>-Cleanse the coccyx area with normal saline, apply pixie dust to wound bed, then fill area with Iodoform then cover with bandage on Monday, Wednesday, and Friday and as needed if soiled or dislodged.</p> <p>Review of the resident's Treatment Administration Record (TAR), dated November 2024, showed staff documented that the treatments to the resident's face wound on the cheek and the coccyx wounds were documented as completed as ordered.</p> <p>Review of the resident's hospice (end of life care) nurse visit summaries, dated November 2024, showed:</p> <p>-On 11/6/24, the resident's wound (location and type not specified) was 1.5-centimeter (cm) x 1.0 cm x 2.0 cm (length x width x depth).</p> <p>-On 11/13/24, the resident's coccyx wound was 1.7 cm x 1.0 cm x 2.0 cm with moderate tan drainage to dressing removed, had no odor, and was circular in shape with rolled edges.</p> <p>-On 11/20/24, the resident's coccyx wound was 2.0 cm x 1.5 cm x 1.5 cm with moderate tan drainage, had undermining with deepest of 2 cm at two o'clock, and was circular with rolled edges.</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>-On 11/29/24, the resident's coccyx wound was 2.0 cm x 1.0 cm x 2.1 cm with blood-tinged tan drainage, had no odor, had undermining with deepest of 2 cm at two o'clock, and was circular with rolled edges.</p> <p>-There was no description of the wound on the resident's right cheek.</p> <p>Review of the resident's EHR showed:</p> <p>-There were no facility wound assessments dated November 2024 for the resident's right facial cheek wound.</p> <p>-There were no facility wound assessments dated November 2024 for the resident's coccyx wound.</p> <p>Review of the resident's POS, dated December 2024, showed the following orders:</p> <p>-Cleanse the right facial cheek with normal saline, pat dry, apply skin prep to whole area, cover with Xeroform (cut to fit), sprinkle with pixie dust, secure with mepilex, change weekly and as needed for soiled until healed end date 12/13/24.</p> <p>-Cleanse the right facial cheek with wound cleanser, allow to air dry, apply skin prep to surrounding skin, apply xerform to raised lesion, apply calcium alginate around the raised areas, cover with a non adherent pad and secure with transparent dressing, change every Monday, Wednesday, Friday and as needed for soiling.</p> <p>-Cleanse the coccyx area with normal saline, apply pixie dust to wound bed, then fill area with Iodoform then cover with bandage on Monday, Wednesday, and Friday and as needed if soiled or dislodged.</p> <p>Review of the resident's TAR dated, December 2024, showed:</p> <p>-The resident's wound treatment to his/her right face cheek was not completed as ordered two out of six opportunities (12/11/24 and 12/27/24).</p> <p>-The resident's wound treatment to his/her coccyx was not completed as ordered five out of 13 opportunities (12/11/24, 12/16/24, 12/20/24, 12/23/24 and 12/27/24).</p> <p>Review of the resident's hospice nurse visit summaries, dated December 2024, showed:</p> <p>-On 12/4/24, the resident's coccyx wound was 2.0 cm x 1.3 cm x 2 cm, had no odor, and had undermining with deepest of 2 cm at two o'clock.</p> <p>-There was no description of the wound on the resident's right cheek.</p> <p>Review of the resident's EHR showed there were no facility wound assessments dated December 2024.</p> <p>Review of the resident's POS, dated January 2025, showed the resident:</p> <p>-Was admitted to hospice due to a stroke on 7/28/23.</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>-Cleanse the right facial cheek with wound cleanser, allow to air dry, apply skin prep to surrounding skin, apply xerform to raised lesion, apply calcium alginate around the raised areas, cover with a non adherent pad and secure with transparent dressing, change every Monday, Wednesday, Friday and as needed for soiling.</p> <p>-Cleanse the coccyx area with normal saline, apply pixie dust to wound bed, then fill area with Iodoform then cover with bandage on Monday, Wednesday, and Friday and as needed if soiled or dislodged.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-The resident was severely cognitively impaired.</p> <p>-The skin section was not assessed.</p> <p>-Section GG - functional abilities was not assessed.</p> <p>-The resident was on hospice.</p> <p>-The resident had a stroke and hemiplegia (paralysis of one side of the body) or hemiparesis (a slight paralysis or weakness on one side of the body).</p> <p>Review of the resident's care plan showed:</p> <p>-The printed care plan, dated 1/24/25, that was provided by the facility at 1:10 P.M. did not include any wounds.</p> <p>-The care plan in the EHR showed:</p> <p>-No care plan for the resident's wound on his/her cheek.</p> <p>--The problem identified updated on 1/24/25 (at an unknown time) was the resident had a venous/stasis ulcer (open lesion caused by poor blood flow) of the coccyx.</p> <p>--The desired outcome was that the resident would not have any signs of infection through the next review date.</p> <p>--Interventions included:</p> <p>---Evaluate wound for size, depth, margins, peri-wound skin, sinuses, undermining, exudates (any fluid that has been forced out of the tissues or its capillaries because of inflammation or injury), edema (swelling), granulation (new connective tissue and tiny blood vessels that form on the surfaces of a wound during the healing process), infection, necrosis, eschar, gangrene (dead tissue caused by an infection or lack of blood flow).</p> <p>---Document progress in wound healing on an ongoing basis.</p> <p>---Notify the resident's physician as indicated.</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>---Monitor, document, and report as needed for signs of infection such as green drainage, foul odor, redness, swelling, red lines coming from the wound, excessive pain, and fever.</p> <p>Review of the resident's POS, dated January 2025, showed:</p> <p>-Cleanse the coccyx area with normal saline, apply pixie dust to wound bed, then fill area with Iodoform then cover with bandage on Monday, Wednesday, and Friday and as needed if soiled or dislodged.</p> <p>-Treatment orders for the resident's coccyx were to be completed daily.</p> <p>-Cleanse the right facial cheek with wound cleanser, allow to air dry, apply skin prep to surrounding skin, apply xerform to raised lesion, apply calcium alginate around the raised areas, cover with a non adherent pad and secure with transparent dressing, change every Monday, Wednesday, Friday and as needed for soiling.</p> <p>-Treatment orders for the resident's right cheek were to be completed every Monday, Wednesday and Friday and as needed for soiling.</p> <p>Review of the resident's TAR, dated January 2025, showed:</p> <p>-The resident's wound treatment to his/her right cheek was not completed three times out of four opportunities (1/3/25, 1/10/25, and 1/17/25).</p> <p>-The resident's wound treatment to his/her coccyx was not completed four times out of four opportunities (1/3/25, 1/10/25, 1/17/25 and 1/24/25).</p> <p>Review of the resident's hospice nurse visit summaries, dated January 2025, showed:</p> <p>-On 1/8/25, the resident's coccyx wound was 2.0 cm x 1.0 cm x 2 cm, was oval, and had undermining all the way around with deepest of 2.1 cm at two o'clock.</p> <p>-On 1/15/25, the resident's coccyx wound was 2.0 cm x 1.0 cm x 2.1 cm, was round with rolled edges, and had undermining with deepest of 2.1 cm.</p> <p>-On 1/20/25, the resident's coccyx wound was 2.0 cm x 1.0 cm x 2.1 cm, was oval with rolled edges, and had undermining with deepest of 2.1 cm.</p> <p>-There was no description of the wound on the resident's right cheek.</p> <p>Review of the resident's EHR showed there were no facility wound assessments dated January 2025.</p> <p>Observation on 1/27/25 at 10:08 A.M. and 10:56 A.M., showed the bandage on the resident's right cheek was, dated 1/22/25, and there was dried reddish-brown drainage down the resident's chin, neck and top of his/her chest.</p> <p>Observation on 1/27/25 at 3:06 P.M., showed:</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>-The bandage on the resident's right cheek showed the dressing was dated Wednesday, 1/22/25 (the treatment should have been completed on 1/24/25) and was saturated through.</p> <p>-There was dried reddish-brown drainage down the resident's chin, neck, and top of his/her chest.</p> <p>During an interview on 1/28/25 at 8:42 A.M., the Director of Nursing (DON) said:</p> <p>-There should have been skin assessments in the EHR.</p> <p>-He/She did not know who was responsible for completing them.</p> <p>During an interview on 1/28/25 at 10:56 A.M., LPN A said:</p> <p>-The resident's right facial cheek and coccyx dressing changes were supposed to be done by hospice staff on Mondays and Wednesdays.</p> <p>-The resident's right facial cheek and coccyx dressing changes were supposed to be done by facility nurses on Fridays and as needed.</p> <p>-It was the DON's responsibility to do the wound assessments.</p> <p>During an interview on 1/29/25 at 10:32 A.M., LPN A said:</p> <p>-The drainage from the wound on the resident's cheek had to be cleaned off the resident's cheek, neck, and chest almost daily.</p> <p>-Hospice did the resident's wound measurements.</p> <p>-The facility wound assessments should have been done by the DON and should have included measurements.</p> <p>-When hospice gave him/her the wound measurements, he/she tried to chart it in the EHR but if he/she couldn't, the documentation was in the resident's hospice book.</p> <p>-There was no process in place to monitor the wounds.</p> <p>-He/She would tell the MDS Coordinator when a care plan needed to be updated.</p> <p>During an interview on 1/30/25 at 9:08 A.M., the MDS Coordinator said:</p> <p>-No one was overseeing wound care.</p> <p>-No one was doing skin assessments.</p> <p>-He/She did not know who should have been doing skin assessments.</p> <p>During an interview on 1/31/25 at 3:25 P.M., the Assistant Director said:</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>-The nurses should have completed wound treatments as ordered.</p> <p>-There should have been documentation of the description of the resident's wounds weekly.</p> <p>-There was no facility-wide tracking system in place to monitor residents' wounds.</p> <p>-They were not discussing wounds in any of their meetings.</p> <p>During an interview on 1/31/25 at 3:25 P.M., the DON said:</p> <p>-The nurses should have completed the wound treatments as ordered for Resident #9.</p> <p>-The nurses on duty were responsible for completing the wound treatments for Resident #9.</p> <p>-The nurses should assess the wounds when doing treatments for Resident #9.</p> <p>-The nurses doing the treatments should determine if the wounds were getting better or not.</p> <p>-The resident's physician should be notified if the wound was not getting better so a different treatment could be ordered.</p> <p>-There were skin assessments in the EHR that should have been completed weekly and they staff should have documented about the wounds in the progress notes for Resident #9.</p> <p>-Resident #9's wound assessments should have been completed and should have included descriptions and measurements of the wounds.</p> <p>-No one was classifying the wounds at this time.</p> <p>-The resident should have been kept clean from drainage from his/her cheek wound.</p> <p>37576</p> <p>2. Review of Resident #29's Admission Record showed he/she admitted on [DATE] and readmitted on [DATE] with the following diagnoses:</p> <p>-Chronic Kidney Disease, stage 3A (CKD- is a condition characterized by a moderate loss of kidney function over time) 1/16/24.</p> <p>-Chronic Congestive Heart Failure (CHF-chronic condition in which the heart doesn't pump blood as well as it should) 1/5/24.</p> <p>-Fracture of base of neck of unspecified femur (fracture at the top of the femur [thigh bone] near the hip joint with the exact location not specified) 11/14/24.</p> <p>Review of the resident's progress note, dated 11/10/24 at 3:28 P.M., showed the resident was transported to the hospital post fall with dizziness, left hip pain, pain in the head due to hitting head on the floor and a laceration on his/her nose with mild bleeding.</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>Review of the resident's progress note, dated 11/14/24 at 2:41 P.M., showed:</p> <ul style="list-style-type: none"> <li>-The resident arrived back at the facility from the hospital.</li> <li>-The hospital found a left hip fracture with open reduction and internal fixation (ORIF-a surgical procedure to realign broken bones and stabilize them with metal hardware) conducted.</li> <li>-Weight-bearing as tolerated.</li> </ul> <p>Review of the resident's hospital discharge paperwork, dated 11/15/25, showed:</p> <ul style="list-style-type: none"> <li>-discharge date : 11/14/25.</li> <li>-Discharge diagnosis: left hip fracture.</li> <li>-Orthopedic surgery evaluated.</li> <li>-Now status post Open Reduction Internal Fixation (ORIF) of the left hip on 11/11/24.</li> <li>-Weight Bearing As Tolerated (WBAT), Left Lower Extremity (LLE), range of motion (ROM - the range on which a joint can move) as tolerated.</li> <li>-Pain control as needed.</li> <li>-Follow up with doctor in two weeks for skin check and suture/staple removal, call to schedule appointment.</li> </ul> <p>Review of the resident's progress note, dated 11/15/2024 at 5:21 A.M., showed:</p> <ul style="list-style-type: none"> <li>-Resident's dressing to left hip was clean, dry and intact.</li> <li>-Nine staples to surgical site.</li> <li>-No swelling or drainage noted and minimal redness.</li> </ul> <p>Review of the resident's EHR showed:</p> <ul style="list-style-type: none"> <li>-No POS orders for follow-up appointment for skin check and suture/staple removal.</li> </ul> <p>Review of the resident's TAR, dated November 2024, showed no orders for dressing changes or monitoring surgical site.</p> <p>Review of the resident's EHR, dated 11/29/24 to 12/31/24, showed no other nursing documentation of the resident's left hip surgical incision site.</p> <p>Review of the resident's Care Plan, dated 12/18/24, showed:</p> <ul style="list-style-type: none"> <li>-Skin inspection:</li> </ul> <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>--The resident required skin inspection weekly on Sundays.</p> <p>--Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse.</p> <p>-The resident was a moderate risk for falls related to deconditioning, Incontinence, vision/hearing problems.</p> <p>-The resident had left hip fracture of femoral neck related to a fall on 11/10/24.</p> <p>--The resident would remain free of complications related to hip fracture, such as contracture formation (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), embolism (obstruction of an artery) and immobility through review date.</p> <p>--The resident would return to prior level of function after wound healing and rehabilitation by review date.</p> <p>--The resident's surgical incision would heal without signs/symptoms of infection or breakdown by review date.</p> <p>Review of the resident's Health Status Note, dated 12/31/2024 at 2:16 P.M., showed nine staples removed from the resident's left hip this shift, tolerated well, no redness to area and no bleeding noted.</p> <p>During an interview on 1/29/25 at 3:23 P.M., the Receptionist said:</p> <p>-He/She made all appointments for the residents.</p> <p>-The nurses would let him/her know if a resident needed an appointment made from physician orders.</p> <p>-He/She looked at the November 2024 log and the resident did not go out to a follow-up appointment on 11/28/24 to a surgeon revisit.</p> <p>-If he/she was told about a follow up appointment being needed for Resident #29, he/she would have set up a follow up appointment.</p> <p>During an interview on 1/30/25 at 1:59 P.M., LPN C said:</p> <p>-He/She was not aware that the resident had any staples in his/her hip when he/she returned from the hospital.</p> <p>-He/She was not working when the resident returned from hospital.</p> <p>-The nurse who received the hospital discharge paperwork should look at it and put orders into the POS and on the Medication Administration Record (MAR) or the TAR.</p> <p>-The nurse taking off the discharge orders should let the receptionist know when there was a follow-up appointment on orders to be made.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39469</p> <p>Based on observation, interview, and record review, the facility failed to ensure skin and wound assessments were completed for residents who were at high risk for and had pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), failed to provide pressure ulcer treatments as prescribed by the physician, and failed to provide interventions to reduce pressure ulcers for two sampled residents, (Resident #3 and #39) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility's Wound Care Policy, dated 1/1/24, showed:</p> <ul style="list-style-type: none"> <li>-The purpose was to identify factors that placed the residents at risk for the development of pressure ulcers and to implement appropriate interventions to prevent the development of clinically avoidable wounds.</li> <li>-To promote healing of existing pressure ulcers.</li> <li>-Upon identification of the development of a wound, the wound assessment would have been documented on the Initial Wound Assessment Form.</li> <li>-Residents should have been examined thoroughly at least weekly by a licensed nurse to identify existing pressure ulcers.</li> <li>-Findings from the weekly assessment should should have been documented by the licensed nurse on a Body Audit Assessment Form.</li> <li>-(Certified Nursing Assistants (CNA)s should have completed a comprehensive CNA Shower Review on all residents when they were bathed or showered and given to the charge nurse.</li> <li>-After review by the charge nurse the comprehensive CNA shower review should have been given to the Wound Nurse or designee, for appropriate follow-up.</li> <li>-The comprehensive CNA shower review should have been reviewed by the Director of Nursing (DON) routinely.</li> <li>-Any skin impairments, including pressure ulcers should have been assessed and documented weekly by the Wound Nurse or designee, on the Wound Evaluation Flow Sheet or the Computer Weekly Wound Assessment.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Documentation should have covered all pertinent characteristics of existing ulcers, including location, size, depth, maceration (skin than was exposed to moisture for too long, causing it to soften and break down), color of the ulcer and surrounding tissues, and a description of any drainage, eschar (dead tissue that forms over healthy skin), necrosis (dead skin), odor, tunneling (when a channel or tunnel forms under the surface of a wound extending into deeper tissues), or undermining (when the edges of a wound have eroded or separated from the surrounding healthy tissue, creating a cavity or pocket underneath the skin).</p> <p>-Pressure reducing devices should have been provided on beds and chairs for at-risk residents.</p> <p>1. Review of Resident #3's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Muscle weakness.</p> <p>-Hemiplegia (muscle weakness or paralysis on one side of the body).</p> <p>Review of the resident's Treatment Administration Record (TAR), dated December 2024, showed:</p> <p>-Coccyx (the tailbone) wound dressing change one time a day for coccyx wound.</p> <p>--Cleanse wound with wound cleanser, pat dry, apply Xeroform (a petrolatum gauze dressing used to treat wounds) or calcium alginate (an absorbent dressing used to help heal wounds) and cover with sacral (the bone that connects the spine to the pelvis) wound dressing change as needed dated 10/2/24.</p> <p>---The dressing was not documented as completed 10 times out of 31 opportunities.</p> <p>-Apply protective house stock barrier cream/Bordered foam (dressing with an adhesive border) to the Stage I (Intact skin with non-blanchable redness of a localized area usually over a bony prominence) pressure ulcer on the buttock area, every morning and at bedtime for wound healing, dated 6/4/24.</p> <p>--The dressing was not documented as completed seven times out of 62 opportunities.</p> <p>Review of the resident's skin monitoring: comprehensive CNA Shower Review, dated December 2024, showed:</p> <p>-The resident had only one shower in December on 12/18/24.</p> <p>-He/She had a red area on his/her buttocks.</p> <p>Review of the resident's medical record showed no documentation of skin or wound documentation. Skin and wound assessments for December 2024 were requested and none were provided.</p> <p>Review of the resident's Physicians' Order Sheet (POS), dated January 2025, showed the following orders:</p> <p>-Apply protective house stock barrier cream/Boarder foam to Stage I buttock area, every morning and at bedtime for wound healing, dated 6/4/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Coccyx wound dressing change one time a day for coccyx wound. Cleanse wound with wound cleanser, pat dry, apply Xeroform or calcium alginate and cover with sacral wound dressing change as needed, dated 10/3/24.</p> <p>-NOTE: There were no pressure reducing devices listed.</p> <p>Review of the resident's TAR, dated January 2025, showed:</p> <p>-Coccyx wound dressing change one time a day for coccyx wound.</p> <p>--Cleanse wound with wound cleanser, pat dry, apply Xeroform or calcium alginate and cover with sacral wound dressing change as needed.</p> <p>---The dressing was not documented as completed seven times out of 29 opportunities.</p> <p>-Apply protective house stock barrier cream/bordered foam to stage 1 buttock area, every morning and at bedtime for wound healing, dated 6/4/24.</p> <p>-The dressing was not documented as completed five times out of 57 opportunities.</p> <p>Review of the resident's skin monitoring: comprehensive CNA Shower Review dated January 2025 showed:</p> <p>-The resident had only one shower in January on 1/27/25.</p> <p>-He/She had a red area on his/her buttocks.</p> <p>Review of the resident's medical record showed no documentation of skin or wound documentation. Skin and wound assessments for January 2025 were requested and none were provided.