| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265532 | A. Building<br>B. Wing | 04/22/2025 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly complete an assessment for capacity to consent per the facility policy for one sampled resident (Resident #2) including coordination and participation with all health professionals out of 13 sampled residents who were known to engage in sexual activity. The facility census was 49 residents.<br><br>Review of the facility Sexual Activity Abuse and Neglect Policy, dated 5/14/24, showed:<br><br>-Residents that are wishing to engage in sexual activity will be allowed to participate in these activities as long as both parties consent and have the ability to consent. Nonconsensual acts and acts of impact negatively on the resident community such as public displays shall not be allowed.<br><br>-If the resident has a guardian or cognitive impairment an assessment should be completed to determine the resident's ability to consent. This assessment will be completed by the interdisciplinary team with the assistance of the resident physician and or psychiatrist as needed.<br><br>-The assessment shall include the following: 1) awareness of the relationship including the awareness of who is initiating the relationship and comfort level with sexual intimacy; 2) ability to avoid exploitation including resident's values and ability to refuse unwanted advances; 3) awareness of potential risk associated with the relationship.<br><br>-The resident guardian will be invited to provide their guidance.<br><br>1. Review of Resident 1#'s admission Record showed the resident was admitted on [DATE] under the supervision of a legal guardian with diagnoses including Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems), anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus) and depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living).<br><br>Review of Resident 1#'s Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 2/26/25 showed the resident was cognitively intact.<br><br>(continued on next page) |

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

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

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 1#'s Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid) dated 9/20/22 showed the resident:<br><br>-Diagnoses including: schizophrenia, schizoaffective disorder, psychotic disorder, bipolar I disorder, major depressive disorder, polysubstance dependency, amphetamine abuse and malingering.<br><br>-Recommended services included:<br><br>--Behavior support plan.<br><br>--Structured environment.<br><br>--Activities of Daily Living (ADL) program.<br><br>--Crisis intervention services.<br><br>--Personal support network.<br><br>-Behaviors to be addressed in nursing facility plan of care:<br><br>--Verbal aggression.<br><br>--Hallucinations.<br><br>--Wandering.<br><br>--Paranoia.<br><br>--Abnormal thought process.<br><br>--Structured environment.<br><br>Review of Resident #1's undated Care Plan showed:<br><br>-On 12/13/24 he/she was found to have a peer in his/her bed during the night.<br><br>--He/she would have no adverse effects with having peers in his/her bed.<br><br>--He/she was provided education on safe sex practices, guardian updated.<br><br>-Capacity to consent was not identified.<br><br>Review of Resident #2's admission Record showed the resident was admitted on [DATE] with diagnoses including spina bifida and mood disorder due to known psychiatric condition and major depression.<br><br>Review of Resident #2's Annual MDS dated [DATE] showed the resident was cognitively intact.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #2's undated Care Plan showed:<br><br>-On 5/04/23 he/she was sexually active and refused birth control.<br><br>--His/her goal was to not have unprotected sex.<br><br>--Staff were educated on safe sex practices, offer birth control options and provide education to the resident.<br><br>-On 12/13/24 he/she was found in a peer's bed.<br><br>--His/her goal remained to have no adverse reactions related to sexual incidents with peers.<br><br>--He/she was provided education on safe sex practices.<br><br>-Capacity to consent was not identified.<br><br>Review of the facility investigation dated 12/13/24 showed:<br><br>-Certified Nurse Aide (CNA) F found Resident #1 and Resident #2 in bed together.<br><br>-They admitted to having mutually consensual sex.<br><br>-Resident #1 and Resident #2 completed capacity to consent forms and were found to be competent.<br><br>*Note: The investigation did not have copies of the capacity to consent forms.<br><br>Review of Resident #1's Capacity to Consent to Sexual Activity Form dated 12/13/24 showed:<br><br>-He/she had a legal guardian.<br><br>-He/she was able to communicate yes or no decisions.<br><br>-He/she had the ability to understand relevant information.<br><br>-He/she had the ability to appreciate the situation and its likely consequences.<br><br>-He/she had the ability to manipulate information rationally.<br><br>-The resident had the capacity to consent.