STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265532	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Care Center	2323 Swope Parkway Kansas City, MO 64130

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42955 Based on observation, interview, and record review, the facility failed to ensure resident safety when one sampled resident (Resident #1) out of nine sampled residents, drank an unknown liquid substance from an unmarked spray bottle. The facility census was 89 residents. The Administrator was notified on 8/2/24 of Past Non-Compliance which occurred on 7/31/24. The facility had done a safety sweep, put locks on cabinents on the unit for storage and in-serviced all nursing and housekeeping staff before the start of their next shift. The facility had corrected their deficiency 8/1/24. Review of the facility's Accidents and Supervision Policy, revised 5/18/24, showed: -The resident environment was free of accident hazards as much as possible. -Each resident received adequate supervision to prevent hazards, including: --Identify hazards and risks. --Evaluate and analyze hazards and risks. --Implement interventions to reduce hazards and risks. --Monitor for effectiveness and interventions as necessary. -The facility established and utilized a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. -All staff were involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. -The facility made reasonable efforts to identify the hazards and risk factors of each resident. -Implementation of interventions included: --Communication of interventions to all staff. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Assign responsibility. --Provide training. --Document interventions. Review of the facility's Chemical Storage and Labeling policy, revised on 2/2/24, showed: -The purpose of the policy was for a all employees to ensure all chemicals were stored safely. -Chemicals were stored in a vented room. -The chemical storage room was locked at all times. -Only the Housekeeping/Environmental Services (EVS) Manager and his/her designee had access to the chemical room. -Housekeeping/EVS Manager or designee signed chemicals out of the chemical supply room at the beginning of each shift and signed the chemical back in at the end of the shift. -All chemicals were signed out to a locked housekeeping cart and were locked when not in use. -All chemical containers were labeled with the identity of the chemicals and appropriate hazard warnings. -Each chemical was labeled with a number that was used when signing the chemicals in and out. 1. Review of Resident #1's face sheet, undated showed: -The resident was diagnosed with: --Vascular dementia (loss of memory, language, problem-solving and other thinking abilities that were severe causing impaired supply of blood to the brain). --Chronic kidney disease (a gradual loss of kidney function over time). --End stage heart failure (the final and most severe stage of heart failure). Review of the resident's care plan (an individualized plan designed to meet a person's health or personal care needs when they can no longer perform everyday activities on their own), dated 3/7/24, showed: -The resident had impaired cognitive function and thought processes related to dementia. -NOTE: The care plan did not address the resident's wandering or drinking, eating, or picking up items not belonging to him/her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 5/2/24, showed the resident was severely cognitively impaired. Review of the Registered Nurse (RN) Investigation, dated 7/31/24, showed: -Licensed Practical Nurse (LPN) A reported to the Director of Nursing (DON) that the resident was seated on the floor with the under-the-sink cabinet door open and drinking an unknown substance from a clear plastic spray bottle. -The bottle was immediately removed from the resident and resident was assessed with no abnormal findings noted. -The resident's vital signs (blood pressure, temperature, pulse, respirations) were monitored. -The physician was notified and ordered the resident to be taken to the hospital emergency room . -The resident was returned to the facility with no signs of poisoning. Review of the employee statements for the 7/31/24 RN investigation showed: -LPN E stated that on 7/31/24 approximately 7:15 A.M., that LPN A informed him/her the resident got into a cabinet and drank a liquid-type housekeeping chemical. -LPN E stated he/she contacted the poison control center and was told to have the resident drink milk. -LPN A observed the resident drink from a cleaner bottle from under the sink in the dining room close to the nurses station. -LPN A took the bottle from the resident and notified LPN E of the situation. -LPN E was in the nurse's station charting when LPN A informed him/her that the resident drank cleaner from a spray bottle. -LPN E called poison control