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning), dated 1/16/25, showed:</p> <p>-Did not show if the resident was cognitively intact.</p> <p>-He/She was at risk of pressure ulcers.</p> <p>-Pressure ulcer was not checked.</p> <p>-He/She needed assistance from staff for bathing/showering.</p> <p>-He/She was a Hemiplegic.</p> <p>Review of the resident's care plan, dated 1/27/25, showed:</p> <p>-The resident was bedfast all or most of the time.</p> <p>-The resident required a mechanical lift with assistance of two staff for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The wound to the resident's coccyx was to have been cleansed with wound cleanser, barrier cream applied Xeroform foam dressing with Boarder dressing applied.</p> <p>-Staff were to monitor for signs of infection.</p> <p>-He/She had a self-care performance deficit related to limited range of motion, Quadriplegia (weakness in upper and lower limbs).</p> <p>-He/She had the potential impairment to skin integrity related to decreased bed mobility.</p> <p>-Staff were to educate caregivers of measures to prevent skin injury.</p> <p>-Staff were to identify and document potential causative factors and eliminate or resolve where possible.</p> <p>-Staff were to provide treatments as ordered.</p> <p>-NOTE: There were no pressure reducing devices listed in the care plan.</p> <p>Observation on 1/22/25 at 10:40 A.M., 1:00 P.M., and 2:30 P.M., showed the resident:</p> <p>-Was in bed, flat on his/her back watching television.</p> <p>-There were no pressure reducing devices on the bed.</p> <p>Observation on 1/23/25 at 10:00 A.M., 12:25 P.M., and 3:00 P.M. showed the resident:</p> <p>-Was in bed, flat on his/her back asleep.</p> <p>-There were no pressure reducing devices on the bed.</p> <p>Observation on 1/24/25 at 1:45 P.M. and 2:30 P.M., showed the resident:</p> <p>-Was in bed, flat on his/her back watching television.</p> <p>-There were no pressure reducing devices on the bed.</p> <p>Observation on 1/30/25 at 9:10 A.M., of wound care with Licensed Practical Nurse (LPN) C and Certified Medication Technician (CMT) C showed:</p> <p>-The resident was in his/her bed, flat on his/her back.</p> <p>-The resident had a 6 centimeter (cm) by 2 cm Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister) on his/her coccyx.</p> <p>-The wound had no drainage and was pink/red in color.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The area around the pressure ulcer was reddened.</p> <p>-There were no pressure reducing devices on the bed.</p> <p>During an interview on 1/30/25 at 9:45 A.M., CMT C said:</p> <p>-They don't always have two CNAs to use the mechanical lift to move the resident from his/her bed into his/her Broda chair (a type of wheel chair that was able to tip the person backwards so they did not have to sit upright) so he/she was in bed a lot.</p> <p>-When a resident received a bath, a bath sheet should have been filled out which would have showed if there were any scratches or sores and then the bath sheet was given to the charge nurse.</p> <p>-The nurses should have done skin or wound assessments.</p> <p>During an interview on 1/30/25 at 9:50 A.M., LPN C said:</p> <p>-The resident spent a lot of time in the bed.</p> <p>-They tried to get him/her up into the Broda chair when they could.</p> <p>-He/She would assess the wound when he/she did wound care.</p> <p>-He/She did not document what the wound looked like in the computer.</p> <p>-He/She had not taken any extra training to have been able to stage a wound.</p> <p>-He/She was not able to say what stage the resident's wound was.</p> <p>-The resident would have benefited from a Low Air Loss mattress (LAL a mattress that alternated the pressure).</p> <p>-The facility did not have any LAL mattresses.</p> <p>-He/She had not asked the physician for a LAL mattress.</p> <p>-He/She was not able to voice any other measures to reduce or prevent pressure ulcers.</p> <p>-At this time the facility did not have a Wound Nurse.</p> <p>-There was no one assigned to complete wound or skin assessments.</p> <p>-Wound treatments should have been documented when completed.</p> <p>During an interview on 1/30/25 at 9:55 A.M., the MDS Coordinator said:</p> <p>-They did not have a Wound Care nurse and he/she had been trying to help out.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There should have been weekly documentation of what a wound looked like and no one had been documenting on the appearance of the wound.</p> <p>-A Registered Nurse (RN) would have had to stage and assess the wounds.</p> <p>-There was a wound care company that came to see some of the residents, but did not see this resident.</p> <p>-Wound care has not always been done as there was not enough staff.</p> <p>-The CNA's should document on the bath sheets if a resident had an open wound or scratch.</p> <p>-The CNA's would give the charge nurse the bath sheet and he/she should have looked at the resident's wounds.</p> <p>-The resident did not get out of bed often and could have benefited from a LAL mattress.</p> <p>-The facility did not have a LAL mattress.</p> <p>-He/She had not called to obtain an order for a LAL mattress.</p> <p>-Treatments should have been done as ordered. If the treatment was not done there should have been documentation explaining why the treatment was not done.</p> <p>2. Review of Resident #39's Admission MDS, dated [DATE], showed:</p> <p>-The resident was cognitively intact.</p> <p>-The resident had no skin issues.</p> <p>-The resident had no pressure ulcers.</p> <p>Review of the resident's Skin Monitoring and CNA Shower Review, dated November 2024, showed:</p> <p>-On 11/7/24 the shower sheet did not show any skin issue, signed by a CNA and a nurse.</p> <p>-On 11/11/24 the shower sheet showed the resident had a sore on his/her coccyx area, signed by a CNA and a nurse.</p> <p>-On 11/14/24 the shower sheet showed the resident had a sore on his/her coccyx area, signed by a CNA.</p> <p>-On 11/21/24 the shower sheet showed the resident had a sore on his/her coccyx area, signed by a CNA.</p> <p>Review of the resident's Skin Monitoring and CNA Shower Review, dated December 2024, showed:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 12/5/24 the shower sheet showed the resident had a sore on his/her coccyx area, signed by a CNA and a nurse.</p> <p>-On 12/9/24 the shower sheet showed the resident had bruising around the outer arm pit, signed by CNA and a nurse.</p> <p>-On 12/12/24 the shower sheet showed the resident had bruising under the right arm pit and a sore on his/her coccyx area, signed by a CNA.</p> <p>-There were no other shower sheets for the resident dated after 12/12/24.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-He/She was cognitively intact.</p> <p>-He/She was at risk for pressure sores.</p> <p>-He/She had limited range of motion on both sides, upper and lower extremities.</p> <p>-He/She was dependent on staff for bathing.</p> <p>-He/She did not have any skin issues or pressure ulcers marked.</p> <p>Review of the resident's TAR, dated December 2024, showed the following order:</p> <p>-Cleanse the coccyx with wound cleanser, gently pat dry, and cover with sacral dressing daily and as needed.</p> <p>-The dressing was not documented as completed two out of five opportunities.</p> <p>Review of the resident's Skin Monitoring and CNA Shower Review, dated January 2025, showed:</p> <p>-No documentation of a shower or skin review dated 1/1/25 to 1/13/25.</p> <p>-On 1/13/25 the shower sheet showed the resident had open sores on both sides of his/her coccyx area and his/her peri area was red, signed by a CNA and Director of Nursing (DON).</p> <p>-On 1/20/25 the shower sheet showed the resident had skin irritation on both sides of his/her abdomen and a sore on his/her coccyx area, signed by a CNA, nurse and DON.</p> <p>Review of the resident's TAR, dated January 2025, showed the following order:</p> <p>-Cleanse the coccyx with wound cleanser, gently pat dry, and cover sacral dressing daily and as needed, dated 12/27/24.</p> <p>-The dressing was not documented as completed two times out of 30 opportunities.</p> <p>During an interview on 1/22/25 at 3:40 P.M., a family member said:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The family was upset about the staff not getting the resident up from bed into a wheel chair as often as he/she should have been and now had a pressure ulcer on his/her coccyx area.</p> <p>-The family member had talked to administration regarding wound care and they have not done anything.</p> <p>-The family member had pictures of the resident's coccyx on his/her phone take three weeks ago.</p> <p>-The resident currently had three open areas on his/her coccyx/sacral area which were:</p> <p>--Wound #1 was open and measured 10 centimeters (cm) in length by 2 cm in width.</p> <p>--Wound #2 was open and was round about the size of a quarter.</p> <p>--Wound #3 was open and was round about the size of a dime.</p> <p>Observation on 1/23/25 at 11:00 A.M. and 2:30 P.M. showed the resident did not have a LAL mattress.</p> <p>Observation on 1/24/25 at 9:36 A.M. showed the resident did not have a LAL mattress.</p> <p>During an interview on 1/24/25 at 9:36 A.M., the resident said:</p> <p>-The staff were not getting him/her up out of bed enough.</p> <p>-He/She had bed sores on his/her back.</p> <p>-Treatments were not done daily.</p> <p>-He/She would receive excuses from staff when the treatments were not done (would be back later to do it).</p> <p>Observation of wound care on 1/28/25 at 10:16 A.M., with LPN B, CNA E, and CNA F showed:</p> <p>-The resident had one pressure ulcer about the size of a quarter that was pink on his/her coccyx.</p> <p>-No drainage was seen.</p> <p>-The other two areas on his/her coccyx were pink and closed.</p> <p>During an interview on 1/28/25 at 10:40 A.M., CNA E and CNA F said:</p> <p>-When staff gave a resident a shower, bath, or bed bath they should have documented if the resident had any open areas on their skin.</p> <p>-Staff would give the nurse the shower/skin sheet and then the DON should have signed it.</p> <p>-If it was not signed it was not done.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The residents were not getting up as often as they should have. Once in the morning and once for dinner.</p> <p>-The resident did not have any pressure reducing devices in his/her bed or chair.</p> <p>During an interview on 1/30/25 at 10:00 A.M., LPN C said:</p> <p>-No one at the facility was currently doing skin or wound assessments.</p> <p>-The resident had open areas on his/her sacral area for a few weeks.</p> <p>-A RN should do the assessments.</p> <p>3. During an interview on 10/28/25 at 10:45 A.M., LPN B said:</p> <p>-The residents should have been offered a shower twice a week and at that time the CNA should have notified the nurse if there were any skin issues.</p> <p>-The CNA should have documented on the shower/skin assessment form any skin issues that they had found.</p> <p>-The CNA then should have told the nurse so the nurse could see the skin issue.</p> <p>-All shower/skin assessment sheets would then go to the DON so he/she could ensure showers were done twice a week.</p> <p>-If there was a skin issue the nurse would have documented it and notified the Physician.</p> <p>-He/She did not think there was a Wound Nurse at the facility currently.</p> <p>-Wounds on Resident #3 and Resident #39 should have been looked at by the Wound Nurse or DON to stage them.</p> <p>-A LPN could not stage a wound.</p> <p>-He/She could not find any documentation regarding Resident #3 or Resident #39's wounds and something should have been documented weekly.</p> <p>-Treatments to Resident #3 and Resident #39 should have been completed as ordered.</p> <p>-There should not have been any blank areas on Resident #3 or Resident #39's TAR's. If there was no documentation the treatment was not done.</p> <p>-The DON would have addressed the pressure reducing devices with the physician.</p> <p>-Resident # 3 and Resident #39 both should have had pressure reducing devices in place in their bed and/or wheelchair.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/31/25 at 3:30 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-If a resident had open areas on his/her skin such as a pressure sore the nurse should have assessed the wound weekly.</li> <li>-He/She was not aware that a LPN was not able to assess or stage a wound unless they had taken a class for that, only a RN was able to assess.</li> <li>-They did not have a Wound Nurse and no one was currently documenting the progression of wounds.</li> <li>-There should have been a description of the wound and measurements.</li> <li>-If a resident was not able to move in bed and was at risk for pressure sores he/she would have expected the staff to turn the resident every two hours, get them out of bed, had a LAL mattress and document those interventions were done.</li> <li>-They did not have a process in place to monitor the residents' wounds.</li> <li>-Resident #3 and Resident #39 should have had pressure reducing devices in their bed and/or wheelchair.</li> <li>-Resident #3 and Resident #39 did not currently have pressure reducing devices in place.</li> <li>-All ordered treatments should have been documented as complete.</li> <li>-The preventative measures should have been on the resident's care plan.</li> </ul> <p>MO00247435</p> <p>MO00247918</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</b></p> <p>Based on observation, interview and record review, the facility failed to investigate a fall, failed to assess a resident after a fall, and failed to implement new interventions after a fall for one sampled resident (Resident #30) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility's policy titled Accidents and Incidents - Investigating and Reporting, dated as revised July 2017, showed:</p> <ul style="list-style-type: none"> <li>-All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on the facility property shall be investigated and reported to the Administrator.</li> <li>-The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.</li> <li>-The Report of Incident/Accident form shall include: <ul style="list-style-type: none"> <li>--The date and time the accident or incident took place.</li> <li>--The nature of the injury/illness (bruise, fall, nausea, etc.).</li> <li>--The circumstances surrounding the accident or incident.</li> <li>--Where the accident or incident took place.</li> <li>--The name(s) of witnesses and their accounts of the accident or incident.</li> <li>--The time the physician was notified and the time of the physician's response and his/her instructions.</li> <li>--The date and time of the resident's family member notification.</li> <li>--The condition of the resident including vital signs.</li> <li>--Where the resident was sent.</li> <li>--Any corrective action taken.</li> <li>--Follow-up information.</li> <li>--Other pertinent data as necessary.</li> </ul> </li> <li>--The signature and title of the person completing the report.</li> </ul> <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 - Few</p>	<p>-The Report of Incident/Accident form shall be completed and submitted to the Director of Nursing (DON) for each occurrence.</p> <p>-Incident/accident reports were reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.</p> <p>Review of the facility's policy titled Incident and Accident Investigation, dated 1/1/24, showed:</p> <p>-Accidents/incidents will be reported to the department supervisor and the supervisor will report to the Administrator and the DON.</p> <p>-An Incident/Event Report or Electronic Health Record (EHR) Risk Management Report shall be completed upon the identification of any accident/incident.</p> <p>-All accidents/incidents will be investigated and reported to the Administrator.</p> <p>-A licensed nurse shall initiate an assessment and gathering preliminary investigative data.</p> <p>-An investigation will be coordinated and analyzed by the Administrator and/or DON to determine systemic changes necessary to prevent further occurrences.</p> <p>-The administrative staff shall complete the investigation and document a summary of the findings on the Risk Management Event Investigation Report.</p> <p>-The Risk Management Event Investigation Report will be present to the Quality Assurance Committee for discussion.</p> <p>-Accidents and incidents shall be tracked to identify trends and reported in the Quality Assurance meetings.</p> <p>-A performance improvement plan and/or disciplinary action shall be developed as indicated.</p> <p>1. Review of Resident #30's Admission Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning), dated 5/15/24, showed:</p> <p>-He/She was severely cognitively impaired.</p> <p>-Was dependent on staff for most of cares.</p> <p>-Had a diagnosis of Cancer.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following staff assessment of the resident:</p> <p>-Moderately cognitively impaired.</p> <p>-Had no functional limitation in range of motion in any extremities.</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 - Few</p>	<p>-Required maximum assistance with toileting hygiene, dressing, and personal hygiene.</p> <p>-Required moderate assistance with bathing and going from sitting to standing.</p> <p>-Used a manual wheelchair.</p> <p>-Did not stand.</p> <p>-Was always incontinent of bowel and bladder.</p> <p>-Some of his/her diagnoses included cancer and high blood pressure.</p> <p>-Had not fallen in the past three months.</p> <p>Review of the resident's care plan, dated 11/18/24, (the last time the resident's care plan was updated) showed it did not include anything about falls/skin injuries.</p> <p>Review of the resident's incident note, dated 1/16/25 at 10:31 A.M., showed:</p> <p>-The resident was found on the floor with his/her wheelchair next to him/her and the brakes were not engaged.</p> <p>-The resident's feet were under his/her bed and he/she was on his/her right side.</p> <p>-A huge bump with bruising was forming on his/her right temple area.</p> <p>-The resident was not moved.</p> <p>-Vital signs were documented as taken but the results were not recorded.</p> <p>-Emergency Medical Services (EMS) was called.</p> <p>-EMS arrived applied a c-collar and placed the resident on the stretcher for transport to the hospital.</p> <p>Review of the resident's EHR showed:</p> <p>-There was no documentation an assessment had been completed after the resident's fall on 1/16/25.</p> <p>-There was no documentation an investigation into the cause of the resident's fall had been completed.</p> <p>Review of the resident's care plan showed:</p> <p>-There were no new interventions put into place after the resident's fall on 1/16/25.</p> <p>-There were no new interventions put into place to prevent further falls.</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 - Few</p>	<p>Review of the resident's fall risk evaluation, dated 1/16/25, showed the resident:</p> <ul style="list-style-type: none"> <li>-Did not fall in the past three months.</li> <li>-Was alert and oriented.</li> <li>-Was chairbound.</li> <li>-Was incontinent.</li> <li>-Had no noted drop between blood pressure between lying down and standing.</li> <li>-Had adequate vision.</li> </ul> <p>Review of the resident's vital signs documented in the resident's medical record showed:</p> <ul style="list-style-type: none"> <li>-The resident's pain was mild on 1/16/25 at 10:16 A.M.</li> <li>-No blood pressure, pulse, respirations, oxygen saturation levels, blood glucose levels or neurochecks (neurological checkpoints to monitor level of consciousness, ability to move extremities, eye responses and change in pupils and vital signs) were documented on 1/16/25.</li> </ul> <p>During an interview on 1/30/25 at 9:08 A.M., the MDS Coordinator said:</p> <ul style="list-style-type: none"> <li>-The resident usually turned on his/her call light and didn't usually try to get up on his/her own.</li> <li>-The resident would yell out for help if his/her call light wasn't in reach.</li> <li>-There had not been a MDS completed after the resident's fall on 1/16/25 as it was not due yet.</li> <li>-Falls should be captured on the MDS.</li> <li>-Care plans should include falls.</li> <li>-The resident's fall on 1/16/25 should have been on the care plan.</li> </ul> <p>During an interview on 1/30/25 at 11:26 A.M., the DON said:</p> <ul style="list-style-type: none"> <li>-Staff found the resident on the floor beside his/her bed (on 1/16/25).</li> <li>-He/She didn't know any cause of the resident's fall or any of the resident's other injuries.</li> <li>-He/She did not know an investigation was required when a resident fell , to determine the root cause or contributing factors of the fall or injury.</li> <li>-When a resident fell , the nursing staff should do neurochecks, assess their cognition compared to their baseline, take vital signs, check the movement of their extremities, and do a full assessment of the resident.</li> </ul> <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 - Few</p>	<p>-EMS was called and took the resident to the hospital.</p> <p>-The resident's vital signs should have been documented.</p> <p>During an interview on 1/30/25 11:50 A.M., the DON said:</p> <p>-There was a risk management form they could enter after a fall, but he/she could not open it.</p> <p>-There were no incident reports or investigations on the resident's fall.</p> <p>Observation on 1/30/25 at 2:09 P.M. showed the resident was in his/her room in his/her wheelchair asleep and had a large bruise that was dark purple, yellow, and green on the right side of his/her face that covered his/her forehead, was around the resident's right eye and down to his/her cheek.</p> <p>During an interview on 1/31/25 at 9:41 A.M., Licensed Practical Nurse (LPN) C said:</p> <p>-They found the resident on the floor (on 1/16/25).</p> <p>-He/She assessed the resident after finding him/her on the floor.</p> <p>-The assessment should be in the EHR.</p> <p>-He/She took his/her vital signs but did not do neurochecks because he/she did not want to move the resident.</p> <p>-No new measures were taken to prevent the resident from falling again.</p> <p>-The DON was responsible for investigating the cause of accidents and incidents and determining new measures to put in place.