<br><br>-Only one signature was listed on the form. It was the Social Services Designee (SSD).<br><br>-There was no signature for the resident, legal guardian, evaluator or Administrator.<br><br>Review of the medical record for Resident #2 showed no capacity to consent form completed in December 2024.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #2's Progress Note dated 12/16/24 showed:<br><br>-SSD received an email from the legal guardian.<br><br>-Resident #2 had been adjudicated as incapacitated and disabled by the courts.<br><br>-Legally he/she does not have the legal capacity to consent to sex, nor is he/she allowed to sign any type of written consent or contract.<br><br>-Only his/her legal guardian may sign consents and we (the guardian) cannot consent to sexual activity on behalf of our ward due to the aforementioned lack of capacity after adjudication.<br><br>-Please ensure he/she is not left alone with opposite sex residents, as these types of situations jeopardize his/her safety, as it puts him/her in the position of possibly being accused of inappropriate behavior.<br><br>Review of Resident #2's Progress Note dated 12/18/24 showed:<br><br>-SSD documented the Director of Nursing (DON) and Administrator present, the legal guardian shared the resident had a history of sexual indecencies and felt that because he/she had been declared an incapacitated adult by the courts, he/she does not have the cognition to consent to sexual relations.<br><br>-Guardian requested the resident be moved to a locked same sex unit to protect him/her.<br><br>Review of Resident #1's Progress Note dated 3/25/25 said:<br><br>-The resident verbalized concerns to SSD about his/he romantic relationship with Resident #2.<br><br>-Therapy services were offered at that time.<br><br>Review of Resident #2's Progress Note dated 3/31/25 showed:<br><br>-He/She was visiting with SSD about bladder training due to the desire to be sexually active.<br><br>-He/She disclosed he/she engaged in sexual activity with Resident #1 on 3/27/25.<br><br>-He/She said the sexual encounter was mutually consensual.<br><br>-He/She completed the sexual consent form.<br><br>Review of Resident #1's Brief Interview for Mental Status (BIMS) dated 3/31/25 showed the resident was cognitively intact with a score of 13 out of 15.<br><br>Review of Resident #1's Progress Note dated 3/31/25 showed:<br><br>-He/She clarified that Resident #2 remained in his/her room from after the last smoke break of the night until approximately 2:00 A.M.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -They both were unclothed in bed and engaged in penetration before falling asleep.<br><br>-He/She was unaware Resident #2 planned to visit him/her after their last smoke break.<br><br>Review of the Resident #1's Capacity to Consent to Sexual Activity Form dated 3/31/25 showed:<br><br>-The resident had a legal guardian.<br><br>-He/she was not able to communicate yes or no decision.<br><br>-He/she did not have the ability to understand relevant information.<br><br>-He/she did not have the ability to appreciate the situation and its likely consequences.<br><br>-He/she did not have the ability to manipulate information rationally.<br><br>-There was doubt about Resident #1's capacity to consent at this time and further evaluation was necessary.<br><br>-The signature of the resident and the former Administrator.<br><br>-There was no signature for the guardian, evaluator or SSD.<br><br>Review of Resident #2's Capacity to Consent to Sexual Activity Form dated 3/31/25 showed:<br><br>-The resident did not have a guardian.<br><br>-Was able to communicate yes or no decision.<br><br>-Had the ability to understand relevant information.<br><br>-Had the ability to appreciate the situation and its likely consequences.<br><br>-Had the ability to manipulate information rationally.<br><br>-It was concluded the resident had the capacity to consent at that time.<br><br>-Signature of resident and Administrator.<br><br>-No signature for the evaluator or SSD.<br><br>Review of Resident #2's Progress Note dated 3/31/25 showed:<br><br>-Reported he/she engaged in sexual activity with another resident in the other resident's room from approximately 9:58 P.M. to 3:00 A.M. on the night of 3/27/25.<br><br>-They had intercourse and he/she fell asleep and did not wake up until 3:00 A.M.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She was escorted back to his/her room by the other resident when he/she woke up unnoticed by staff.<br><br>Review of Resident #1's Progress Notes dated 4/1/25 showed:<br><br>-SSD communicated with the legal guardian.<br><br>-Resident to be placed on a 30-day restriction as a result of having sex.<br><br>-The legal guardian informed SSD while the resident has a legal right to sign a consent for sexual activity, the office policy/principal dictates, that due to the resident being under a Public Administrator and deemed incompetent, the office does not permit the reside to participate in or consent to sexual activity.<br><br>-Resident signed consent to sexual activity with the understanding that he/she does not have the capacity to consent to sexual activity.