and Emergency Medical Services (EMS). -LPN E was instructed by poison control and EMS to give the resident milk to drink. Review of the resident's hospital discharge paperwork, dated 7/31/24, showed: -Follow up with the nursing home physician in 2-3 days. -Remove chemical/cleaning agents from the resident's room and avoid possible ingestion's in the future. -Keep household cleaners in their original containers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Keep all substances in a safe place. - Call 911 if the resident experienced trouble breathing, swallowing, severe confusion, extreme drowsiness, fainting, rapid heart rate, very slow heart rate, very low or high blood pressure, vomiting blood or large amounts of blood in the stool, seizures, shortness of breath, shakiness, fast breathing, fever of 100.4 or more, abdominal pain, dizziness or weakness. During an interview on 7/31/24 at 6:25 P.M., Certified Nursing Assistant (CNA) A said: -He/She was outside on the smoke deck when the resident got into the cabinet. -The resident got into things regularly. -LPN E told him/her what happened. -EMS told LPN E to give the resident milk. -There were no locks on the cabinets. -The cabinet was under the sink in the unit's dining room. -The bottle was under the sink. -The Housekeeping/EVS director said they cleaned out the cabinets last week. -He/She was unaware if the cabinets were ever cleaned out. -He/She left at 7:30 A.M. due to his/her shift being over. During an interview on 7/31/24 at 6:34 P.M., CNA B said: -He/She was not working on the unit when it happened. -He/She was helping with the resident's who smoked on the smoke patio outside of the dementia care unit. -LPN A was on the unit talking to LPN E. -LPN A said the resident drank a chemical from under the sink. -He/She had not seen anything chemicals like that under the sink before. -The resident had to be watched closely because he/she liked to pick stuff up and drink or eat it. -He/She did not see the resident drink the chemical. During an interview on 7/31/24 at 6:42 P.M., CNA C said: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was outside with the residents who were smoking. -He/She did not see the resident drinking the liquid. -The resident liked to touch things and put things in his/her mouth. -The ones who work on the unit knew that about the resident. -He/She was unsure where the resident got the bottle of cleaner. -Sometimes they kept cleaners in the cabinet under the sink. -He/She did not believe the cabinet was locked. During an interview on 7/31/24 at 6:50 P.M., LPN A said: -He/She came on the unit and saw the resident drinking from a cleaning bottle. -He/She took the bottle from the resident and took it to LPN E, who was the charge nurse on the unit. -LPN E was in the nurses station doing charting on the computer. -The cleaner was kept under the sink without a lock. Observation on 8/1/24 at 9:10 A.M. showed the resident sitting at a table in the dining area with a glass of apple juice in front of him/her. During an interview on 8/1/24 at 9:14 A.M., LPN B said: -The resident was being monitored every 30 minutes for signs and symptoms of pain and discomfort. -It was documented on paper and the Treatment Administration Record (TAR). -The cleaner was not normally kept under the sink. -The bottle should have been with housekeeping. -The resident was a wanderer, and it was care planned. During an interview on 8/1/24 at 9:49 A.M., the Housekeeping/EVS Director said: -He/She gave the spray bottle to the Administrator. -It was not normal to keep cleaners on the locked unit. -He/She did not know how the bottle got under the sink. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Anyone could have put it there. -He/She did not believe it was housekeeping staff as they have been trained multiple times on where cleaners need to be kept. -Cleaning supplies remained on the cart unless they were actively being used. -Staff had an in-service yesterday regarding storing of chemicals. During an interview on 8/1/24 at 11:25 A.M., Housekeeper A said: -He/She heard a resident drank some solution. -The resident probably found it under the sink. -He/She was not sure who put it there, but it was not him/her. -He/She received training today regarding storage of chemicals. -Chemicals had to now be signed out and only the person who signed them out could use them. During an interview on 8/1/24 at 11:25 A.M., Housekeeper B said: -He/She was unsure where the resident got the chemical. -It was not from his/her cart. -If it was under the sink, he/she did not put it there. -He/She kept all chemicals on the cart. -He/She received training yesterday regarding signing chemicals out. Observation on 8/1/24 at 12:44 P.M. showed there was a smoke deck outside of the dementia unit. It had large glass windows between the dining area and the outside smoking