</p> <p>MO00247918</p> <p>MO00248157</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39469</p> <p>Based on observation, interview, and record review, the facility failed to assess a resident who had a feeding tube (a medical device inserted into the stomach to provide nutrition when a person could not eat) by not checking placement of the feeding tube or checking for residual (withdrawing stomach contents from a feeding tube to determine how much formula was left after a feeding) before administering medications and a liquid feeding; failed to ensure documentation was completed when tube feeding was administered; and failed to ensure nursing staff had received education for taking care of a resident with a feeding tube for one sampled resident (Resident #3) out of 14 sampled residents. The facility census was 55 residents.</p> <p>Review of the facility's Enteral Nutrition (liquid nutrition for persons who could not eat) policy, dated November 2018, showed:</p> <ul style="list-style-type: none"> <li>-The nurse would have confirmed that the order for enteral nutrition was complete.</li> <li>-Complete orders would have included: <ul style="list-style-type: none"> <li>--Tip placement.</li> <li>--Instructions for placement.</li> </ul> </li> <li>-The provider would have considered the need for supplemental orders: <ul style="list-style-type: none"> <li>--Confirmation of tube placement.</li> <li>--Checks for gastric residual volume.</li> </ul> </li> <li>-Staff caring for residents with feeding tubes were to have been trained on how to recognize and report complications such as: <ul style="list-style-type: none"> <li>--Tube misplacement or migration (movement from original surgical site).</li> </ul> </li> </ul> <p>1. Review of Resident #3's face sheet showed he/she admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Dysphagia (difficulty swallowing foods or liquids).</li> <li>-Gastrostomy (G-tube - a thin, flexible tube inserted through the abdominal wall and into the stomach).</li> <li>-Gastro-Esophageal Reflux Disease (GERD - a digestive disease in which stomach acid irritates the food pipe lining).</li> <li>-Diarrhea (loose watery stools that occur frequently).</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Skills Fair, dated 11/18/24 to 11/21/24, showed education on gastrostomy tubes was not included.</p> <p>Review of the resident's Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff for care planning, dated 10/16/24 showed:</p> <ul style="list-style-type: none"> <li>-The cognitive section was not filled out.</li> <li>-The activities of daily living section was not filled out.</li> <li>-Refusal of care was not exhibited.</li> <li>-The nutrition section did not have feeding tube marked as present.</li> </ul> <p>Review of the resident's nurse's Medication Administration Record (MAR), dated December 2024, showed:</p> <ul style="list-style-type: none"> <li>-Give one carton of Jevity 1.2 calorie (a therapeutic nutrition formula that provides calories, protein, fiber, vitamins, and minerals for tube feeding) three times a day at 4:00 A.M., 4:00 P.M., and 8:00 P.M. with 100 milliliter (ml) flush of water.</li> <li>--Hold for residual (amount of liquid food left in tube) greater than 60 ml.</li> <li>--Out of 93 opportunities six were blank, 41 opportunities showed the resident received more than 100% of the tube feeding.</li> <li>-Cholestyramine light (used to treat high cholesterol) packet four grams give one packet via peg tube before meals for diarrhea , mix in eight ounces of water per peg tube. Flush well.</li> <li>--Administer prior to scheduled tube feedings.</li> <li>--Five out of 93 opportunities were blank.</li> <li>-Metoclopramide Hydrochloric Solution 5 milligram (mg) per 5 ml via peg tube before meals and at bedtime related to GERD.</li> <li>--Five out of 124 opportunities were blank.</li> </ul> <p>Review of the resident's Treatment Administration Record (TAR), dated December 2024, showed:</p> <ul style="list-style-type: none"> <li>-Tube feeding every day and night shift, check and record residuals every shift.</li> <li>--Five out of 62 opportunities were blank.</li> <li>--62 out of 62 opportunities did not have a residual amount documented (including zero residual).</li> <li>-Flush tube with 20 to 30 ml of water before and after administration of medication pass.</li> </ul> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-31 out of 169 opportunities were blank.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning), dated 1/16/25, showed:</p> <p>-He/She had a feeding tube.</p> <p>-GERD was not checked.</p> <p>Review of the resident's care plan, dated 1/27/25, showed:</p> <p>-He/She had a peg tube in place for feeding.</p> <p>-He/She had a potential nutritional problem related to peg tube in place for feeding.</p> <p>-Staff were to administer medications as ordered, monitor for side effects.</p> <p>Review of the resident's POS, dated January 2025, showed:</p> <p>-Nothing by mouth (NPO).</p> <p>-Check and record tube feeding residuals every day and night shift.</p> <p>--Contact the physician if residual exceeds 30 cubic centimeters (cc).</p> <p>-Give one and one half cartons of Jevity 1.2 twice a day at 8:00 A.M. and at 12:00 P.M. with 100 ml water flush.</p> <p>--Hold for residual greater than 60 ml.</p> <p>-Give one carton of Jevity 1.2 three times a day at 4:00 A.M., 4:00 P.M., and at 8:00 P.M. with 100 ml water flush.</p> <p>--Hold for residual greater than 60 ml.</p> <p>-Cholestyramine light packet four grams give one packet via peg tube before meals for diarrhea , mix in eight ounces of water per peg tube. Flush well.</p> <p>--Administer prior to scheduled tube feedings.</p> <p>-Metoclopramide Hydrochloric Solution 5 mg per 5 ml via peg tube before meals and at bedtime related to GERD.</p> <p>-Flush tube with 20 to 30 ml of water before and after administration of medication pass.</p> <p>Review of the resident's nurse's MAR, dated January 2025, showed:</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Give one carton of Jevity 1.2 three times a day at 4:00 A.M., 4:00 P.M., and at 8:00 P.M. with 100 ml flush.</p> <p>--Hold for residual greater than 60 ml.</p> <p>--Two out of 85 opportunities were blank.</p> <p>--20 out of 85 opportunities showed the resident received more than 100% of the tube feeding.</p> <p>--Four out of 85 opportunities showed less than 100 % given with no nurses notes explaining why less than 100% was given.</p> <p>Review of the resident's TAR, dated January 2025, showed:</p> <p>-Check and record tube feeding residuals every day and night shift.</p> <p>--Seven out of 56 opportunities seven were blank.</p> <p>--56 out of 56 opportunities had no documentation of residual including zero residual.</p> <p>-Flush tube with 20 to 30 ml of water before and after administration of medication pass.</p> <p>--28 out of 141 opportunities were blank.</p> <p>Observation on 1/29/25 at 12:00 P.M., of medication administration via peg tube showed LPN C:</p> <p>-Did not check placement of the peg tube before administering the medications in the peg tube.</p> <p>-Did not check residual before giving medications.</p> <p>During an interview on 1/29/25 at 12:00 P.M., LPN C said:</p> <p>-Staff should document on the MAR or TAR how much residual was obtained when checked.</p> <p>-Staff should document on the MAR or TAR how much tube feeding was administered and if it was tolerated by the resident.</p> <p>-The documentation of the amount of tube feeding given should not have been more than 100%.</p> <p>-Staff should have documented how much residual there was, including if there was zero residual.</p> <p>-No one had documented any residual amounts, including zero residual.</p> <p>-The DON was responsible for ensuring medications were given and documented correctly.</p> <p>-He/She did not know if the DON had been checking any physician's orders or staff charting.</p> <p>During an interview on 1/31/25 at 9:20 A.M., LPN B said:</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-When giving medications he/she would flush the peg tube with water.</p> <p>-He/She had education in nursing school about medication administration using a peg tube, but none from the facility.</p> <p>-He/She had been administering medications and tube feedings to the resident via peg tube.</p> <p>-He/She was not told about how to check placement, check residual, when to hold meds or tube feeding, and to have the head of the bed up.</p> <p>-He/She had not charted the residual or amount of feeding the resident received.</p> <p>During an interview on 1/31/25 at 3:30 P.M. the DON said:</p> <p>-He/She did not know how to check placement of a feeding tube.</p> <p>-He/She would have to look up how to check placement of the feeding tube.</p> <p>-He/She would have to look up how to check residual.</p> <p>-He/She would have to educate himself/herself and then educate the staff on the procedure.</p> <p>-The facility had not provided staff with education on peg tubes, it was not done during the skills fair.</p> <p>-If there was not an order to give the medications together then they should have been administered separately.</p> <p>-Staff should follow the physicians' orders.</p> <p>-He/She had not done any audits to ensure charting was done correctly nor to see if staff was doing cares correctly.</p> <p>-If something was not charted it was not done.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure oxygen and nebulizer equipment was stored in a sanitary condition for two sampled residents (Resident #40 and #3) and one supplemental resident (Resident #51) out of 14 sampled residents and one supplemental resident. The facility census was 55 residents.</p> <p>Review of the facility's policy titled Oxygen Administration, dated as revised 6/8/23, showed:</p> <ul style="list-style-type: none"> <li>-Tubing and nasal cannula (tube in the nose) should be placed in a baggies when not in use.</li> <li>-Replace tubing and nasal cannula if they are on the floor.</li> <li>-The tubing and cannula should be changed weekly every Sunday night.</li> </ul> <p>1. Review of Resident #40's care plan, dated 4/22/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident had altered respiratory status with shortness of breath.</li> <li>-The resident was on hospice (end of life care).</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident was on hospice and did not use oxygen.</p> <p>Review of the resident's Physician's Order Sheet (POS), dated January 2024, showed physician's orders dated 11/25/24 for oxygen 2-3 liters per minute for shortness of breath as needed.</p> <p>Observation on 1/22/25 at 10:24 A.M., on 1/24/25 at 9:28 A.M., on 1/27/25 at 10:18 A.M., and on 1/28/25 at 10:20 A.M., showed there was an oxygen concentrator in the resident's room with tubing including the nasal cannula on the floor with no baggie present for storage.</p> <p>During an interview on 1/29/25 at 10:32 A.M., Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> <li>-The resident had pneumonia a while ago and used the oxygen during that time.</li> <li>-The oxygen was as needed.</li> <li>-Anyone that went in his/her room should check to see that the oxygen tubing was not on the floor and should make sure it was bagged.</li> <li>-The night shift was responsible for changing the oxygen tubing weekly.</li> </ul> <p>39469</p> <p>2. Review of Resident #3's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and making it difficult to breathe).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed Oxygen therapy was not checked.</p> <p>Review of the resident's POS, dated January 2025, showed the following order for Ipratropium-Albuterol Solution 0.5 - 2.5 (3) milligram (mg)/3 milliliter (ml) one vial inhale orally every 6 hours as needed for shortness of breath related to COPD.</p> <p>Review of the resident's care plan, dated 1/27/25, showed there was problem area or concern that addressed the resident's use of medications for COPD.</p> <p>Observation on 1/29/25 at 11:14 A.M., showed:</p> <ul style="list-style-type: none"> <li>-The resident's oxygen equipment was on a tray at the foot of his/her bed.</li> <li>-There was a bag on the tray.</li> <li>-The nebulizer pipe (a machine that turns liquid medicine into a mist that could be easily inhaled) was sitting on the tray not in the bag.</li> <li>-The oxygen tubing was not connected to the nebulizer pipe, it was dangling down off of the tray touching the floor.</li> </ul> <p>During an interview on 1/29/25 at 11:25 A.M., Certified Nursing Assistant (CNA) J said:</p> <ul style="list-style-type: none"> <li>-The tubing should be in a bag not touching the floor.</li> <li>-The nebulizer pipe should be in a bag.</li> <li>-The nurses were responsible for the oxygen tubing.</li> </ul> <p>During an observation on 1/29/25 at 11:25 A.M. showed CNA J:</p> <ul style="list-style-type: none"> <li>-Left the room without changing the tubing, cleaning the pipe or telling the nurse.</li> </ul> <p>During an interview on 1/29/25 at 11:30 A.M., LPN C said:</p> <ul style="list-style-type: none"> <li>-The tubing should be in a bag not touching the floor.</li> <li>-The nebulizer pipe should be in a bag.</li> <li>-The night CNA's were responsible for the oxygen tubing.</li> </ul> <p>During an observation on 1/29/25 at 11:30 A.M. showed LPN C:</p> <ul style="list-style-type: none"> <li>-Left the room without changing the tubing or cleaning the pipe.</li> </ul> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of supplemental Resident #51's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-He/She was severely cognitively impaired.</li> <li>-Had COPD.</li> <li>-Had Respiratory failure.</li> <li>-Oxygen therapy was not checked.</li> </ul> <p>Review of the resident's POS, dated January 2025, showed the following order:</p> <ul style="list-style-type: none"> <li>-Change nebulizer tubing mask every Sunday.</li> <li>-Change oxygen tubing every Sunday.</li> <li>-NOTE: There was no oxygen order.</li> <li>-NOTE: There was no nebulizer order.</li> </ul> <p>Observation on 1/20/25 at 10:12 A.M., showed:</p> <ul style="list-style-type: none"> <li>-The oxygen tubing was wound around the oxygen concentrator (a medical device that separates nitrogen from the air so you can breathe up to 95% pure oxygen), not in a bag.</li> <li>-The nebulizer pipe was sitting in the resident's drawer of night stand, not in a bag.</li> </ul> <p>Observation on 1/22/25 at 11:12 A.M., showed:</p> <ul style="list-style-type: none"> <li>-The oxygen tubing was wound around the oxygen concentrator, not in a bag.</li> <li>-The nebulizer pipe was sitting in the resident's drawer of night stand, not in a bag.</li> </ul> <p>Observation on 1/22/25 at 3:14 P.M. showed:</p> <ul style="list-style-type: none"> <li>-The oxygen tubing was wound around the oxygen concentrator, not in a bag.</li> <li>-The nebulizer pipe was sitting in the resident's drawer of night stand, not in a bag.</li> </ul> <p>4. During an interview on 1/31/25 at 3:25 P.M., with the Director of Nursing (DON) present, the Executive Director said:</p> <ul style="list-style-type: none"> <li>-The oxygen tubing shouldn't be on the floor.</li> <li>-The oxygen tubing should be stored in a bag.</li> <li>-Anyone that walked in the room should take care of oxygen tubing on the floor.</li> </ul> <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>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>22727</p> <p>Based on interview and record review, the facility administrative staff failed to plan for and provide a sufficient number of nursing staff over a 48-hour period to relieve overworked staff that stayed on shift and worked over during a winter storm which caused the working nursing staff to not feel safe in administering routine medications to seven sampled residents (Residents #8, #2, #9, #40, #29, #35, and #50) out of seven sampled residents for medications administration. The facility census was 55 residents.</p> <p>Review of the facility's staffing, sufficient and competent nursing policy, dated revised August 2022, showed:</p> <ul style="list-style-type: none"> <li>-Licensed nurses and certified nursing assistants are available 24 hours a day, seven days a week to provide competent resident care services including:</li> <li>--Assuring resident safety.</li> <li>--Attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident.</li> <li>--Responding to resident needs.</li> </ul> <p>Review of the facility's undated Job description- Director of Nursing (DON) showed:</p> <ul style="list-style-type: none"> <li>-Will be responsible for planning, organizing, establishing, administering, and implementing a nursing program that will cooperate with all disciplines to provide for the maximum physical, mental, and spiritual well-being of each resident.</li> <li>-Responsible for the day-to-day operation of the nursing department.</li> <li>-To find replacements for absentees.</li> <li>-To be responsible for the supervision and nursing procedures and what to do in case of an emergency.</li> <li>-Flexibility in job assignments during emergencies and at the direction of the Administrator, as needed.</li> </ul> <p>Review of the facility's Director of Nursing Services (DNS) policy, dated revised August 2022, showed:</p> <ul style="list-style-type: none"> <li>-The director is employed full-time (40-hours per week) and is responsible for, but is not necessarily limited to:</li> <li>--Providing direct resident care when needed.</li> </ul> <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>--Ensuring sufficient and competent staffing levels to meet the needs of the residents.</p> <p>Review showed no facility emergency plan was documented.</p> <p>Review of the Facility Assessment, dated 1/16/25, showed:</p> <ul style="list-style-type: none"> <li>-The facility was licensed for 118 residents.</li> <li>-41 current full-time staff.</li> <li>-Three part-time staff.</li> <li>-Four as needed (PRN) staff.</li> <li>-Hours per a resident days (HPRD) showed</li> </ul> <p>--Day shift:</p> <ul style="list-style-type: none"> <li>---Two Registered Nurses (RN)</li> <li>---Two Licensed Practical Nurses (LPN).</li> <li>---Four Certified Nursing Assistants (CNA)/Nurse Assistant (NA).</li> </ul> <p>--Night shift:</p> <ul style="list-style-type: none"> <li>---No RN.</li> <li>---Two LPNs.</li> <li>---Four CNA/NAs.</li> </ul> <p>-Note: Facility Assessment did not list Certified Medication Technicians (CMT).</p> <p>-Contingency plan for staffing:</p> <ul style="list-style-type: none"> <li>--Planning for events that do not require activation of an emergency plan but do have the potential to affect resident care, including:</li> <li>---How facility accounts for staff call-offs and process for covering shifts:</li> <li>----Staffing phone/agency utilization if needed.</li> <li>----Facility calls in Full-Time staff and agency to assist.</li> <li>----Restorative Aide (RA) or shower aides also assist on floor if needed.</li> <li>----Facility had a designated staff member that had on call phone.</li> </ul> <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>1. Review of Resident #8's Medication Administration Record (MAR), dated January 2025, showed on 1/5/25:</p> <ul style="list-style-type: none"> <li>-The resident did not receive nine out of 11 medications ordered all day.</li> <li>-The medications the resident did not receive included medications for high cholesterol, diabetes (a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin), heart failure, hypothyroidism (below normal function of the thyroid gland which regulates metabolism), embolism and thrombosis of unspecified artery (a condition where blood clots form in an artery, which can cause the artery to narrow or become blocked), atrial fibrillation (the heart beats irregularly and rapidly), and high blood pressure.</li> </ul> <p>2. Review of Resident #2's MAR, dated January 2025 showed on 1/5/25:</p> <ul style="list-style-type: none"> <li>-The resident did not receive four out of four medications ordered all day.</li> <li>-The medications the resident did not receive included medications for dementia (a progressive mental disorder characterized by memory problems, impaired reasoning and personality changes), depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life), anxiety (a psychiatric disorder that involve extreme fear, worry and nervousness) and edema (swelling).</li> </ul> <p>3. Review of Resident #9's MAR, dated January 2025, showed:</p> <ul style="list-style-type: none"> <li>-Throughout the day on 1/5/25, the resident did not receive one oral medication out of one oral medications ordered which was for edema.</li> <li>-Throughout the day on 1/5/25, the resident did not receive his/her inhaler three times a day for asthma.</li> <li>-Throughout the day on 1/5/25, the resident did not receive his/her eye drops four times a day for dry eye syndrome.</li> <li>-The resident had a treatment order for a skin tear to be done every three days.</li> <li>-The resident's skin tear treatment was not completed on 1/5/25 which resulted in the resident not having his/her skin tear treatment completed until 1/8/25 (three days late).</li> </ul> <p>4. Review of Resident #40's MAR, dated January 2025, showed:</p> <ul style="list-style-type: none"> <li>-On 1/5/25 the resident did not receive seven out of eight medications ordered all day.</li> <li>-The medications the resident did not receive included medications for heart disease, pain, acid reflux, dementia, benign prostatic hyperplasia (enlargement of the prostate gland), allergies, and high blood pressure.</li> <li>-The resident did not receive his/her eye drops four times a day for dry eye syndrome throughout the day on 1/5/25.</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	