<br><br>Review of facility Incident Report dated 4/1/25 showed:<br><br>-Alleged sexual contact on 3/27/25 between Resident #1 and Resident #2.<br><br>-Statements received from witnesses and residents involved.<br><br>-On 3/31/25 Resident #2 disclosed to the SSD that he/she and Resident #1 engaged in consensual sexual intercourse on 3/27/25.<br><br>-Resident #2 stated the interaction was voluntary and mutual.<br><br>-SSD and Registered Nurse (RN) approached Resident #1 to assess the resident's well-being and confirm the interactions was consensual.<br><br>-Both residents were evaluated for cognitive capacity and understanding of consent. The report did not identify when Resident #1 or Resident #2 was evaluated or how they were evaluated.<br><br>-After the investigation, it was determined the residents were able to consent but after reading the previous incident that took place on 12/13/24, it was determined by Resident #2's guardian that he/she was not able to consent.<br><br>-There was no notation the interdisciplinary team was consulted about assessment and determination of the capacity to consent as indicated in the facility policy.<br><br>During an interview on 4/10/25 at 11:30 the Director of Nursing (DON) said:<br><br>-Resident #2 was transferred out of the facility to ensure no sexual activity would occur again with Resident #1.<br><br>-The legal guardian was not in favor of consent for Resident #1 to engage in sexual activity mostly due to how the residents went about things, being sneaky.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -There was a policy related to sexual activity and this was the second infraction for both residents.<br><br>-Resident #2 disclosed sexual activity to the SSD.<br><br>During an interview on 4/10/25 at 5:53 P.M. Resident #1 said:<br><br>-He/She was trying to get a hold of someone because someone was supposed to follow up with him/her and Resident #2 about them being together from the last time they were sexually active in December 2024.<br><br>-He/She just found out consensual sex was not allowed in the facility.<br><br>-Staff said he/she could engage in consensual sexual activities if he/she signed papers.<br><br>-He/She was told Resident #2 would get an assault charge if he/she did not sign papers, then he/she was given restrictions.<br><br>-He/She was dating Resident #2.<br><br>-They were caught before when a staff member walked in on them while they were in his/her bed.<br><br>-A couple of weeks ago Resident #2 came into his/her room and exposed him/herself to him/her and they began making out.<br><br>-He/She did not have any sex protection and Resident #2 was ok with engaging in intercourse without protection.<br><br>-He/She has had a legal guardian after being homeless.<br><br>-He/She admitted to having sexual relations with other residents in the past, one of which was no longer living in the facility.<br><br>-He/She was told on 4/1/25 that he/she could not consent to sexual activity but was told to sign a paper saying he/she did not know consequences of sexual activity.<br><br>-He/She did not understand why he/she was asked to sign if he/she had a legal guardian.<br><br>During an interview on 4/16/25 at 1:20 P.M. Resident #2 said:<br><br>-He/She had been having sex with his/her boyfriend and the first time they had sex they got caught and the facility staff had them sign a papers. A consent paper saying they consented to have sex and they also signed an abuse/neglect regarding sexual activity paper.<br><br>-He/She had to sign a sex consent and then with Resident #1 was put on a 90 day restriction because Resident #1's guardian disapproved of them having sex.<br><br>-He/She said the form they made Resident #1 sign was the consent to have sex.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/16/25 at 2:32 P.M. Nurse Practitioner (NP) A said:<br><br>-He/She was aware of Resident #1 and Resident #2 engaging in sexual activity.<br><br>-Due to his/her limited interaction with the residents, he/she could not confirm if the residents were competent to consent to sexual activity.<br><br>-He/She was unaware of the sexual activity that occurred 12/13/24 until about a month ago.<br><br>-Residents have the right to be sexually active.<br><br>-If the resident is not competent and/or not their own guardian, he/she is not sure if a decision could be made for them to consent to sexual activity.<br><br>-If the resident is competent to be his/her own guardian, then should be competent to decide to engage in sexual activity.<br><br>-He/She has not conducted any assessments for competency to consent to sexual activity.<br><br>During an interview on 4/17/25 at 11:44 A.M. the Physician said:<br><br>-He/She expects that there are residents that are still young men and women with desires and the facility should sit down with each of them to explain the risks.<br><br>-He/She does not support or condone sexual activity for residents.<br><br>-There should be education and appropriate steps taken to prevent the spread of sexually transmitted disease.