area. The nurse's station was in a corner with two glass walls and two wood walls. The desk where the nurses do charging was in front of the glass wall and could see most of the dining area. To the right of the desk there was a small area not visible from the desk due to the wood wall blocking the view. This is the area the resident was found sitting on the floor drinking from the bottle. The cabinet where the resident allegedly got the bottle from had a lock on it. The other cabinets were observed to be empty or containing not hazardous materials. During an interview on 8/2/24 at 12:44 P.M., the Administrator said: -LPN E was unable to view the resident from the position he/she said he/she was at the time of the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-As of now the only cleaning solution on the unit is a red bucket of soap and water kept in the locked nurse's station, to be used to clean off surfaces after meals. -At the time of the incident there were three residents on the smoke deck with CNA A and CNA C. -There were five residents in the dining area. -There were ten residents still in bed. -The cabinet where the solution was found is to be locked at all times with only the charge nurse and the administrator having access to the key. -Leadership and department heads do rounds three to four times a day to monitor for locked cabinets and chemicals not allowed on the unit. -Nursing does rounds a minimum of every two hours to monitor the entire unit. -The solution was believed to be diluted air freshener. Observation on 8/1/24 at 1:10 P.M. showed the empty squirt bottle the resident drank from was unmarked. It was a general household spray bottle which had a cloudy finish but able to see inside the bottle. A few drops of the diluted solution were still in the bottom of the bottle. It smelled like weak fresh scent air freshener. Observation of the undiluted bottle of liquid air freshener and deodorizer, showed a green solution with a strong fresh smell. The first aid instructions on the label on the bottle indicated if swallowed to rinse mouth, no not induce vomiting, get medical attention if felt unwell. During an interview on 8/2/24 at 11:32 A.M., the DON said: -All employee training regarding chemical storage and use on the units was completed today. -It was unable to be determined who put the bottle in the cabinet on the dementia care unit. -All staff were responsible for keeping residents and the areas they occupy safe. -It was common knowledge to not sit in the blind spot if a resident area was not visible. -He/She expected staff to mark or label all cleaning supply bottles. During an interview on 8/2/24 at 11:32 A.M., the Administrator said: -Once informed of the incident he/she immediately initiated training of all staff. -He/She developed and implemented a new policy yesterday regarding signing out chemicals. -After the resident drank the solution staff called poison control and EMS. -There was no way to identify exactly what the solution was or how much the resident drank. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing was checking vitals and assessing the resident. -There should not have been any bottle of solution that was unlabeled. -He/She expected all staff to be observant of resident's and resident areas. During an interview on 8/5/24 at 8:08 A.M., LPN E said: -He/She was the charge nurse on the dementia care unit the day of the incident. -LPN A came on to the unit. -LPN A brought him/her an empty spray bottle and said the resident was drinking from it. -He/She opened the bottle and smelled it. -He/She did not smell like bleach or ammonia, he/she believed it smelled like the air freshener housekeeping used. -He/She called EMS and the poison control center. -The resident showed no signs or symptoms of pain or discomfort. -When EMS arrived, they spoke to the poison control agent on the phone and was advised to give the resident milk now and again in 30 minutes. -He/She was unsure of how the bottle got on the unit or under the sink. -He/She could not say for sure what or how much was in the bottle. -When the DON was notified, he/she said to send to the resident to the hospital emergency room . During an interview on 8/5/24 at 12:51 P.M., the facility's Medical Director said: -He/She was made aware of the incident. -The facility was instructed to send the resident to the emergency room . -It would not hurt to have closer supervision of the residents on that unit. -He/She had not seen the resident since it happened. -The Nurse Practitioner was going to be at the facility this week. -He/She expected the resident's care plan should reflect the resident's behavior of eating and drinking things that were not the resident's. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not expect the unit to have cleaner in an unmarked container nor for it to be on the unit. MO00239833