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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>37576</p> <p>5. Review of Resident #29's MAR January 2025 showed:</p> <p>-The resident did not receive 15 out of 15 medications ordered throughout the day.</p> <p>-The medications the resident did not receive included medications for vitamin deficiency, diuretic (drugs causing increased passing of urine), heart failure, Glaucoma (an eye condition that damages the optic nerve), sleep supplement, constipation, mineral supplement, Anticoagulant (medications that help prevent blood clots), eye drops, allergies, pain patch, ulcerative colitis (inflammatory bowel disease [IBD]) and pain.</p> <p>6. Review of Resident #35's MAR January 2025 showed:</p> <p>-The resident did not receive 5 out of 5 medications ordered throughout the day.</p> <p>-The medications the resident did not receive included medications for anemia (a condition of lack of enough healthy red blood cells to carry adequate oxygen to the body's tissues), vitamin deficiency, Hypertension, primary (HTN-abnormally high blood pressure that's not the result of a medical condition), constipation, macular degeneration (deterioration of the macula, which is the small central area of the retina of the eye that controls visual acuity).</p> <p>7. Review of Resident #50's MAR January 2025 showed:</p> <p>-The resident did not receive nine out of nine medications ordered throughout the day.</p> <p>-The medications the resident did not receive included medications for high cholesterol, vitamin deficiency, diabetes (a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin), Gastroesophageal Reflux Disease (GERD), Benign Prostatic Hyperplasia [BPH-enlargement of the prostate gland blocks the urethra (the tube that carries urine from the bladder out of the body) causing problems with urinating). Anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus), Hypertension [primary or Essential] (HTN-abnormally high blood pressure that's not the result of a medical condition), Antifungal powder (a topical medication that treats fungal [fungus occurs as yeasts or molds] infections of the skin).</p> <p>8. Review of LPN F's electronic time card print out showed he/she clocked in on Saturday January 4, 2025, at approximately 6:00 A.M. and stayed on shift through Monday January 6, 2025, until approximately 7:00 A.M., for a total of approximately 49 hours straight.</p> <p>Review of LPN B's electronic time card print out showed:</p> <p>-He/She clocked in on Saturday January 4, 2025, at approximately 6:00 A.M., until approximately 10:30 P.M. , for a total of approximately 16.5 hours.</p> <p>-He/She clocked in on Sunday January 5, 2025, at approximately 9:45 A.M., and stayed on shift through Monday January 6, 2025, until approximately 7:00 A.M., for a total of approximately 21 hours and 15 minutes straight.</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>--LPN's A, B, and F worked day shift.</p> <p>--CMT G worked day shift.</p> <p>--CNA H worked day shift.</p> <p>-Sunday 1/5/25 night shift showed:</p> <p>--LPN's A, B, and F worked day shift.</p> <p>--CMT's F and G worked night shift.</p> <p>--CNA's H, L, Q, R, and S worked night shift.</p> <p>9. During an interview on 1/27/25 at 1:03 P.M., CMT D said:</p> <p>-Did not work weekends.</p> <p>-Did not work on Saturday 1/4/25 or Sunday 1/5/25.</p> <p>-Did get a text message about coming in to work.</p> <p>-Could not get there.</p> <p>-Was able to make it into the facility on Monday 1/6/25.</p> <p>-Thought there were three LPNs, One CMT, and one CNA on Saturday night.</p> <p>-Did not know the schedule each of them worked on Sunday, but they were at the facility when he/she came to work on Monday 1/6/25.</p> <p>During an interview on 1/28/25 at 10:07 A.M., LPN A said:</p> <p>-Worked Tuesday, Wednesday and every other weekend 12-hour shifts.</p> <p>-A major storm started Saturday 1/4/25 in the afternoon.</p> <p>-Saturday 1/4/25 day shift 6:00 A.M., to 6:00 P.M., was staffed for both wings and included LPN B.</p> <p>-On Saturday 1/4/25 night shift 6:00 P.M., to 6:00 A.M., staff started calling off.</p> <p>-He/She stayed over since there were staff calling off.</p> <p>-On Saturday night there were a total of three nurses, two CMT's and two CNA's and that was manageable.</p> <p>-The nurses called the Assistant Director several times each shift and the Assistant Director kept saying he/she was working on it, but no other staff came in.</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>-On Sunday morning 1/5/25 there were the same three nurses from Saturday morning and 1 CMT, and CNA H came in and stayed till Monday morning.</p> <p>-On Sunday night there were the same three nurses, a CMT, and two CNA's from Saturday morning.</p> <p>-He/She was one of the nurses that stayed from Saturday morning through Monday morning.</p> <p>-LPN B was the third nurse who worked and was an orientee and wasn't counted as staff when orienting but was a body to help with medications and tube feeding.</p> <p>-LPN B worked the A wing with LPN F and probably passed meds on the A wing.</p> <p>-He/She only gave residents their narcotic medications and insulin's and did accuchecks.</p> <p>-He/She did not give residents their regular medications on Sunday day and night shifts due to being too exhausted from working over 24 hours and did not feel safe in administering all the medications on the B wing.</p> <p>-It was his/her responsibility to pass medications.</p> <p>-He/She texted administrative staff about being exhausted because of working so many hours.</p> <p>--He/She did not receive responses to the texts sent.</p> <p>--He/She was told to sleep in rotation with the other staff to stay rested until other staff arrived to work.</p> <p>-He/She helped keep residents clean and dry.</p> <p>-He/she did give the 5:00 A.M., medications on Monday 1/6/25.</p> <p>-The Assistant Director was supposed to be working on getting staff in for Sunday.</p> <p>-One housekeeping staff and two kitchen staff made it in on Sunday morning and did breakfast and lunch.</p> <p>-A text message was sent out by the Assistant Director which read if a staff left their shift without being relieved it would be considered abandonment of the shift and would be fired.</p> <p>-The staff who were working were told to take turns and rest if staff were not able to make it in to work.</p> <p>-None of the staff went to an empty room to rest.</p> <p>--The staff didn't feel right going to an empty room to rest, so they didn't.</p> <p>-Two other kitchen staff came in Sunday afternoon and did dinner.</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>-Nurses came in on Monday morning and the three that stayed from Saturday went home.</p> <p>-He/She worked a total of 49 hours for the weekend.</p> <p>During an interview on 1/28/25 at 10:30 A.M., LPN B said:</p> <p>-He/She worked Saturday January 4, 2025.</p> <p>-He/She and the other two nurses called other staff and administration to see if they would come in.</p> <p>-Administration staff would not answer their phone.</p> <p>-He/She had been at the facility for two days as orientation before the storm and should have still been on orientation.</p> <p>-He/She was a new graduate LPN.</p> <p>-On Saturday 1/4/25 he/she worked 16 hours from 6:00 A.M., to about 10:30 P.M.</p> <p>-He/She went home and rested and came back on Sunday 1/5/25 about 9:45 A.M., and stayed until about 7:00 A.M., on Monday 1/6/25 and worked about 21 hours.</p> <p>-All three nurses were so tired that they did not get all the medications passed.</p> <p>-The staff who were working were told to take turns and rest if staff were not able to make it in to work.</p> <p>-None of the staff went to an empty room to rest.</p> <p>--The staff didn't feel right going to an empty room to rest, so they didn't.</p> <p>-Residents got their insulin and medications that were needed.</p> <p>-He/She was afraid for the residents because there was no one else to work.</p> <p>During an interview on 1/28/25 at 12:39 P.M., the DON said:</p> <p>-He/She had heard alerts that there could be bad weather coming.</p> <p>-He/She didn't know if it was really coming on Friday 1/3/25.</p> <p>-He/She heard there might be bad weather on Sunday the 1/5/25.</p> <p>-He/She did not know if plans were made to be sure there would be enough staff coverage if there was a large storm.</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 staffing coordinator would have been the one to see that there was enough staff if the weather was bad.</p> <p>-He/She started on Tuesday December 31, 2024, as the Interim DON.</p> <p>-He/She didn't know anything about the staffing at that time and still was not sure how the staffing was done.</p> <p>-He/She was not aware of what the staffing was during the weekend of the storm.</p> <p>-He/She was the night nurse and transitioning to the position of DON.</p> <p>-The Assistant Director asked him/her to come in on Friday morning due to being short staffed that morning.</p> <p>-Was not aware he/she should have been at the facility when there were staffing issues.</p> <p>-He/She never got a call to come in for the weekend from the Assistant Director.</p> <p>-He/She didn't call the facility to check if there was enough staff or call the Assistant Director to see if staffing was covered.</p> <p>-He/She thought if there was an issue that the Assistant Director would have called him/her.</p> <p>-Didn't know for sure who was responsible for making sure staffing was covered during bad weather.</p> <p>-He/she would assume all administration would be responsible.</p> <p>-He/She didn't know if there was an emergency plan for ensuring enough staff.</p> <p>-He/She didn't know what the plan was to get additional staff to the facility for emergencies.</p> <p>-The Assistant Director said there were rooms where staff could take naps.</p> <p>-He/She didn't know if agency staff was called.</p> <p>-He/She would expect administrative staff to come in and help.</p> <p>-There was a weekend RN but didn't know if he/she was here that weekend or not.</p> <p>-He/She would have also thought the Administrator would have called to check on staff or came in.</p> <p>-He/She was not sure if residents got medications or other cares.</p> <p>During an interview on 1/28/25 at 1:12 P.M., the Assistant Director said:</p> <p>-He/She did the staffing.</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 heard there was bad weather possibly coming, but didn't think it was going to be bad.</p> <p>-He/She did not watch the news or listen to weather reports.</p> <p>-He/She did not know the weather was bad until he/she got up on Saturday morning 1/4/25.</p> <p>-He/She got on the staffing phone and sent text messages out to everyone on the schedule.</p> <p>-He/She told staff they needed to try and come in early.</p> <p>-He/She put it on the facility's Paylocity time clock &amp; communication board also, this was accessible to all staff via their phone.</p> <p>-He/She did not receive any responses back from staff as to whether they would or would not be at work.</p> <p>-He/She tried to get out of his/her street to come and check and did not make it in.</p> <p>-He/She sent a text out and put the text message on Paylocity communication board on 1/3/25 at 4:16 P.M., that said:</p> <p>--The corporation policy from handbook showing facility recognized that the weather conditions due to nature of work and caring for health and safety of resident's facility strongly encouraged employees to make every reasonable but safe attempt to get to work during severe weather conditions.</p> <p>Employees should notify department supervisor or Administrator as soon as possible when travel condition delayed or prevented getting to work. Employees who exhibited a pattern of missing or avoiding work because of threat or because of inclement weather would be in violation of the policy if other employees in area could get to work with reasonable effort during severe weather conditions. He/she understood there might be bad weather this weekend but staff still needed to try and get to work even if late just call facility and let know if will be late. Please remember at all times you can't leave the building unless your relief had accepted the hall, if you left without a relief it was and would be considered abandonment of your employment.</p> <p>---The Paylocity communication board showed that 49 staff had reviewed it.</p> <p>-On Sunday 1/5/25 Former Executive Director put on the Paylocity communication board: Good morning he/she wanted to thank everyone who had come into work but unfortunately the ice that had accumulated had prevented others from coming in. For everyone's safety if you were stuck at work find an empty room and sleep in shifts until others were able to arrive. Meals could be provided. If you called in due to road conditions please continue to try to come in once your roads have been cleared. Others from night shift at the campus would like to go home. Unfortunately, some things were out of their control but first and foremost was our residents being cared for and your safety.</p> <p>--65 staff viewed this message.</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 put on the Paylocity communication board on 1/6/25 at 9:05 A.M. Please if you were on the schedule for Monday and Tuesday and overnights please make provisions early to get to work. He/she was letting everyone know in plenty of time by Lift, Uber, or taxi to get to work. Everyone needs to make a good faith attempt to get to work on time or early as possible. Everyone wants to go home just like everyone else. Please to make a good faith attempt to get to work early or at least get there. Some staff who live in and around the area made it to work slowly but made it. Please make a good attempt to get to work tonight and Tuesday on days and nights.</p> <p>--65 staff viewed this message.</p> <p>-He/She was responsible for ensuring there was enough staff.</p> <p>-He/She was unable to find alternate transportation to come in on Saturday or Sunday.</p> <p>-He/She would have expected other administrative staff to have tried to make it in to the facility.</p> <p>-He/She sent a management group text to come in if they could safely make it.</p> <p>-Management did not clock in.</p> <p>-No management came in to work.</p> <p>-He/She did not have the new DON's phone number.</p> <p>-He/She would not expect them to do their responsibilities without rest.</p> <p>-In the text he/she had sent, staff were told to take turns and rest while at the facility.</p> <p>-The staff were told to sleep in shifts and alternate so meds could be administered safely, and cares done safely.</p> <p>-He/She would expect all residents medications to have been given per Physicians orders.</p> <p>-The Former Executive Director put out a staffing need to the staffing agency and no agency staff picked up any shifts.</p> <p>-The new DON was not officially the DON until 1/14/25 he/she had still been working night shift as the nurse.</p> <p>During an interview on 1/31/25 at 3:25 P.M., the DON, Assistant Director, and the Executive Director said:</p> <p>-The Assistant Director does the staffing.</p> <p>-Staffing sheets were done in advance and if there were empty positions he/she would try to find full time staff who would pick up the shift.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>37576</p> <p>Based on interview and record review, the facility failed to ensure the services of a Registered Nurse (RN) were utilized eight hours per day, seven days per week. This had the potential to affect all residents of the facility. The facility census was 55 residents.</p> <p>Review of the facility's Staffing, Sufficient and Competent Nursing policy, dated as revised August 2022, showed:</p> <ul style="list-style-type: none"> <li>-Licensed nurses and Certified Nursing Assistants (CNA) were available 24 hours a day, seven days a week to provide competent resident care services.</li> <li>-A RN provides services at least eight consecutive hours every 24 hours, seven days a week.</li> <li>-RNs may be scheduled more than eight hours depending on the acuity needs of the resident.</li> </ul> <p>1. Review of the Facility Assessment, dated 1/16/25, showed:</p> <ul style="list-style-type: none"> <li>-The facility was licensed for 118 residents.</li> <li>-Current full-time staff was 41.</li> <li>-Part-time staff was 3.</li> <li>-As needed (PRN) staff was 4.</li> </ul> <p>Hours per resident days (HPRD) showed:</p> <ul style="list-style-type: none"> <li>-Day shift: <ul style="list-style-type: none"> <li>--Two RNs.</li> <li>--Two Licensed Practical Nurses (LPNs).</li> <li>--Four CNA/Nurse Assistants (NA).</li> </ul> </li> <li>-Night shift: <ul style="list-style-type: none"> <li>--No RN.</li> <li>--Two LPNs.</li> <li>--Four CNA/NAs.</li> </ul> </li> </ul> <p>Review of the facility staffing sheet, dated 1/4/25, showed:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	
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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-RN A was scheduled to work the day shift on 1/4/25.</p> <p>Review of the facility staffing sheet, dated 1/5/25, showed:</p> <p>-RN A was not scheduled to work on 1/5/25.</p> <p>-There was no other RN scheduled to work.</p> <p>-The Director of Nursing (DON) did not come in to the building and work as the RN coverage.</p> <p>Review of the facility staffing sheet, dated 1/6/25, showed:</p> <p>-The DON was scheduled to be the RN in the building on 1/6/25.</p> <p>-There was no other RN scheduled to work.</p> <p>-The DON did not work on 1/6/25.</p> <p>Review of the facility's current staff list, dated 1/17/25, showed:</p> <p>-The DON as a RN.</p> <p>-RN A as the weekend and part time RN.</p> <p>-RN B as a full-time RN.</p> <p>During an interview on 1/28/25 at 12:39 P.M., the DON said:</p> <p>-He/She was a RN.</p> <p>-He/She had started on December 31, 2024, as the Interim DON.</p> <p>-The staffing coordinator was responsible to make sure there was enough staff for each position.</p> <p>-He/She didn't know anything about the staffing at that time and still was not sure how the staffing was done.</p> <p>-Was not aware the RN scheduled for 1/5/25 or 1/6/25 did not show.</p> <p>-He/She sometimes filled in as the RN and would work the floor if there was no other RN scheduled.</p> <p>-He/She was scheduled to work as the DON on 1/6/25, but was unable to come in.</p> <p>-He/She did not know there was no other RN working on 1/6/25.</p> <p>During an interview on 1/28/25 at 1:12 P.M., the Assistant Director said:</p> <p>-He/She did the staffing.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Staffing sheets were done in advance and if there were empty positions he/she tried to see if the full-time staff would pick up the shift.</p> <p>-If full time staff didn't pick up a shift then he/she called the staffing agency the facility contracts with.</p> <p>-If the staffing agency couldn't fill the position, the facility offered incentives to staff such as a bonus for working an extra shift.</p> <p>-The facility had a scheduled RN to work the weekends.</p> <p>-That RN worked Saturday 1/4/25.</p> <p>-Sunday 1/5/25 there was no RN scheduled to work.</p> <p>-The DON did not work on 1/5/25.</p> <p>-The DON was scheduled to work Monday 1/6/25 and would have been the RN, but he/she was unable to make it in.</p> <p>-There was no RN on duty on 1/5/25 and 1/6/25.</p> <p>During an interview on 1/31/25 at 3:25 P.M., the DON, Assistant Director, and the Executive Director said:</p> <p>-There should be RN coverage for at least eight hours in a 24-hour period.</p> <p>-There should have been a RN working on 1/5/25 and 1/6/25.</p> <p>-When a RN was not scheduled or if the RN called off, the DON was expected to cover the position.</p> <p>-Staffing sheets were done in advance and if a RN was needed, the Assistant Director would call the staffing agency to see if they could fill the spot.</p> <p>-The DON was not aware he/she was expected to cover shifts that did not have RN coverage.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>37576</p> <p>Based on observation and interview, the facility failed to post nurse staffing information, which included the facility census, the total number of each staff and actual hours worked by both licensed and unlicensed staff directly responsible for resident care, per shift on a daily basis and visible for residents, visitors, and staff to view at each nursing station. The facility census was 55 residents.</p> <p>A copy of the facility policy regarding posting of nursing staff type, hours worked by each discipline, and facility census was requested and not received at the time of exit.</p> <p>1. Observation on 1/22/25 at 2:17 P.M., showed a staffing sheet was posted at the far right of the reception desk, but was not visible to residents or visitors who did not stop at the desk.</p> <p>During an interview on 1/22/25 at 2:17 P.M., the receptionist said:</p> <ul style="list-style-type: none"> <li>-The staffing sheets were posted every morning at the far right of the reception desk.</li> <li>-The staffing sheets showed the facility census, the number of staff and total hours worked for each nursing staff position.</li> <li>-The staffing sheets were not posted at each nursing station.</li> </ul> <p>During an interview on 1/22/25 at 2:21 P.M., Licensed Practical Nurse (LPN) D working the A wing said:</p> <ul style="list-style-type: none"> <li>-Staffing was posted at the front reception desk.</li> <li>-When residents or visitors wanted to know the number of staff or which staff were working, they needed to ask one of the staff who was working.</li> <li>-When an agency staff was working, that staff went to the front receptionist to find out.</li> </ul> <p>During an interview on 1/22/25 at 2:25 P.M., LPN A working the B wing said:</p> <ul style="list-style-type: none"> <li>-Staffing was posted at the front reception desk.</li> <li>-Residents or visitors could ask which staff were working.</li> </ul> <p>During an interview on 1/24/25 at 10:47 A.M., Certified Nursing Assistant (CNA) G said:</p> <ul style="list-style-type: none"> <li>-Staffing was posted at the front reception desk.</li> <li>-Today there were two CNA's, one Certified Medication Technician (CMT), one nurse, and one bath aide working the A wing.</li> </ul> <p>(continued on next page)</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/31/25 at 3:25 P.M., the Director of Nursing, Assistant Director and the Executive Director said:</p> <ul style="list-style-type: none"> <li>-The daily staffing information was posted daily.</li> <li>-The staffing sheets showed the facility daily census, the number of each nursing staff and the total hours of each position worked in 24 hours.</li> <li>-The staffing was posted at the front reception desk and at both nursing stations.</li> <li>-The staffing information should be posted in areas where it was easily accessible to all residents, visitors, and staff.