<br><br>-Residents should engage in sexual activity at least in a semi-private room.<br><br>-The most important thing for sexual activity is consent.<br><br>-Felt like psych should be involved with assessing for competency to consent for sexual activity.<br><br>During an interview on 4/17/25 at 4:18 P.M. the Former DON said:<br><br>-He/She conducted a full investigation related to the sexual interaction between Resident #1 and Resident #2 on 12/13/24.<br><br>-Based off the legal guardian statement Resident #1 was not able to consent to sexual activity as the guardian did not feel the resident had the capacity to consent.<br><br>-Resident #1 was not assessed specifically for capacity to consent, something about legal ramifications.<br><br>-Resident #1 said he/she had not been educated on that part of his/her guardianship.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The issue was Resident #2 was his/her own person.<br><br>During an interview on 4/18/25 at 11:45 A.M. NP B said:<br><br>-He/She was informed by the current administrator of Resident #1 and Resident #2 engaging in sexual activity.<br><br>-Resident #1 and Resident #2 were aware of the risks and consequences of sexual activity.<br><br>-He/she did not perform competency evaluations or was included in assessment.<br><br>During an interview on 4/21/25 at 5:58 P.M. the Administrator in Training (AIT) said:<br><br>-He/She was a part of the investigation began on 3/31/25 for Resident #1 and Resident #2 when Resident #2 disclosed the residents were engaging in sexual activity on 3/27/25.<br><br>-He/She could not explain why Resident #1 had not been transferred to a secured same sex unit after Resident #1's legal guardian made the request in December 2024 to protect the resident.<br><br>-Resident #1 was not moved as requested by the legal guardian and now the facility is dealing with the incident.<br><br>-Both residents disclosed they were aware they were not to engage in sexual activity from the December incident during the interviews conducted on 4/1/25.<br><br>-He/She did not feel the sexual encounter met the criteria of abuse or neglect. Resident #2 was able to spend from 10:00 P.M. until 2:00 A.M. in bed with Resident #1 and return to his/her own room unnoticed because staff were not doing what they were supposed to.<br><br>-He/She said NP B was performing assessment for competency on a monthly basis, even though NP B state those assessments were done by the mental health team and not by the NP alone.<br><br>-Assessments per the facility policy had not been completed for any residents who met the criteria for an assessment.<br><br>-He/She thought NP B was assessing cognition and capacity during monthly mental health visits.<br><br>-Since NP B was not performing cognition and capacity, then there were no cognition and capacity assessments for the residents that require determination for the ability consent, therefore they were not in compliance with the facility policy.<br><br>MO00252031 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure six sampled residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #7 and Resident #11) received medications as prescribed by the physician out of 13 sampled residents. The facility census was 49 residents.<br><br>Review of the facility's Medication Administration Policy dated 4/6/17 and revised on 6/26/24 showed:<br><br>-Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.<br><br>-It was the policy of this facility to ensure the safe and effective administration of all medications by utilizing best practice guidelines.<br><br>-Sign Medication Administration Record (MAR) after administering medications.<br><br>-For those medications requiring vital signs, record the vital signs onto the MAR.<br><br>-Report and document any adverse side effects or refusals.<br><br>1. Record review of Resident #1's admission Record showed the resident was admitted on [DATE] under the supervision of a legal guardian with diagnoses including schizoaffective disorder (a psychotic disorder characterized by loss of contact with environment, by noticeable deterioration in the level of functioning in everyday life), anxiety and depression.<br><br>Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) dated 2/26/25 showed the resident was cognitively intact.<br><br>Review of the resident's MAR and Treatment Administration Record (TAR) dated March 2025 showed:<br><br>-Atorvastatin Calcium 40 milligram (mg) Tablet, give 40 mg by mouth at bedtime for hyperlipidemia (high cholesterol). The resident did not receive this medication six out of 31 opportunities.<br><br>-Clonazepam 1mg, give one tablet by mouth three times daily for anxiety related to schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others), schizoaffective disorder, bipolar (mood disorders characterized usually by alternating episodes of depression and mania) type. The resident did not receive this medication 18 out of 93 opportunities.<br><br>-Trazodone 50 mg, given one tablet by mouth at bedtime for insomnia related to depression. The resident did not receive this medication six out of 31 opportunities.