</li> </ul>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>19916</p> <p>Based on interview and record review, the facility failed to ensure timely assistance was provided to two sampled residents (Residents #35 and #29) who were Medicaid pending (a person has applied for Medicaid, but had not yet been approved or denied benefits) out of four residents reviewed, in the procurement of Medicaid (a government program that provides health insurance for adults and children with limited income and resources) to assist with their expenses at the facility. The facility census was 55 residents.</p> <p>Review of the Medicaid Nursing Home Application- Helpful Information showed items often needed for Nursing Home Application include the following:</p> <ul style="list-style-type: none"> <li>-Bank Statements (any/all checking and Savings -Last 3 months to the current;</li> <li>-Life Insurance Policies (Cash Surrender Value &amp; is the policy revocable or irrevocable</li> <li>-Stocks, Bonds, IRAs (Individual Retirement Accounts);</li> <li>-Funeral Burial Documents (Contract and irrevocable clause, if applicable);</li> <li>-Pension (verification Letter showing Gross wages and deductions);</li> <li>-Power of Attorney (POA) Guardian/Public Administrator Paperwork;</li> <li>-Deeds/titles to home property and vehicles;</li> <li>-Proof of Marriage;</li> <li>-Shelter expenses such as rent, mortgage, homeowners insurance, and real estate taxes;</li> <li>-Proof of income such as assets, life insurance, burial plan etc. (for spouse) and</li> <li>-Initial date of institutionalization lasting 30 days or more.</li> </ul> <p>1. Review of the facility's midnight census report, dated 1/22/25, showed Resident #35 was listed as Medicaid pending as his/her Primary Payer.</p> <p>During an interview on 1/23/25 at 10:22 A.M., the Social Service Designee (SSD) said:</p> <ul style="list-style-type: none"> <li>-He/she had been in that position since September 2023.</li> <li>-He/she was unaware of which residents were in Medicaid pending status, when he/she got into that position.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she was unaware of the reason why Medicaid was discontinued for that resident in the first place.</p> <p>-Resident #35's Relative B spoke with him/her in November 2024.</p> <p>During a phone interview on 1/23/25 at 10:49 A.M., the resident's Relative B said:</p> <p>-He/she was informed in October 2024 by the previous Business Office Manager (BOM) that the resident became Medicaid pending because of a letter which came to the facility.</p> <p>-As of 1/23/25, he/she had not seen a copy of the letter that he/she was told about.</p> <p>-That letter was not shared with another relative who was able to visit the resident a little more often, because he/she (Relative B) resided at an out of town location.</p> <p>-The former BOM said something needed to be renewed, but the former BOM did not say exactly what needed to be renewed.</p> <p>-The application process for Medicaid only began in November 2024.</p> <p>-The facility's processes and follow through were pitiful.</p> <p>2. Review of the facility's midnight Census Report, dated 1/22/25, showed Resident #29 was listed as Medicaid pending as his/her Primary Payer.</p> <p>During an interview on 1/31/25 at 9:35 A.M., the current BOM said:</p> <p>-The resident was admitted to the facility in October 2022.</p> <p>-The resident's Medicaid Status was inactive since February 2024.</p> <p>-The resident's Relative C said the previous BOM was supposed to be helping him/her fill out the paperwork correctly.</p> <p>During a phone interview on 2/5/25 at 10:16 A.M., the resident's Relative C said:</p> <p>-The current BOM had been helpful, but all the previous BOM's were no help.</p> <p>-His/her relative had been at the facility since October 2022.</p> <p>-He/she started filling out a renewal application for Medicaid in November 2023 for the resident.</p> <p>-He/she received no assistance from any of the BOM's at the facility, until the current BOM started.</p> <p>-He/she tried to answer the questions on the Medicaid application as honestly as he/she could.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she voiced concerns to the former BOM and was told he/she would provide help, but the former BOM did not do anything to help him/her complete the Medicaid application.</p> <p>-He/she had taken this as far as he/she could physically take it.</p> <p>-In November 2023, he/she sent a letter to MO Health Net, then he/she received a reply which stated the resident's case was closed on 12/29/23, he/she would need to reapply.</p> <p>-There have not been proper people in place to assist relatives in the process of completing Medicaid applications.</p> <p>3. During an interview on 1/31/25 at 10:04 A.M., the Executive Director said:</p> <p>-He/she had one conversation about the Medicaid application and submission process.</p> <p>-He/she discussed a checklist.</p> <p>-The BOM had told him/her that those situations existed before his/her (the BOM's) time.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39469</p> <p>Based on interview and record review, the facility failed to ensure the narcotic (a class of drugs that produce insensibility or stupor due to their depressant effect of the central nervous system) medications were counted and signed by two nurses at the beginning and end of each shift, failed to ensure residents' narcotic medications were counted correctly for one supplemental resident (Resident #49), and failed to ensure narcotic medications were documented correctly when administered for one sampled resident (Resident #39) out of 15 sampled residents. The facility census was 55 residents.</p> <p>The facility narcotic drug count policy was requested and not received.</p> <p>1. Review of The Controlled Substance Key Exchange Record, dated December 22, 2024 to December 31, 2024, with Licensed Practical Nurse (LPN) C showed:</p> <p>-There should have been two nurses signatures for two shifts per day.</p> <p>--Two nurses signatures for two shifts per day for seven days equaled 28 opportunities, which verified the narcotic count was correct.</p> <p>---Nine out of 28 opportunities were blank.</p> <p>-The number of cards with narcotics in them should have been counted at the beginning and ending of each shift and a total documented on the Controlled Substance Key Exchange Record.</p> <p>--Four out of 14 opportunities were blank.</p> <p>2. Review of The Controlled Substance Key Exchange Record, dated January 1, 2025 to January 27, 2025, with LPN C showed:</p> <p>-27 out of 106 opportunities were missed.</p> <p>-10 out of 53 opportunities to count narcotic cards were not counted.</p> <p>-On January 1, 2025 there were 42 narcotic cards.</p> <p>--From January 1, 2025 to January 27, 18 narcotic cards were added, 21 were subtracted for a total of 39 cards.</p> <p>3. Review of Resident 39's Medication Administration Record (MAR), dated December 2024, showed:</p> <p>-Hydrocodone-Acetaminophen (a powerful pain medication with the risks of addiction, abuse, or misuse) tablet 7.5-325 milligram (mg) give one by mouth every four hours as needed for pain related to spinal stenosis and lower back pain.</p> <p>--The Hydrocodone-Acetaminophen was signed out 63 times.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Controlled Drug Receipt/Record/Disposition Form, dated 12/6/24 to 12/31/24, showed:</p> <ul style="list-style-type: none"> <li>-The medication was signed out 10 times more on the Controlled Drug Receipt/Record/Disposition form than the amount documented on the Nurses' Medication Administration Record (MAR).</li> <li>--The Hydrocodone-Acetaminophen was signed out 73 times.</li> </ul> <p>Review of the resident's MAR dated January 2025 showed:</p> <ul style="list-style-type: none"> <li>-Hydrocodone-Acetaminophen tablet 7.5-325 mg give one by mouth every four hours as needed for pain related to spinal stenosis and lower back pain.</li> <li>--The Hydrocodone-Acetaminophen was signed out 70 times.</li> </ul> <p>Review of the resident's Controlled Drug Receipt/Record/Disposition Form, dated 1/1/25 to 1/28/25, showed:</p> <ul style="list-style-type: none"> <li>-The medication was signed out 15 times more Controlled Drug Receipt/Record/Disposition form than the amount documented on the Nurses' MAR.</li> <li>--The Hydrocodone-Acetaminophen was signed out 82 times.</li> </ul> <p>4. Review of Resident #49's Controlled Drug Receipt/Record/Disposition Form, dated January 2025, showed:</p> <ul style="list-style-type: none"> <li>-Oxycodone 5 mg tablet, give one half tablet (2.5 mg) by mouth every four hours as needed.</li> <li>-On 1/8/25 the resident had 30 pills.</li> <li>-On 1/27/25 at 9:30 A.M. there were 18 pills documented as given with 12 pills remaining.</li> <li>- Observation on 1/27/25 at 9:35 A.M. showed the actual count was 11 pills remaining, as verified by LPN C.</li> </ul> <p>5. During an interview on 1/27/25 at 11:00 A.M., LPN C said:</p> <ul style="list-style-type: none"> <li>-Two nurses should count the number of narcotic cards at the same time and sign the narcotic count sheet which verified they had counted and the number was correct, it should have been done at the start and end of each shift.</li> <li>-Counting narcotic cards was not done consistently at the facility.</li> <li>-If the pill count on the narcotic card was not correct the Director of Nursing (DON) should have been told.</li> <li>-He/She had never said anything to the DON about the nurses not signing the narcotic count or that the count was not correct.</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The DON was ultimately responsible for ensuring the nursing staff was counting the narcotics and that the count was correct.</p> <p>During an interview on 1/29/25 at 2:00 P.M., LPN A said:</p> <p>-The oncoming and off going nurses should count the narcotics together and sign at the time that they had counted.</p> <p>-The count should be correct and have been the same as the count of medications given on the MAR.</p> <p>-If the count was wrong the DON should have been notified.</p> <p>-He/She had noticed some blank spots on the count sheet and had told the previous DON, but nothing was done.</p> <p>During an interview on 1/31/25 at 3:30 P.M., the DON said:</p> <p>-Narcotics should have been counted at the beginning and end of each shift with both nurses to verify the count was correct.</p> <p>-If the count was not correct or there were blanks indicating both nurses had not verified the count he/she should have been notified.</p> <p>-He/She had not been auditing the narcotic count to ensure it was correct.</p> <p>-He/She had not been notified by anyone on 1/27/25 of the narcotic count being off.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>33134</p> <p>Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR) Pharmacy recommendations were followed and the Physician responded for two sampled residents (Residents #209, and #2) out of five residents sampled for medication review. The facility census was 55 residents.</p> <p>Review of the facility's Medication Regimen Reviews policy, dated as revised May 2019, showed:</p> <ul style="list-style-type: none"> <li>-The consultant pharmacist performed a MRR for every resident in the facility receiving medications.</li> <li>-MRR's were done upon admission and at least monthly.</li> <li>-Within 24 hours of the MRR, the consultant pharmacist provided a written report to the attending physicians for each resident identified as having non-life-threatening medication irregularity.</li> <li>-The MRR included the resident's name, the name of the medication, the identified irregularity and the pharmacist's recommendation.</li> <li>-The attending physician should document in the medical record that the irregularity was reviewed and what (if any) action was taken to address it.</li> <li>-The consultant pharmacist provided the Director of Nursing (DON) and Medical Director with a written, signed, and dated copy of all MRR's.</li> <li>-Copies of the MRR reports, including physicians' responses, are maintained as part of the permanent medical record.</li> </ul> <p>Review of the facility's Medication Therapy policy, dated April 2007, showed all medication orders should have been supported by appropriate care processes and practices.</p> <p>1. Review of Resident #209's progress notes, dated 1/5/25, showed Medication Regimen Review Complete: See report for any noted irregularities and/or recommendations.</p> <p>Review of the resident's MRR, dated 1/5/25, showed:</p> <ul style="list-style-type: none"> <li>-Please update the diagnosis to Benign Prostatic Hypertrophy (BPH a condition where the prostate gland, located below the bladder in men, enlarges without being cancerous) per admission orders for Tamsulosin (used to treat the symptoms of an enlarged prostate) capsule 0.4 milligram (mg).</li> <li>-There was no physician response on the resident's MRR or in the resident's progress notes.</li> </ul> <p>Review of the resident's POS, dated January 2025, showed:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Tamsulosin Oral Capsule 0.4 mg</p> <p>-Give 1 capsule by mouth one time a day for chronic kidney disease.</p> <p>--NOTE: The diagnosis was not updated as recommended by the pharmacist.</p> <p>22727</p> <p>2. Review of Resident #2's MRR notes, dated 1/4/24, 2/1/24, 3/1/24, 4/4/24, and 5/1/24, showed the MRR was completed and referred to the MRR report for any noted irregularities and/or recommendations.</p> <p>Review of the resident's medical record showed no response to the MRR's that were dated 1/4/24, 2/1/24, 3/1/24, 4/4/24, and 5/1/24.</p> <p>The MRR's and the responses to the MRR's dated 1/4/24, 2/1/24, 3/1/24, 4/4/24, and 5/1/24 were requested from the facility and not received.</p> <p>3. During an interview on 1/29/25 at 10:32 A.M., Licensed Practical Nurse (LPN A) said:</p> <p>-The MRR's go to the Director of Nursing (DON).</p> <p>-The DON was responsible for ensuring the MRR's were completed.</p> <p>-He/She had not been given any MRR responses to enter medication order changes for any residents.</p> <p>During an interview on 1/31/25 at 12:05 P.M. with the DON and the Executive Director:</p> <p>-The Executive Director said:</p> <p>--The DON was responsible for ensuring the MRR's were completed.</p> <p>--The order should have been transcribed correctly.</p> <p>-The DON said:</p> <p>--He/She was not aware he/she was responsible for making sure the MRR's were completed.</p> <p>--The charge nurse should have ensured the orders were transcribed correctly.</p> <p>--He/She had not checked to make sure the MRR's were completed or orders were transcribed correctly.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>39469</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' medications that needed to be refrigerated were refrigerated, failed to ensure there were no loose pills in the medication cart, failed to ensure the temperature was checked daily for the medication refrigerator which stored the resident's prescribed medications, failed to ensure there was soap in the only soap dispenser in the medication room, and failed to ensure the only sink in the medication room was clean.</p> <p>The facility census was 55 residents.</p> <p>Review of the facility's Storage of Medications policy, dated November 2020, showed:</p> <ul style="list-style-type: none"> <li>-Drugs and biologicals used the the facility were to have been stored in locked compartments under proper temperature, light and humidity controls.</li> <li>-Only persons authorized to prepare and administer medications had access to locked medications.</li> <li>-The nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</li> </ul> <p>1. Observation on 1/27/25 at 9:15 A.M., with Licensed Practical Nurse (LPN) C of the Medication cart on A hallway showed:</p> <ul style="list-style-type: none"> <li>--The Gabapentin bottle had the following instructions; refrigerate after opening. The bottle was in the medication cart and was not refrigerated.</li> <li>-There were two round white pills loose in the bottom of the medication cart drawer.</li> </ul> <p>2. Review of the medication refrigerator temperature log on A hallway, dated December 2024, showed:</p> <ul style="list-style-type: none"> <li>-The refrigerator temperature should have been between 36 to 46 degrees Fahrenheit for medication storage.</li> <li>-Only 20 out of 31 days were documented as done and there were 11 missed opportunities to document the refrigerator temperature.</li> </ul> <p>3. Review of the medication refrigerator temperature log on A hallway, dated January 2025 on 1/27/25, showed:</p> <ul style="list-style-type: none"> <li>-The refrigerator temperature should have been between 36 to 46 degrees Fahrenheit for medication storage.</li> </ul> <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 - Few</p>	<p>-Only 12 out of 27 days were the temperature documented as done and there were 15 missed opportunities to document the refrigerator temperature.</p> <p>4. Observation on 1/27/25 at 9:30 A.M., of medication room A showed:</p> <p>-There was no soap in the only soap dispenser.</p> <p>-The sinks were stained with a brown reddish color.</p> <p>5. During an interview on 1/27/25 at 9:45 A.M., LPN C said:</p> <p>-There should not have been any loose pills in the drawer of the medication cart.</p> <p>-The charge nurse was responsible for ensuring the medication carts were cleaned.</p> <p>-Medication that was to have been refrigerated should have been refrigerated.</p> <p>-The night nurse should have ensured the refrigerator with the residents' medications in it was checked every night and documented on the temperature log.</p> <p>-The medication room should have been cleaned daily by the housekeeping staff.</p> <p>During an interview on 1/29/25 at 2:01 P.M., LPN A said:</p> <p>-There should not have been any loose pills in the medication cart drawers.</p> <p>-Anyone who used the medication cart was responsible for keeping it clean.</p> <p>-If a medication said it was to have been in the refrigerator it should have been in the refrigerator.</p> <p>-Nursing should have ensured that housekeeping was cleaning the medication room daily and that it was stocked.</p> <p>-The Director of Nursing (DON) should have ensured the night nurse was checking the temperature of the medication refrigerator.</p> <p>During an interview on 1/31/25 at 3:30 P.M., the DON said:</p> <p>-If a medication showed it needed to have been refrigerated on it, it should have been refrigerated.</p> <p>-The person who used the medication cart should have ensured it was kept clean.</p> <p>-There should not have been any loose pills in the drawers of the medication cart.</p> <p>-The day nurse was responsible for ensuring the medication refrigerator was within acceptable range and documenting it daily.</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 - Few</p>	<p>-Housekeeping under supervision of the nursing staff was responsible for cleaning and ensuring the medication room was stocked with soap and paper towels.</p> <p>-He/She did not know how often the medication rooms were cleaned by housekeeping.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19916</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physician's orders pertaining to the diet texture were correct and followed, and failed to discontinue a diet order after the resident was reassessed for a change in diet texture for one sampled resident (Resident #30) out of 14 sampled residents. The facility census was 55 residents.</p> <p>1. Review of Resident #30's Admission Face Sheet showed the resident was admitted with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-High blood pressure.</li> <li>-Hyperlipidemia (condition in which there are abnormally high levels of lipids (fats) in the blood).</li> <li>-Malignant neoplasm (an abnormal mass of tissue that forms when cells grow and divide uncontrollably. of unspecified site.</li> </ul> <p>Review of the resident's physician's orders, dated 5/8/24, showed a physician's order for a regular diet with a regular texture.</p> <p>Review of the resident's Admission Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning), dated 5/15/24, showed:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment.</li> <li>-The resident required a mechanically altered diet.</li> <li>-The resident required supervision or touching assistance for eating.</li> </ul> <p>Review of the resident's physician's orders, dated 5/15/24, showed a physician's order for a regular diet with a pureed (food that is blended, chopped, mashed, or strained until it becomes a soft and smooth consistency) texture.</p> <p>Review of the resident's Speech Therapy order, dated 7/5/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident should be upright in his/her chair and in the dining room for all meals, unless family was present.</li> <li>-Encourage drinks between bites to clear food.</li> <li>-Stay up for 30 minutes after eating.</li> </ul> <p>-NOTE: There was no type of diet texture mentioned in the order.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan, dated 7/25/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident had a diagnosis of Oropharyngeal dysphagia (swallowing difficulty that occurs in the mouth or throat).</li> <li>-The problem was the resident had a nutritional problem or potential nutritional problem related to a diagnosis of dysphagia.</li> <li>-The goal was to explain and reinforce the importance of maintaining the diet ordered.</li> <li>-The interventions were: <ul style="list-style-type: none"> <li>--Monitor/document/report any signs or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appeared concerned during meals.</li> </ul> </li> </ul> <p>Review of the resident's Dietary Profile, dated 8/20/24, showed the resident's current diet order was for a regular texture with partial assistance required.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-The resident had moderate cognitive impairment.</li> <li>-The resident required a mechanically altered diet.</li> <li>-The resident required supervision or touching assistance for eating.</li> </ul> <p>Review of the resident's Dietary Profile, dated 11/18/24, showed the resident's current diet order was for a regular texture with independent in eating.