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Risperdal Consta intramuscular (IM) suspension Extended Release (ER) 50 mg, inject one application IM one time a day every 14 days for schizophrenia. The resident did not receive this medication one out of two opportunities.<br><br>Review of the resident's MAR and TAR dated April 2025 showed:<br><br>-Abilify 10 mg, give one tablet by mouth daily for schizoaffective disorder. The resident did not receive this medication eight out of 16 opportunities. All eight doses were consecutive doses from 4/1/25 to 4/8/25.<br><br>-Clonazepam 1 mg, give one tablet by mouth three times daily for anxiety related to schizophrenia, schizoaffective disorder, bipolar type. The resident did not receive this medication six out of 48 opportunities.<br><br>-Trazodone 50 mg, given one tablet by mouth at bedtime for insomnia related to depression. The resident did not receive this medication four out of 16 opportunities.<br><br>-Risperdal Consta IM suspension ER 50 mg, inject one application IM one time a day every 14 days for schizophrenia. The resident did not receive this medication one out of one opportunities.<br><br>During an interview on 4/10/25 at 5:53 P.M., Resident #1 said:<br><br>-He/She does not get his/her medication consistently due to no staff to give his/her medications.<br><br>-He/She does not refuse his/her medications.<br><br>2. Review of Resident #2's admission Record showed the resident was admitted on [DATE] with diagnoses including spina bifida (is a condition that occurs when the spine and spinal cord did not form properly), mood disorder (a serious mental illness that causes persistent and intense changes in a person's mood, energy, and behavior) due to known psychiatric condition and major depression.<br><br>Review of the resident's Annual MDS dated [DATE] showed the resident was cognitively intact.<br><br>Review of the resident's MAR and TAR dated March 2025 showed:<br><br>-Clonazepam 0.5 mg, give 0.5 mg by mouth two times a day for Anxiety. This resident did not receive this medication seven out of 62 opportunities.<br><br>-Haloperidol 5 mg, give 5 mg by mouth two times a day related to mood disorder due to known physiological condition with major depressive-like episode. This resident did not receive this medication four out of 62 opportunities.<br><br>-Hydroxyzine Pamoate 25 mg, give 25 mg by mouth three times a day for Anxiety. This resident did not receive this medication eight out of 93 opportunities.<br><br>-Trazodone 100 mg, give 100 mg by mouth at bedtime for depression. This resident did not receive this medication eight out of 31 opportunities.<br><br>(continued on next page) |

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| | 265532 | A. Building<br>B. Wing | 04/22/2025 |

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

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/16/25 at 1:20 P.M. Resident #2 said he/she has missed several doses of medications due to them being on order or no nurse or Certified Medication Technician (CMT) to pass medications.<br><br>3. Review of Resident #3's admission Record showed the resident admitted on [DATE] with diagnoses including diffuse traumatic brain injury (TBI - a sudden injury that causes damage to the brain) with loss of consciousness of unspecified duration sequela and paranoid schizophrenia (a type of schizophrenia accompanied by paranoia, delusions and hallucinations).<br><br>Review of the resident's Quarterly MDS dated [DATE], moderately cognitively impaired.<br><br>Review of the resident's MAR and TAR dated February 2025 showed Cephalexin 500 mg Capsule (an antibiotic), give 500 mg capsule by mouth three times a day for five days for sepsis (severe infection) start date 2/26/25. This resident did not receive this medication seven out of seven opportunities.<br><br>4. Review of Resident #5's admission Record showed the resident was admitted on [DATE], readmitted on [DATE] with the following diagnosis:<br><br>-Diabetes Mellitus Type II (a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).<br><br>-Chronic Kidney Disease (is when the kidneys are damaged and lose their ability to filter waste and fluid out of the body).<br><br>-Schizophrenia.<br><br>-Depression.<br><br>-High blood pressure.<br><br>-Chronic Obstructive Pulmonary Disease (COPD - a progressive lung disease that prevents airflow to the lungs, causing breathing problems).<br><br>-Anxiety.<br><br>Review of the resident's Quarterly MDS dated [DATE] showed the resident was cognitively intact.<br><br>Review of the resident's MAR & TAR dated March 2025 showed:<br><br>-Atorvastatin Calcium 80 mg Tablet, give 80 mg by mouth at bedtime for hyperlipidemia. The resident did not receive this medication five out of 19 opportunities.<br><br>-Pantoprazole Sodium 40 mg Tablet, give 40 mg by mouth in the morning for gastroesophageal reflux disease (GERD - back-up of stomach acid/heartburn). The resident did not receive this medication nine out of 19 opportunities.