</p> <p>Review of the resident's care plan, dated 11/18/24, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident had nutritional problem or potential nutritional problem related to malignant neoplasm, essential primary hypertension, and hyperlipidemia.</li> <li>-Goals: The resident would maintain adequate nutritional status as evidenced by maintaining weight within 5% of 140.2, pounds with no signs and symptoms of malnutrition, and consuming at least 50% of at least two meals daily through review date.</li> <li>-Interventions included: <ul style="list-style-type: none"> <li>--Explain and reinforce to the resident the importance of maintaining the diet ordered.</li> <li>--Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors.</li> </ul> </li> </ul> <p>(continued on next page)</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>--Monitor/document/report any signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in his/her mouth, several attempts at swallowing, Refusing to eat, Appears concerned during meals as needed</p> <p>--Monitor/record/report to his/her physician as needed for signs and symptoms of malnutrition, such as Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs. (pounds) in 1 week, &gt;5% in 1 month, &gt;7.5% in 3 months, &gt;10% in 6 months.</p> <p>--Occupational Therapy (OT) to screen and provide adaptive equipment for feeding as needed.</p> <p>--Provide, serve diet as ordered. Monitor intake and record every meal.</p> <p>--The Registered Dietitian (RD) should evaluate and make diet change recommendations as needed.</p> <p>Review of the resident's POS, dated January 2025, showed the following diet orders:</p> <p>-Regular diet regular consistency with regular thin consistency liquids.</p> <p>-Regular diet puree consistency.</p> <p>Observation on 1/24/25 at 7:57 A.M., during the breakfast meal showed:</p> <p>-The resident was served a regular diet meal which consisted of coffee cake, omelet, and oatmeal with regular thin liquids.</p> <p>-The meal was not cut into smaller pieces for the resident.</p> <p>-The resident coughed on and off during the entire meal.</p> <p>-The resident coughed when he/she took drinks.</p> <p>-Facility staff did not assist the resident.</p> <p>Observation on 1/24/25 from 12:10 P.M. through 12:38 P.M., during the lunch meal showed:</p> <p>-The resident was served chicken, broccoli, and a roll at a regular consistency.</p> <p>-The staff member cut up the chicken for the resident.</p> <p>-The resident's relative A cut the broccoli for the resident.</p> <p>-The resident's relative A assisted with feeding.</p> <p>-The resident had occasional coughing while eating.</p> <p>During an interview on 1/24/25 at 12:14 P.M., the resident's relative A said:</p> <p>-The resident ate slow.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident had trouble using the utensils.</p> <p>-The facility had not asked him/her anything related to the resident's dietary assessment.</p> <p>During an interview on 1/27/25 at 3:09 P.M., Certified Medication Technician (CMT) C said he/she has noticed that the resident coughed while he/she ate in the dining room.</p> <p>During an interview on 1/27/25 at 3:10 P.M., Certified Nursing Assistant (CNA) F said he/she had noticed that the resident coughed while he/she ate his/her food.</p> <p>During an interview on 1/27/25 at 3:11 P.M., Licensed Practical Nurse (LPN) C said:</p> <p>-The original physician's order for regular diet was started on 5/8/24 and discontinued on 5/15/24.</p> <p>-Between 5/8/24 and 5/15/24, the resident was evaluated by Speech Therapy and at the end of that period, they should have discontinued one of the diets, and fixed the orders.</p> <p>-On 7/5/24, there was an upgrade in the resident's diet from pureed texture diet to regular texture diet.</p> <p>-The Registered Dietitian (RD) came to the facility on ce per month.</p> <p>During an interview on 1/27/25 at 3:36 P.M., the MDS Coordinator said:</p> <p>-There were two orders, one for a regular diet dated 5/8/24 and one for a pureed diet started on 5/15/24.</p> <p>-The order for the regular diet should have been discontinued on 5/15/24, while the order for the pureed diet had an indefinite end date.</p> <p>-An order was done by Speech Therapy in July 2024, to put the resident on a regular diet.</p> <p>-Speech Therapy saw the resident on 7/5/24, but the Speech Therapist did not communicate what diet texture the resident should have.</p> <p>-The order for a regular textured diet in May, 2024, was not discontinued by the physician.</p> <p>-At the completion of the most recent MDS in November 2024, the resident should have still received a pureed diet.</p> <p>-The order for the pureed diet was in effect currently and the order for the regular diet was also in effect at this time.</p> <p>Review of the resident's Progress Note, dated 1/27/2025, documented by the MDS Coordinator, showed:</p> <p>-The resident had two diets in his/her orders.</p> <p>-The MDS had the resident assessed for a pureed diet (mechanically altered).</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A regular textured diet was prescribed to the resident during a swallow study.</p> <p>-The Speech Therapist did not conform the start and stop dates for the different texture of diets.</p> <p>-The order for regular diet had continued on the orders along with the orders for pureed textured diet.</p> <p>-The resident had been served a regular diet.</p> <p>-The order put in by a nurse did not specify which diet texture to serve.</p> <p>-The current order for pureed texture was given to the dietary manager so the correct textured diet would be served to the resident.</p> <p>During an interview on 1/28/25 at 1:22 P.M., the Speech Therapist said:</p> <p>-There was a different Speech Therapist who evaluated the resident in July 2024.</p> <p>-There was an evaluation of the resident from 7/5/24 through 7/22/24, due to a request from someone (but he/she did not know who).</p> <p>-If the Speech Therapist was going to change a diet order, one diet should have been discontinued then started a new order.</p> <p>-The speech evaluation showed the resident tolerated an upgraded diet in July with no issues.</p> <p>-It looked like the Speech Therapist in July 2024 recommended a diet upgrade from a pureed texture to a mechanical soft.</p> <p>-The resident had not been referred to Speech Therapy for a reevaluation in the last three months.</p> <p>-He/she could not speak to which order would be correct until a full evaluation was done.</p> <p>-The Speech Therapist recommended a regular diet back in July 2024.</p> <p>Observation on 1/29/25 from 12:05 P.M. to 12:37 P.M., during the lunch meal showed:</p> <p>-The resident sat at the table in the dining room with, one small cup of ice water at the table.</p> <p>-The resident was served pureed ham, pureed sweet potatoes, pureed broccoli.</p> <p>-The resident unrolled silverware from napkin and placed silverware and napkin on table.</p> <p>-The resident started to feed himself/herself with a spoon by eating the pureed ham.</p> <p>-The resident ate six bites of ham.</p> <p>-The resident ate four bites of the dessert.</p> <p>(continued on next page)</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident ate most of the ham but not the broccoli nor the sweet potatoes.</p> <p>During an interview on 1/30/25 at 3:11 P.M., the Director of Nursing (DON) said:</p> <p>-The resident did not eat very much.</p> <p>-The resident fed himself/herself.</p> <p>-Sometimes the resident ate well.</p> <p>-Family brought food to the resident frequently.</p> <p>-He/she was not aware of the conflicting orders.</p> <p>-The nurse who placed the order for the pureed diet should have had the order for the regular diet discontinued.</p> <p>During a phone interview on 1/31/25 at 10:56 A.M., the Registered Dietitian (RD) said:</p> <p>-He/she did an annual assessment of the resident in September 2024.</p> <p>-As far as he/she knew, the resident should be served a pureed diet.</p> <p>-The resident's medical record indicated pureed diet.</p> <p>-The order was changed from regular to pureed on 1/27/25.</p> <p>-There had been some degree of turnover in the dietary department.</p> <p>MO 00248157</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19916</p> <p>Based on observation, interview, and record review, the facility failed to maintain hot meal items on room trays at or close to 120 F (degrees Fahrenheit) for five sampled residents (Resident #11, #159, #4, #19, and #109) out of 10 residents who received room trays. The facility census was 55 residents.</p> <p>Review of the facility policy titled The dining experience, staff roles dated 2020 showed:</p> <ul style="list-style-type: none"> <li>-The Dietary Services Manager or designee would be present in the dining room for all meals to ensure that the meals served:</li> <li>--Were palatable.</li> <li>--Were served at the appropriate temperatures.</li> </ul> <p>1. Review of the resident council minutes, dated January 2025, showed the residents mentioned the food was cold and the food was not good.</p> <p>During an interview on 1/31/25 at 12:21 P.M., the Life Enrichment Coordinator said:</p> <ul style="list-style-type: none"> <li>-He/she made copies of the resident council minutes and gave them to each department to respond to the residents' concerns.</li> <li>-When each department head had developed a plan to address the resident's concerns, they were supposed to give that plan to the Social Service Designee (SSD).</li> <li>-The SSD was supposed to check with each department to see if the resident concerns has been resolved.</li> </ul> <p>2. Review of Resident #11's quarterly Minimum Data Set (MDS--a federally mandated assessment tool completed by the facility for care planning), dated 11/29/24, showed the resident was cognitively intact.</p> <p>During an interview on 1/22/25 at 1:21 P. M.,the resident said:</p> <ul style="list-style-type: none"> <li>-He/she at in his/her room and had room trays.</li> <li>-The food was often cold.</li> </ul> <p>3. Observation on 1/24/25 at 7:10 A.M., showed the temperature of the hot items in the kitchen at the steam table were as follows:</p> <ul style="list-style-type: none"> <li>-The omelet was 186 F.</li> <li>-The sausage patties were between 157 F to 160 F.</li> </ul> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	

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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>During an interview on 1/24/25 at 7:31 A.M., Certified Nursing Assistant (CNA) G said:</p> <ul style="list-style-type: none"> <li>-He/she had not seen anyone from dietary come and check the temperatures of the food items on the trays.</li> <li>-He/she or the person delivering room trays, usually delivered the drinks and the food trays.</li> </ul> <p>Observation on 1/24/25 of the room tray delivery process showed:</p> <ul style="list-style-type: none"> <li>-At 7:33 A.M., CNA G started to deliver room trays.</li> <li>-At 7:38 A.M., CNA G delivered food to resident room [ROOM NUMBER] and had to awaken the resident before he/she was able to serve the resident his/her tray.</li> <li>-At 7:40 A.M., CNA G delivered food to resident room [ROOM NUMBER].</li> <li>-At 7:46 A.M., CNA G delivered food to resident room [ROOM NUMBER].</li> <li>-At 7:50 A.M., CNA G delivered food to resident room [ROOM NUMBER].</li> <li>--That resident needed help to go to the restroom.</li> <li>-At 7:54 A.M., CNA G delivered food to resident room [ROOM NUMBER].</li> <li>-At 7:57 P.M., CNA G delivered food to resident room [ROOM NUMBER].</li> <li>-At 8:03 P.M., CNA G delivered food to resident room [ROOM NUMBER].</li> <li>-At 8:07 A.M., CNA G delivered food to resident room [ROOM NUMBER].</li> <li>--The resident needed ice water.</li> <li>---CNA G went back to the kitchen to get ice water.</li> </ul> <p>4. Observation on 1/24/25 at 8:14 A.M., showed the food delivered to Resident #159, had the following temperatures:</p> <ul style="list-style-type: none"> <li>-The egg omelet was 104 F.</li> <li>-The sausage link was 92.8 F.</li> <li>-The hot cereal was 112.1 F.</li> </ul> <p>During an interview on 1/24/25 at 8:18 A.M., the resident said:</p> <ul style="list-style-type: none"> <li>-He/she has breakfast in his/her room and typically by the time the food was delivered it was cold.</li> </ul> <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 breakfast meal was cold on most mornings.</p> <p>-This morning, he/she felt the food was cold and he/she turned the food away.</p> <p>--A new plate of food was not offered by the staff.</p> <p>5. Review of Resident #4's Admission MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>During an interview on 1/24/25 at 10:23 A.M., the resident said:</p> <p>-All three meals were delivered to him/her cold.</p> <p>-The breakfast that morning was lukewarm.</p> <p>6. Review of Resident #19's quarterly MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>During an interview on 1/24/25 at 10:27 A.M., the resident said:</p> <p>-He/She received room trays every day for all meals.</p> <p>-His/her food was always cold.</p> <p>-The cold food negatively affected the amount of food that he/she consumed.</p> <p>-There were times, he/she did not get full.</p> <p>7. Review of Resident #109's Admission MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>During an interview on 1/24/25 at 10:29 A.M., the resident said:</p> <p>-Almost every morning, the breakfast was cold.</p> <p>-At times, the vegetables served with is/her dinner were cold, because they stay out for a long time before being delivered.</p> <p>-He/she was at the end of the hall and usually was the last tray delivered.</p> <p>-The breakfast that morning was cold.</p> <p>8. Review of the resident council minutes dated 10/24/24 showed:</p> <p>-There were 11 residents in attendance.</p> <p>-Dietary concerns were brought up during the meeting.</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>-The food needs a little work (there was no further description of what was a concern).</p> <p>Review of the resident council minutes dated 12/19/24 showed:</p> <p>-There were eight residents in attendance.</p> <p>-Dietary concerns were brought up during the meeting.</p> <p>-The food was cold.</p> <p>-The food was not as good as it used to be.</p> <p>-The food was delivered late.</p> <p>9. During an interview on 1/24/25 at 8:24 A.M., the Dietary Manager (DM) said:</p> <p>-He/she had not sent any dietary staff out to the floor to check temperatures of meals on room trays.</p> <p>-He/she had heard complaints from residents about the food being cold.</p> <p>During an interview on 1/31/25 at 10:41 A.M., the Registered Dietitian (RD) said:</p> <p>-He/she had not checked room tray temperatures in a while.</p> <p>-He/she went to the facility once a month.</p> <p>-He/she did not always check the rooms tray temperatures.</p> <p>During an interview on 1/31/25 at 3:30 P.M. the Director of Nursing said:</p> <p>-The Dietary Manager was in charge of the dietary department.</p> <p>-The Dietary Manager should have addressed any issues or concerns regarding the food.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>42955</p> <p>Based on interview and record review, the facility failed to address areas of needed improvement by not developing and implementing Performance Improvement Plans (PIP - a process designed to help facilities address and fix deficiencies) which could affect all facility areas including residents quality of life. The facility census was 55 residents.</p> <p>Review of the facility's Quality Assurance and Performance Improvement (QAPI - a data driven and proactive approach to quality improvement) Program - Governance and Leadership Policy, dated March 2020, showed:</p> <ul style="list-style-type: none"> <li>-The QAPI program was overseen and implemented by the QAPI committee and reported findings, actions and results to the administrator and governing body.</li> <li>-The Administrator was ultimately responsible for the QAPI program and for interpreting results, and findings to the governing body.</li> <li>-The QAPI committee was responsible for: <ul style="list-style-type: none"> <li>--Coordinating, developing, implementing, monitoring and evaluation of performance improvement projects to achieve specific goals.</li> <li>--Establishing performance outcome indicators for quality of care and services delivered in the facility.</li> <li>--Choosing and implementing tools that best captured and measured dated about chose indicators.</li> </ul> </li> </ul> <p>1. During an interview on 1/31/25 at 9:18 A.M., the Assistant Director said:</p> <ul style="list-style-type: none"> <li>-There were no current PIPs the facility was working on.</li> <li>-The survey process identified several areas needing improvement: <ul style="list-style-type: none"> <li>--Showers for residents.</li> <li>--Wound care.</li> <li>--General documentation.</li> <li>--Investigations in all areas.</li> </ul> </li> <li>-He/She did not know what a PIP was until about two weeks ago.</li> </ul> <p>During an interview on 1/31/25 at 4:55 P.M. the Executive Director said:</p> <ul style="list-style-type: none"> <li>-He/She would have expected to see PIPs in place.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She expected areas of improvement to be identified in stand-up meetings (a daily meeting that involved the core team) every morning with department heads.</p> <p>-These areas of improvement would be carried over into a PIP.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>42955</p> <p>Based on interview and record review, the facility failed to develop and implement written procedures for its Quality Assurance and Performance Improvement (QAPI - a data driven and proactive approach to quality improvement) Program which led to the inability to gather feedback for quality improvement. This practice had the ability to affect all residents. The facility census was 55 residents.</p> <p>Review of the facility's QAPI Program - Governance and Leadership policy, dated March 2020, showed:</p> <ul style="list-style-type: none"> <li>-The Administrator was ultimately responsible for the QAPI program.</li> <li>-The QAPI program was based on data, resident and staff input, and other information that measured performance.</li> <li>-The QAPI program focused on problems and opportunities that reflected processes, functions, and services provided by the residents.</li> <li>-The responsibilities of the QAPI committee were to: <ul style="list-style-type: none"> <li>--Collect and analyze performance indicator data.</li> <li>--Identify, evaluate, monitor, and improve facility systems and processes.</li> <li>--Identify and resolve negative outcomes.</li> <li>--Establish benchmarks and goals.</li> <li>--Utilize root cause analysis to help identify problems.</li> </ul> </li> </ul> <p>1. Review of the facility's Quality Assurance (QA) Meetings agenda, dated 11/19/24, showed:</p> <ul style="list-style-type: none"> <li>-Number of staff breakdown by position, call-ins, and terminations.</li> <li>-Staff attended: <ul style="list-style-type: none"> <li>--Medical Director.</li> <li>--Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) Coordinator.</li> <li>--Activities Director.</li> <li>--Human Resources Director.</li> </ul> </li> <li>-NOTE: No other notes were available.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility's QA Meetings agenda, dated December 2024, showed:</p> <ul style="list-style-type: none"> <li>-Staff attended:</li> <li>--Medical Director.</li> <li>--MDS Coordinator.</li> <li>--Bookkeeper.</li> <li>--Dietary Manager.</li> </ul> <p>-COVID-19 status for residents was reviewed showing five residents.</p> <p>-NOTE: No other notes were available.</p> <p>Records for a January 2025 QA Meeting were requested and not provided.</p> <p>During an interview on 1/31/25 at 9:18 A.M., the Assistant Director said:</p> <ul style="list-style-type: none"> <li>-The QAPI committee met once a month, depending on the physicians schedule.</li> <li>-The Administrator, Director of Nursing (DON), MDS coordinator, Business Office Director (BOD), Maintenance Director, Dietary Manager, Activities Coordinator, Social Services Designee (SSD), Therapy and Human Resources (HR) attended the meetings.</li> <li>-The QAPI Committee only had a policy to go by.</li> <li>-There were no procedures or guidelines.</li> <li>-The committee did not meet in January 2025.</li> <li>-The committee had no current improvement projects.</li> <li>-During monthly QAPI meetings, all staff brought in packets with their concerns and information to report to the committee.</li> <li>-Those concerns were not tracked for improvement.</li> </ul> <p>During an interview on 1/31/25 at 4:55 P.M., the Executive Director said:</p> <ul style="list-style-type: none"> <li>-He/She requested copies of QAPI policies and procedures from the corporate office and was only provided the policy.</li> <li>-He/She expected staff to follow committee policies and procedures.</li> <li>-He/She was unaware the QAPI committee did not have procedures or guidelines to follow.</li> </ul>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure five sampled residents (Resident #3, #9, #30, #39, and #37) who should have been on Enhanced Barrier Precautions (EBP), a set of infection control measures that used personal protective equipment (PPE- specialized clothing or gear worn to protect the wearer from injury, infection, or illness) to reduce the spread of multidrug-resistant organism (MDRO - bacteria or microorganisms that have become resistant to multiple antibiotics) for residents who had wounds or indwelling medical devices. The facility also failed to educate staff about EBP, failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases when the facility failed to provide Tuberculosis (TB-a communicable disease that affects the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) testing for three sampled residents (Residents #2, #9, and #109); failed to ensure staff used hand hygiene during wound care for two sampled residents, (Resident #3 and #39); and failed to wear gloves when administering eye drops to one sampled resident (Resident #39) out of 14 sampled residents. The facility identified three residents as having pressure ulcers (any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s)) not present upon admission, one resident with tube feeding (a medical device used to provide nutrition to patients who cannot obtain nutrition by swallowing), one resident with a colostomy (an alternative exit from the colon created to divert waste through a hole in the colon and through the wall of the abdomen), and three residents with a catheter (a tube passed through the urethra into the bladder to drain urine) who should have had EBP in place. The facility census was 55 residents.</p> <p>Review of the facility's Tuberculosis, Screening Residents policy, dated August 2019, showed:</p> <ul style="list-style-type: none"> <li>-The facility screened all residents for TB.</li> <li>-Individuals identified with active TB would be isolated form other residents and staff.</li> <li>-The admitting nurse screened new residents prior to admission and readmission for information regarding exposure to the symptoms to TB, including: <ul style="list-style-type: none"> <li>--Coughing for more than three weeks.</li> <li>--Loss of appetite.</li> <li>--Fatigue.</li> <li>--Weight loss.</li> <li>--Night sweats.</li> <li>--Bloody sputum (a blood-tinged thick mucus from the lung).</li> <li>--Hoarseness.</li> </ul> </li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The second step of the TST was done about two weeks later;</p> <p>-The admitting nurse was responsible for completing the TST;</p> <p>-There was a form the resident completed and signed giving permission or if the resident refused;</p> <p>-He/She was unsure what the protocol was if the resident refused;</p> <p>-The administering of the TST and results should be uploaded to the resident's medical file;</p> <p>-He/She was unaware if anyone was tracking them.</p> <p>During an interview on 1/31/25 at 4:55 P.M., the Executive Director said:</p> <p>-Nurses knew there was a physician's order for the TST and they were supposed to administer them;</p> <p>-TST's and results should be documented on the MAR/TAR, as well as on a progress note;</p> <p>-The Electronic Health Record system generated tasks when the tests were to be completed;</p> <p>-If there was no documentation of the TST being administered then it was not done.</p> <p>During an interview on 1/28/25 at 8:42 A.M., the DON said he/she was still looking into who was responsible for doing resident TB testing/screening.</p> <p>5. Review of the facility's policy, Enhanced Barrier Precautions, dated August 2022 showed:</p> <p>-EBPs would be used as an infection prevention and control intervention to reduce the spread of MDROs to residents.</p> <p>-EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.</p> <p>-Gloves and gown would be applied prior to performing the high contact resident care activity.</p> <p>-Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:</p> <p>--Providing hygiene.</p> <p>--Changing briefs or assisting with toileting.</p> <p>--Device care or use (urinary catheter, feeding tube.</p> <p>--Wound care (any skin opening requiring a dressing).</p> <p>-Staff would be trained prior to caring for residents on EBPs.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Signs would be posted on the door or wall outside the resident's room indicating the type of precautions and PPE required.</p> <p>-PPE would be available outside the resident's room.</p> <p>Review of Resident #9's Physician's Order Sheet (POS), dated January 2025, showed:</p> <p>-Treatment orders for the resident's coccyx wound were to be completed daily;</p> <p>-Treatment orders for the resident's right cheek wound were to be completed every Monday, Wednesday and Friday and as needed for soiling.</p> <p>Observation on 1/22/25 at 10:15 A.M. showed:</p> <p>-Staff were inside the resident's room and responded doing cares when the door was knocked on;</p> <p>-There were no signs on the resident's door indicating EBP should have been used while doing cares on them;</p> <p>-There were no isolation carts that held PPE to have been worn while doing cares.</p> <p>Observation on 1/22/25 at 11:10 A.M. showed:</p> <p>-An unidentified staff brought a mechanical lift into the resident's room and said he/she would be right back to get the resident up;</p> <p>-The unidentified staff went and got another unidentified staff person, they went into the resident's room and closed the door behind them, not wearing any PPE;</p> <p>-There were no signs on the resident's door indicating EBP should have been used while doing cares on them;</p> <p>-There were no isolation carts that held PPE to have been worn while doing cares.</p> <p>Observation on 1/22/25 at 11:59 A.M. showed:</p> <p>-There were no signs on the resident's door indicating EBP should have been used while doing cares on them;</p> <p>-There were no isolation carts that held PPE to have been worn while doing cares.</p> <p>Review of the resident's care plan showed:</p> <p>-The printed care plan dated 1/24/25 provided by the facility did not include any wounds;</p> <p>-The care plan in the EHR showed:</p> <p>--No care plan for the resident's wound on his/her cheek;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>--The problem identified updated on 1/24/25 was the resident had a venous/stasis ulcer (open lesion caused by poor blood flow) of the coccyx.</p> <p>Observation on 1/24/25 at 9:25 A.M. showed:</p> <ul style="list-style-type: none"> <li>-There were no signs on the resident's door indicating EBP should have been used while doing cares on them;</li> <li>-There were no isolation carts that held PPE to have been worn while doing cares.</li> </ul> <p>Observation on 1/27/25 at 10:08 A.M. showed:</p> <ul style="list-style-type: none"> <li>-There were no signs on the resident's door indicating EBP should have been used while doing cares on them;</li> <li>-There were no isolation carts that held PPE to have been worn while doing cares.</li> </ul> <p>Observation on 1/27/25 at 3:06 P.M. showed:</p> <ul style="list-style-type: none"> <li>-Agency Licensed Practical Nurse (LPN) E did not wear a gown during the resident's wound treatments;</li> <li>-There were no signs on the resident's door indicating EBP should have been used while doing cares on them;</li> <li>-There were no isolation carts that held PPE to have been worn while doing cares.</li> </ul> <p>During an interview on 1/28/25 at 10:40 A.M., LPN B said he/she did not know anything about EBP, and the facility had not provided any education on EBP.</p> <p>During an interview on 1/28/25 at 10:45 A.M. Certified Nursing Assistant (CNA) E and CNA F said:</p> <ul style="list-style-type: none"> <li>-They had never heard of EBP;</li> <li>-They were not doing EBP at the facility;</li> <li>-There had been no education on EBP at the facility.</li> </ul> <p>During an interview on 1/30/25 at 9:30 A.M. Certified Medication Technician (CMT) C said:</p> <ul style="list-style-type: none"> <li>-They were not doing EBP at the facility before this week;</li> <li>-Staff had not had education on EBP;</li> <li>-He/She did not know which residents should have been on EBP or what was expected of staff other than what was now on the signs.</li> </ul> <p>During an interview on 1/30/25 at 9:40 A.M. LPN C said:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She had not known what EBP was before this week;</p> <p>-They had not had education on EBP as to what was expected or who should have been on it.</p> <p>During an interview on 1/31/25 at 3:30 P.M. the DON said:</p> <p>-He/She had not heard of EBP before and were not following it;</p> <p>-There should have been an EBP sign on the resident's door and an isolation cart with PPE also at the door.</p> <p>42955</p> <p>6. Review of Resident #37's face sheet, undated, showed the resident had the following diagnoses:</p> <p>-Quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso)</p> <p>-The resident had a colostomy and a suprapubic catheter;</p> <p>-The resident had cystostomy (an opening into the urinary bladder by surgical incision).</p> <p>Review of the resident's TAR dated November 2024 showed:</p> <p>-The resident received colostomy care as ordered;</p> <p>-The resident received urinary catheter care as ordered.</p> <p>Review of the resident's December 2024 TAR, showed:</p> <p>-The resident received colostomy care as ordered;</p> <p>-The resident received urinary catheter care as ordered.</p> <p>Review of the resident's care plan dated 12/17/24, showed:</p> <p>-The resident had Clostridium Difficile (C-diff -a bacterium that caused an infection of the colon);</p> <p>--The resident was on contact isolation (gowns and masks should be worn when changing contaminated linens);</p> <p>--The resident remained free from discomfort, complications or signs and symptoms of gastro-intestinal alterations;</p> <p>-The resident had an indwelling suprapubic catheter;</p> <p>-The resident had a colostomy.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's POS for all orders until 1/28/25, showed the resident had orders for:</p> <ul style="list-style-type: none"> <li>-Change colostomy bag every three days as needed;</li> <li>-Urinary catheter care every shift;</li> <li>-Change the urinary drainage bag every night shift on Sundays.</li> </ul> <p>During an interview on 1/27/25 at 12:54 P.M., CNA A said:</p> <ul style="list-style-type: none"> <li>-The resident had catheter care;</li> <li>-He/She used gloves when catheter care was provided;</li> <li>-No other PPE was used;</li> <li>-He/She did not remember a PPE cart being outside of the resident's door;</li> <li>-He/She was unaware of EBP.</li> </ul> <p>During an interview on 1/27/25 at 1:12 P.M., CNA B said:</p> <ul style="list-style-type: none"> <li>-He/She provided catheter care to the resident;</li> <li>-He/She was unaware of any issues with the residents catheter care;</li> <li>-He/She wore gloves as part of the residents catheter care;</li> <li>-He/She did not wear other PPE;</li> <li>-He/She was unaware that he/she was supposed to.</li> </ul> <p>During an interview on 1/28/25 at 9:30 A.M., LPN A said:</p> <ul style="list-style-type: none"> <li>-The resident had a catheter;</li> <li>-The resident received catheter and colostomy care from the CNA's;</li> <li>-He/She was familiar with and implemented EBP practices;</li> <li>-The other staff should have used EBP during catheter and colostomy cares, but he/she was unaware if other staff were;</li> <li>-There were no PPE carts outside of the resident's room;</li> <li>-He/She had PPE in the medication cart, in the clean utility closet and sometimes behind the nurses station desk.</li> </ul> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/31/25 at 4:55 P.M. the Assistant Director said:</p> <ul style="list-style-type: none"> <li>-There were no EBPs put into place for this resident;</li> <li>-The resident should have been on EBP;</li> <li>-He/She received EBP training on 1/28/25;</li> <li>-The new DON was not aware of the EBP protocols;</li> <li>-The nurses were responsible for providing the care to the resident and should have used EBP;</li> <li>-They were not practicing EBP;</li> <li>-He/She was unaware if appropriate PPE was available for EBP;</li> <li>-He/She was unaware of the location of the PPE.</li> </ul> <p>39469</p> <p>7. Observation on 1/22/25 at 2:00 P.M. showed:</p> <ul style="list-style-type: none"> <li>-There were no signs on Resident #3, #9, #30, #39, and #37's doors indicating EBP should have been used while doing cares on them;</li> <li>-There were no isolation carts that held PPE to have been worn while doing cares on residents who should have been on EBP.</li> </ul> <p>Observation on 1/23/25 at 10:00 A.M. showed:</p> <ul style="list-style-type: none"> <li>-There were no signs on Resident #3, #9, #30, #39, and #37's doors indicating EBP should have been used while doing cares on them;</li> <li>-There were no isolation carts that held PPE to have been worn while doing cares on residents who should have been on EBP.</li> </ul> <p>Observation on 1/24/25 at 9:36 A.M. showed:</p> <ul style="list-style-type: none"> <li>-There were no signs on Resident #3, #9, #30, #39, and #37's doors indicating EBP should have been used while doing cares on them;</li> <li>-There were no isolation carts that held PPE to have been worn while doing cares on residents who should have been on EBP.</li> </ul> <p>Observation on 1/27/25 at 9:00 A.M. showed:</p> <ul style="list-style-type: none"> <li>-There were no signs on Resident #3, #9, #30, #39, and #37's doors indicating EBP should have been used while doing cares on them;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The resident's care plan was requested and not provided by time of exit.</p> <p>Observation on 1/28/25 at 10:16 A.M. of wound care with Licensed Practical Nurse (LPN) B showed:</p> <ul style="list-style-type: none"> <li>-There was no EBP sign on the resident's door;</li> <li>-There was no isolation cart with PPE outside the resident's door;</li> <li>-CNA's E and F had moved the resident from his/her wheelchair to the bed;</li> <li>-CNA's E and F had assisted the nurse to reposition the resident in the bed and took off his/her pants to do wound care;</li> <li>-LPN B and CNA E and F had gloves on but no gown;</li> <li>-CNA's E and F removed the resident's paper brief;</li> <li>-LPN B wiped off the old cream on the resident's coccyx area;</li> <li>-The resident then urinated;</li> <li>-LPN B cleaned the urine off of the resident;</li> <li>-LPN B did not change gloves or wash hands before applying the cream.;</li> <li>-LPN B and CNA E and F took off their gloves but did not wash their hands when they left the room.</li> </ul> <p>During an interview on 1/28/25 at 10:40 A.M. LPN B said:</p> <ul style="list-style-type: none"> <li>-They should have washed their hands before they left the resident's room;</li> <li>-He/She did not know anything about EBP, the facility had not provided any education on EBP.</li> </ul> <p>During an interview on 1/28/25 at 10:45 A.M. CNA E and CNA F said:</p> <ul style="list-style-type: none"> <li>-They had never heard of EBP;</li> <li>-There had been no education on EBP at the facility;</li> <li>-They should have washed their hands after they took their gloves off before they left the room.</li> </ul> <p>Observation on 1/28/25 at 3:40 P.M. of pictures of the resident's buttock wounds showed:</p> <ul style="list-style-type: none"> <li>-There were three quarter sized stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister) wounds on the residents coccyx area three weeks ago;</li> <li>-An area around the wounds that measured 10 centimeters (cm) by 6 cm was extremely reddened.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/30/25 at 4:00 P.M. the resident's family member said:</p> <ul style="list-style-type: none"> <li>-He/She came to to see the resident every night when he/she got off of work;</li> <li>-In the evening, staff were not wearing a gown or gloves when doing cares on the resident even though there has been a sign on the door and an isolation cart by the resident's door;</li> <li>-The Certified Medication Technician (CMT) C never wore gloves when he/she administered eye drops to the resident.</li> </ul> <p>10. Review of Resident #3's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Gastrostomy status (a thin, flexible tube inserted through the abdominal wall and into the stomach to provide nutrition for those who can not eat);</li> <li>-Bladder neck obstruction (a condition in which the opening of the bladder is narrowed or blocked preventing urine from flowing freely);</li> <li>-Retention of urine (difficulty urinating and completely emptying the bladder).</li> <li>-Diarrhea (loose watery stools that occur frequently).</li> </ul> <p>Review of the resident's quarterly MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-He/She was cognitively intact;</li> <li>-Having a catheter was not checked;</li> <li>-He/She was incontinent of bowel and bladder;</li> <li>-Had a feeding tube;</li> <li>-He/She did not have a pressure ulcer.</li> </ul> <p>Review of the resident's Skin monitoring/Shower sheet dated December 2024 showed on 12/18/24 the resident had a red area on his/her buttock and abdomen.</p> <p>Review of the resident's Skin monitoring/Shower sheet dated January 2025 showed on 1/27/25 his/her peri area and buttock were red.</p> <p>Review of the resident's POS dated January 2025 showed:</p> <ul style="list-style-type: none"> <li>-Give one and one half cartons of Jevity (a calorie dense therapeutic nutrition) 1.2 calorie three times a day;</li> <li>-Urinary catheter (a tube placed in the body to drain the urine) care every shift related to bladder-neck obstruction;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Nothing by mouth (NPO);</p> <p>-Apply protective house stock barrier cream/boarder foam to Stage I (skin that appears red but does not have a break in it) buttock area every morning and night for wound healing/infection prevention;</p> <p>-Cleanse lower abdominal rash/abrasion with wound cleanser cover with boarder gauze (a absorptive dressing that consists of three layers) one time a day for wound care relate to cellulitis (a potentially serious bacterial skin infection) of abdominal wall;</p> <p>-Cleanse coccyx wound area with wound cleanser, pat dry, apply Xeroform (a non adherent dressing that maintains a moist wound) or calcium alginate (absorbs wound fluid) and cover with wound dressing.</p> <p>Review of the resident's care plan dated 1/27/25 showed:</p> <p>-He/She had a peg tube for feeding daily;</p> <p>-He/She had an indwelling suprapubic catheter;</p> <p>-NOTE: The resident did not have a suprapubic catheter, the resident had an indwelling catheter;</p> <p>--Staff was to change indwelling catheter as indicated;</p> <p>-He/She had potential impairment to skin integrity related to decreased bed mobility. Lower abdominal rash/abrasion;</p> <p>--Staff was to cleanse wound with wound cleanser, barrier cream, foam dressing, border gauze;</p> <p>-He/She had a urinary tract infection on 8/25/24;</p> <p>--Staff should follow good hygiene practices;</p> <p>-He/She had a nutritional problem or potential nutritional problem related to being NPO and having a feeding tube for feeding;</p> <p>-Staff was to provide and serve diet as ordered;</p> <p>--NOTE: The resident was NPO and was not have anything by mouth;</p> <p>-Staff was to have snacks available between meals;</p> <p>--NOTE: The resident was NPO and was not have anything by mouth.</p> <p>Observation on 1/30/25 at 9:10 A.M. of the resident's wound care with LPN C and LPN C showed:</p> <p>-The resident's anal area was reddened and had stool on it;</p> <p>-LPN C cleaned the stool off the resident and then changed gloves without washing his/her hands;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-LPN C wiped off the old ointment;</p> <p>-LPN C helped to change the residents position;</p> <p>-LPN C did not change gloves or wash his/her hands before applying the boarder gauze;</p> <p>-LPN C applied zinc oxide then took off gloves and washed his/her hands.</p> <p>During an interview on 1/30/25 at 9:30 A.M. CMT C said:</p> <p>-They were not doing EBP at the facility before this week;</p> <p>-Staff had not had education on EBP;</p> <p>-He/She did not know which residents should have been on EBP;</p> <p>-He/She did not know what was expected of staff other than what was now on the signs;</p> <p>-Staff should wash their hands every time gloves were changed;</p> <p>-When staff do resident cares hands should be washed before and after cares.</p> <p>During an interview on 1/30/25 at 9:40 A.M. LPN C said:</p> <p>-He/She should have washed his/her hands every time he/she changed gloves.</p> <p>-He/She forgot to do that.</p> <p>-He/She had not known what EBP was before this week.</p> <p>-They have not had education on EBP or told what was expected or who should have been on EBP.</p> <p>-The resident had an indwelling catheter, a feeding tube, and open areas on his/her skin.</p> <p>11. During an interview on 1/31/25 at 3:30 P.M. the DON said:</p> <p>-No one was responsible to ensure staff were performing appropriate hand hygiene;</p> <p>-He/She had not heard of EBP and was not following it;</p> <p>-When doing wound care staff should have washed their hands before and after cares;</p> <p>-Staff were expected to wash hands and change gloves when going from dirty to clean during wound care;</p> <p>-Staff were expected to use gloves when administering eye drops;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Baptist Homes of Independence		STREET ADDRESS, CITY, STATE, ZIP CODE  17451 Medical Center Parkway Independence, MO 64057	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She recently learned that any resident who had a catheter, feeding tube, or open areas should have been on EBP;</p> <p>-There should have been a sign on the door and an isolation cart also at the door;</p> <p>-Residents who were on EBP was something that should have been passed on during report.</p> <p>MO00247709</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>39469</p> <p>Based on interview and record review, the facility failed to establish an Antibiotic Stewardship program and a system to monitor antibiotic usage. The facility census was 55 residents.</p> <p>Review of the facility's policy ,Infection Preventionist, dated September 2022 showed:</p> <ul style="list-style-type: none"> <li>-The Infection Preventionist was responsible for coordinating the implementation and updating of the infection prevention and control program;</li> <li>-The Infection Preventionist collects, analyzes and provides infection and antibiotic usage data and trends to nursing staff and health care practitioners;</li> <li>-The Infection Preventionist has obtained specialized training beyond initial professional training or education prior to assuming the role including antibiotic stewardship;</li> <li>-The Infection Preventionist was employed on site and at least part time.</li> </ul> <p>Review of the facility policy titled Antibiotic Stewardship-Order for Antibiotics dated December 2016 showed:</p> <ul style="list-style-type: none"> <li>-Antibiotics would be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program and in conjunction with the facility's general policy for medication utilization and prescribing.</li> <li>-If an antibiotic was indicated, prescribers would provide complete antibiotic orders including the following elements: <ul style="list-style-type: none"> <li>--Drug name.</li> <li>--Dose.</li> <li>--Frequency of administration.</li> <li>--Duration of treatment:</li> <li>---Start and stop date.</li> <li>---Number of days of therapy.</li> <li>--Route of administration.</li> <li>--Indication of use.</li> </ul> </li> <li>-Appropriate indications for use of antibiotics included:</li> </ul> <p>(continued on next page)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--Criteria met for clinical definition of active infection or suspected sepsis.</p> <p>--Pathogen susceptibility, based on culture and sensitivity (or therapy begun while culture was pending).</p> <p>-When antibiotics were prescribed over the phone, the primary care practitioner would assess the resident within 72 hours of the telephone order.</p> <p>-When a culture and sensitivity was ordered, it would be completed.</p> <p>-As soon as clinically appropriate, the prescriber would be asked to review converting intravenous antibiotics to an oral formulation.</p> <p>1. Review of the facility Antibiotic order list from Pharmacy dated November 2024, December 2024 and January 2025 showed:</p> <p>-In November 2024 there were seven residents who had been on antibiotics.</p> <p>-In December 2024 there were seven residents who had been on antibiotics.</p> <p>-In January 2025 there were 12 residents who were currently or had been on antibiotics.</p> <p>During an interview on 1/31/25 at 10:00 A.M. the Executive Director said:</p> <p>-There was currently no one in the role of the Infection Preventionist.</p> <p>-There should have been someone in the role or completing the tasks and responsibilities of the Infection Preventionist.</p> <p>-The Infection Preventionist would have been the person completing Antibiotic Stewardship.</p> <p>-There was no one performing the the tasks or taking the responsibility of maintaining Antibiotic Stewardship at this time.</p> <p>During an interview on 1/31/25 at 3:30 P.M. the Director of Nursing (DON) said:</p> <p>-He/She was not the Infection Preventionist.</p> <p>-The Infection Preventionist would be responsible for Antibiotic Stewardship.</p> <p>-He/She was not doing anything with Antibiotic Stewardship.</p> <p>-He/She did not know if anyone else was doing anything with Antibiotic Stewardship.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>39469</p> <p>Based on interview and record review, the facility failed to have anyone in the position, or performing the tasks and responsibilities of the Infection Preventionist. The facility census was 55 residents.</p> <p>Review of the facility's policy ,Infection Preventionist, dated September 2022 showed:</p> <ul style="list-style-type: none"> <li>-The Infection Preventionist was responsible for coordinating the implementation and updating of the infection prevention and control program.</li> <li>-The Infection Preventionist collects, analyzes and provides infection and antibiotic usage data and trends to nursing staff and health care practitioners.</li> <li>-The Infection Preventionist has obtained specialized training beyond initial professional training or education prior to assuming the role including antibiotic stewardship.</li> <li>-The Infection Preventionist was employed on site and at least part time.</li> </ul> <p>1. During an interview on 1/31/25 at 10:00 AM the Administrator said:</p> <ul style="list-style-type: none"> <li>-There was currently no one in the role of the Infection Preventionist.</li> <li>-They have not had an Infection Preventionist at the facility for years.</li> </ul> <p>-The Infection Preventionist would be responsible for monitoring, tracking infections, antibiotic usage, monitoring Transmission Based Precautions, and Enhanced Barrier Protection (a set of infection control measures that use personal protective equipment (PPE- specialized clothing or gear worn to protect the wearer from injury, infection, or illness) to reduce the spread of multidrug-resistant organism (MDRO - bacteria or microorganisms that have become resistant to multiple antibiotics) for residents who had wounds or indwelling medical devices) and education of staff and resident regarding infections, antibiotic usage, and the use of Transmission Based Precautions and Enhanced Barrier Protection.</p> <p>During an interview on 1/31/25 at 3:30 P.M. the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>-There should have been an Infection Preventionist at the facility.</li> <li>-There was not anyone in the role of Infection Preventionist at this time.</li> <li>-No one was performing the tasks or responsibilities of the Infection Preventionist.</li> </ul>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955</b></p> <p>Based on interview and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases when the facility failed to provide pneumococcal (pneumonia-lung inflammation caused by bacterial or viral infection) and influenza (flu - an infection of the respiratory system: nose, throat and lungs) vaccines for four sampled residents (Resident #44, #109, #2, and #9) out of five residents sampled for immunizations. The facility census was 55 residents.</p> <p>Review of the facility's Influenza Vaccine policy, dated March 2022, showed:</p> <ul style="list-style-type: none"> <li>-All residents who have no medical contraindications to the vaccine were offered the flu vaccine annually.</li> <li>-The facility provided information about the significant risks and benefits of vaccines to residents.</li> <li>-Between October 1st and March 31st each year, the flu vaccine was offered to residents.</li> <li>-For those who received the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination was documented in the resident's medical record.</li> </ul> <p>Review of the facility's Pneumococcal Vaccine policy, dated March 2022, showed:</p> <ul style="list-style-type: none"> <li>-All residents were offered the pneumonia vaccine.</li> <li>-Assessments of the pneumonia vaccination status were conducted within five working days of the resident's admission.</li> <li>-Prior to receiving the vaccine, the resident or resident representative received information and education regarding the benefits and potential side effects of the vaccine.</li> <li>-Education was documented in the resident's medical record.</li> <li>-If the resident or resident representative refused the vaccine it was documented in the resident's medical record.</li> <li>-For each resident who received the vaccine, the date of vaccination, lot number, expiration dated, person administering, and the site of vaccination were documented in the resident's medical file.</li> </ul> <p>1. Review of Resident #44's face sheet, undated, showed the resident was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Chronic Obstructive Pulmonary Disease (COPD- a condition that constricted the airways and caused difficulty or discomfort in breathing).</li> </ul> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diabetes (a disease that occurred when blood sugar was too high).</p> <p>-Heart disease.</p> <p>Review of the resident's care plan dated 10/11/24, showed:</p> <p>-The resident had an Activities of Daily Living (ADL) self-care performance deficit related to dementia.</p> <p>During an interview on 1/22/25 at 1:06 P.M., the resident's family member said:</p> <p>-They were unaware if the resident received any vaccines when admitted .</p> <p>-They thought the resident had a flu shot but could not be sure.</p> <p>Review of the resident's Physician Order Summary (POS) dated January 2025, showed no orders for the flu or pneumonia vaccines.</p> <p>Review of the resident's Immunizations Record, generated from the Electronic Health Record (EHR), dated 1/20/25, showed the resident had no flu or pneumonia vaccinations on file.</p> <p>2. Review of Resident #109's face sheet, undated, showed the resident was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Dependence on supplemental oxygen.</p> <p>-COPD.</p> <p>-Heart failure.</p> <p>Review of the resident's POS dated January 2025, showed the resident may receive the influenza vaccine.</p> <p>Review of the resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated December 2024 showed the flu and pneumonia vaccine were not given.</p> <p>Review of the resident's MAR/TAR dated January 2025 showed the flu and pneumonia vaccine were not given.</p> <p>Review of the resident's Immunizations Record, generated from the EHR, dated 1/20/25, showed:</p> <p>-The resident had no received flu or pneumonia vaccines on file.</p> <p>During an interview on 1/29/25 at 8:54 A.M., the resident said he/she did not remember if he/she received any vaccines when he/she was admitted to the facility.</p> <p>22727</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of Resident #2's entry tracking form showed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's immunizations form showed:</p> <ul style="list-style-type: none"> <li>-There was no documentation of the resident's pneumonia vaccine status.</li> <li>-The resident received the influenza vaccine on 11/16/23.</li> <li>-There was no documentation regarding the resident's influenza vaccine for 2024.</li> </ul> <p>4. Review of Resident #9's entry tracking form showed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's immunizations form showed:</p> <ul style="list-style-type: none"> <li>-There was no documentation of the resident's pneumonia vaccine status.</li> <li>-The resident refused the flu vaccine.</li> <li>-There was not a date that the resident refused the flu vaccine and there was no documentation of any education provided for the risks and benefits of receiving the flu vaccine.</li> </ul> <p>5. During an interview on 1/28/25 at 8:42 A.M., the Director of Nursing (DON) said they were looking into who was responsible for administering resident flu and pneumonia vaccines.</p> <p>During an interview on 1/29/25 at 10:15 A.M., Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> <li>-The nurse on duty completed the new admission's assessments, including administering any requested or appropriate vaccines.</li> <li>-New residents were supposed to be offered the flu and pneumonia vaccine, if appropriate based on age and other factors, however residents were not offered either vaccine.</li> <li>-He/She had not completed any recent vaccines on newly admitted residents.</li> <li>-The DON reviewed the new admission chart within 72 hours of admission and should have seen if the vaccines were offered or completed.</li> </ul> <p>During an interview on 1/31/25 at 4:55 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-New residents were offered flu and pneumonia vaccines upon admission.</li> <li>-Current residents were offered the flu and pneumonia vaccines once a year.</li> <li>-The Social Services Designee (SSD) obtained consent from the residents.</li> <li>-Residents signed a form that stated if they consented or refused vaccines.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-If refused the SSD provided risks and benefits of each vaccine.</p> <p>-The consent forms had been misplaced and were not able to be located.</p> <p>-He/She was unsure where the resident's vaccines would be documented.</p> <p>During an interview on 1/31/25 at 4:55 P.M., the Executive Director said:</p> <p>-The SSD was responsible for offering vaccines to residents and getting their consent or refusal.</p> <p>-The consent documentation he/she obtained was missing.</p> <p>-If the flu and pneumonia vaccines were not documented then they were not done.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</b></p> <p>Based on interview and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases when the facility failed to provide COVID-19 (a highly contagious respiratory disease caused by a new coronavirus that emerged in December 2019) vaccines for three sampled residents (Residents #2, #9, and #109) out of five residents sampled for immunizations. The facility census was 55 residents.</p> <p>Review of the facility policy titled Coronavirus Disease - Vaccination of Residents dated as revised June 2022 showed:</p> <ul style="list-style-type: none"> <li>-Residents who were eligible to receive the COVID-19 vaccine were strongly encouraged to do so.</li> <li>-The resident or resident representative could accept or refuse a COVID-19 vaccine and to change his/her decision.</li> <li>-COVID-19 vaccine education, documentation, and reporting were supposed to be overseen by the infection preventionist and coordinated by his/her designee.</li> <li>-The individual who coordinates the responsibilities in the facility was left blank.</li> <li>-The COVID-19 vaccine could be offered and provided directly by the facility or indirectly through an arrangement with a pharmacy partner or other appropriate health entity.</li> <li>-Before the COVID-19 vaccine was offered, the resident was to be provided with education regarding the benefits, risks, and potential side effects associated with the vaccine.</li> <li>-Residents were to sign a vaccine consent form prior to receiving the vaccine.</li> <li>-Booster vaccine doses were provided in accordance with current Center for Disease Control guidance.</li> <li>-A vaccine administration record was to be provided to the resident and a copy is filed in the resident's record.</li> <li>-The resident's medical record included documentation that included the signed consent, and that the vaccine was administered to the resident.</li> <li>-If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior to vaccination or refusal, appropriate documentation should be made in the resident's record.</li> </ul> <p>1. Review of Resident #2's entry tracking form showed the resident admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's immunizations form showed:</p> <ul style="list-style-type: none"> <li>-The resident received the initial two COVID-19 vaccine doses on 2/10/21 and 3/10/21.</li> <li>-The resident received a COVID-19 booster on 10/27/21.</li> <li>-There was not a date that any additional boosters were offered to the resident.</li> </ul> <p>2. Review of Resident #9's entry tracking form showed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's immunizations form showed there was no documentation regarding the resident's COVID-19 vaccine status.</p> <p>42955</p> <p>3. Review of Resident #44's face sheet, undated, showed the resident was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Chronic Obstructive Pulmonary Disease (COPD- a condition that constricted the airways and caused difficulty or discomfort in breathing).</li> <li>-Diabetes (a disease that occurred when blood sugar was too high).</li> <li>-Heart disease.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/5/24 showed:</p> <ul style="list-style-type: none"> <li>-The resident was severely cognitively impaired.</li> </ul> <p>Review of the resident's Physician Order Summary, dated January 2025, showed no orders for the COVID-19 vaccine.</p> <p>Review of the resident's Immunizations Record dated 1/20/25 showed the resident had no immunizations on file.</p> <p>During an interview on 1/22/25 at 1:06 P.M., the resident's family member said they were unaware if the resident received any vaccines when admitted .</p> <p>4. Review of Resident #109's face sheet, undated, showed the resident was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Dependence on supplemental oxygen.</li> <li>-COPD.</li> <li>-Heart failure.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Physician Order Summary, dated January 2025, showed the resident may receive the COVID-19 vaccine.</p> <p>Review of the resident's Immunizations Record dated 1/20/25 showed the resident had no immunizations on file.</p> <p>During an interview on 1/29/25 at 8:54 A.M., the resident said he/she did not remember if he/she received any vaccines when he/she was admitted to the facility.</p> <p>5. During an interview on 1/29/25 at 10:15 A.M., Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> <li>-The nurse on duty completed the new admissions assessments, including administering any requested or appropriate vaccines.</li> <li>-New residents were supposed to be offered the COVID-19 vaccine, however residents were not offered that vaccine.</li> <li>-He/She had not completed any recent vaccines on newly admitted residents.</li> <li>-The Director of Nursing (DON) reviewed the new admission chart within 72 hours of admission and should have seen if the vaccines were offered or completed.</li> </ul> <p>During an interview on 1/31/25 at 4:55 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-New residents were supposed to be offered COVID-19 vaccines upon admission.</li> <li>-The Social Services Designee (SSD) obtained vaccine consent from the residents.</li> <li>-Residents signed a form that stated if they consented or refused.</li> <li>-If refused the SSD provided risks and benefits of each vaccine.</li> <li>-The consent forms had been misplaced and were not able to be located.</li> <li>-He/She was unsure where the residents COVID-19 vaccine would be documented.</li> </ul> <p>During an interview on 1/31/25 at 4:55 P.M., the Executive Director said:</p> <ul style="list-style-type: none"> <li>-The SSD was responsible for offering vaccines to residents.</li> <li>-The consent documentation he/she obtained was missing.</li> <li>-If the COVID-19 vaccine was not documented then it was not done.</li> </ul>		

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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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39469</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Automated External Defibrillator (AED a portable device that can be used to treat a person whose heart has suddenly stopped working by delivering an electrical shock) was in working condition. The facility census was 55 residents.</p> <p>Review of the facility's policy, Cardiopulmonary Resuscitation, dated February 2018 showed:</p> <ul style="list-style-type: none"> <li>-Early delivery of a shock with a defibrillator within three to five minutes of collapse can further increase chances of survival.</li> <li>-Maintain equipment and supplies necessary in the facility at all times.</li> </ul> <p>Review of the facility's policy, In House Maintenance for Defibrillators - AED dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-Maintenance should have been done monthly.</li> <li>-Verify electrodes (pad that delivers a shock) were connected to the AED and sealed in their package.</li> <li>-Replace if pads were expired.</li> <li>-Verify the green check light indicated ready for use.</li> <li>-Verify the batteries and pads were within expiration date.</li> <li>-Replace if expired.</li> <li>-Check for adequate supplies.</li> </ul> <p>Review of the HeartSine Samaritan PAD model SAM 300 manual dated 2011 showed it was recommended a spare Pad-Pak was kept with the AED machine.</p> <p>1. Observation on [DATE] at 12:45 P.M. of the AED machine on hallway A showed:</p> <ul style="list-style-type: none"> <li>-The AED was not in the AED cabinet, it was in a bag on the crash cart.</li> <li>-The AED did not have a battery in the machine.</li> <li>-There were no pads in the bag with the AED machine.</li> <li>-The Crash cart Checklist did not include checking the AED machine.</li> <li>-The Crash cart checklist had not been done since [DATE].</li> </ul> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on [DATE] at 12:59 P.M. of the AED machine on hallway B showed:</p> <ul style="list-style-type: none"> <li>-The AED was in the AED cupboard.</li> <li>-The pads were stuck together indicating they had been used.</li> <li>-There were no new pads.</li> <li>-The Crash cart checklist for hallway B showed it had not been checked since [DATE].</li> <li>-The Crash cart checklist did not include checking the AED machine.</li> </ul> <p>During an interview on [DATE] at 1:00 P.M. the Assistant Director said:</p> <ul style="list-style-type: none"> <li>-The pads on the AED machine on hallway B were open and stuck together indicating they had been used.</li> <li>-They did not have any extra pads with the AED machine on hallway B.</li> <li>-They did not have any extra batteries with the AED machine on hallway A.</li> <li>--The batteries could not be purchased locally, but needed to be ordered on the Internet.</li> <li>-The night shift charge nurse should have been checking the AED machine to ensure it worked and had the parts that it needed daily.</li> <li>-The AED machine should have been checked each night with the crash cart.</li> <li>-The crash cart check list did not include checking the AED.</li> <li>-He/She verified the crash cart check list on both hallways had not been done since mid December.</li> <li>-At least 30% of the 55 residents were a full code (lifesaving measures were to have been taken if their heart stopped).</li> <li>-The Director of Nursing (DON) was responsible to ensure the crash cart had all the essentials.</li> </ul> <p>During an interview and observation on [DATE] at 2:00 P.M. the Executive Director said:</p> <ul style="list-style-type: none"> <li>-There should have been pads and a battery in the AED pack.</li> <li>-They did not have any extras and would have to order them off of the Internet.</li> <li>-He/She was taking them out of service until he/she could talk to corporate to see what to do.</li> <li>-The crash cart checklist did not include checking the AED machines but it should have.</li> <li>-The crash cart checklist on both hallways had not been done since mid December.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The night shift charge nurse should have checked the crash cart and AED machines.</p> <p>-There should have been extra pads and batteries for each AED machine but they did not have them.</p> <p>During an interview on [DATE] at 3:30 P.M. the DON said:</p> <p>-They had two AED machines in the facility.</p> <p>-Maybe 25% to 30% of the residents were a full code.</p> <p>-The AED machines should have been evaluated monthly to ensure they had all the parts and it was in working order.</p> <p>-They did not have any pads or AED batteries at this time to replace the ones that had been used on both machines.</p> <p>-Checking the AED machine should have been part of the crash cart checklist.</p>		