<br><br>-Prazosin HCl 2 mg Capsule, give 1 capsule by mouth at bedtime for high blood pressure. The resident did not receive this medication six out of 19 opportunities.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Tiotropium Bromide Monohydrate Inhalation Aerosol Solution 2.5 mcg/act, give 1 puff inhale by mouth at bedtime for shortness of air. The resident did not receive this medication six out of 19 opportunities.<br><br>-Trazodone HCl 50 mg Tablet, give 50 mg by mouth at bedtime for insomnia secondary to organic mood disorder. The resident did not receive this medication four out of 19 opportunities.<br><br>-Hydroxyzine HCl 50 mg Tablet, give 50 mg by mouth three times a day for anxiety. The resident did not receive this medication five out of 57 opportunities.<br><br>-Lidoderm External Patch 5 %, Apply to low back topically every morning and at bedtime for back pain. The resident did not receive this medication 11 out of 38 opportunities.<br><br>-Accuchecks (blood sugar monitoring) before meals and at bedtime for diabetes. The resident did not receive accuchecks eight out of 96 opportunities.<br><br>-Novolog Injection Solution (Insulin Aspart - a fast acting insulin), inject as per sliding scale. If the blood sugar is: 150-200 = 1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 5 units; 351-400 = 8 units; Greater than 400 call the NP, subcutaneously before meals and at bedtime for diabetes. The resident did not receive this medication 14 out of 76 opportunities.<br><br>--Six of the missed doses was coded 2 due to resident refusing, blood sugars were within parameters and insulin was due to be given. No note of physician being notified.<br><br>-Lantus Subcutaneously Solution (a long acting insulin) 100 unit/milliliter (ml), inject 45 units subcutaneously at bedtime for diabetes. Do not hold unless blood sugar is below 70. The resident did not receive this medication four out of 19 opportunities.<br><br>Review of the resident's MAR & TAR dated April 2025 showed:<br><br>-Atorvastatin Calcium 80 mg Tablet, give 80 mg by mouth at bedtime for hyperlipidemia. The resident did not receive this medication one out of 16 opportunities.<br><br>-Pantoprazole Sodium 40 mg Tablet, give 40 mg by mouth in the morning for GERD. The resident did not receive this medication 10 out of 16 opportunities.<br><br>-Prazosin HCl 2 mg Capsule, give 1 capsule by mouth at bedtime for high blood pressure. The resident did not receive this medication one out of 16 opportunities.<br><br>-Tiotropium Bromide Monohydrate Inhalation Aerosol Solution 2.5 mcg/act, give 1 puff inhale by mouth at bedtime for shortness of air. The resident did not receive this medication two out of 16 opportunities.<br><br>-Trazodone HCl 50 mg Tablet, give 50 mg by mouth at bedtime for insomnia secondary to organic mood disorder. The resident did not receive this medication two out of 16 opportunities.<br><br>-Hydroxyzine HCl 50 mg Tablet, give 50 mg by mouth three times a day for anxiety. The resident did not receive this medication five out of 57 opportunities.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Lidoderm External Patch 5 %, Apply to low back topically every morning and at bedtime for back pain. The resident did not receive this medication four out of 32 opportunities.<br><br>-Accuchecks before meals and at bedtime for diabetes. The resident did not receive accuchecks eight out of 76 opportunities.<br><br>-Novolog Injection Solution (Insulin Aspart), inject as per sliding scale. If the blood sugar is: 150-200 = 1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 5 units; 351-400 = 8 units; Greater than 400 call the NP, subcutaneously before meals and at bedtime for diabetes. The resident did not receive this medication 13 out of 64 opportunities.<br><br>--Two of the missed doses was coded 2 due to resident refusing, blood sugars were within parameters and insulin was due to be given. No note of physician being notified.<br><br>--One missed dose was code 4 due to the resident having blood sugar on 484, no progress not stating the physician was notified of the high blood sugar or action taken.<br><br>-Lantus Subcutaneously Solution 100 unit/ml, inject 45 units subcutaneously at bedtime for diabetes. Do not hold unless blood sugar is below 70. The resident did not receive this medication two out of 16 opportunities.<br><br>5. Review of Resident #7's admission Record showed the resident admitted on [DATE] with diagnoses including schizoaffective disorder, dementia (is the loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and stroke.<br><br>Review of the resident's Quarterly MDS dated [DATE] showed the resident was mildly cognitively impaired.<br><br>Review of the resident's MAR and TAR dated March 2025 showed:<br><br>-Atorvastatin 20 mg Tablet, give 20 mg by mouth at bedtime for hyperlipidemia. This resident did not receive this medication 10 out of 31 opportunities.<br><br>-Buspirone HCl 10 mg Tablet, give 10 mg by mouth three times a day for anxiety disorder. This resident did not receive this medication 12 out of 93 opportunities.<br><br>-Donepezil HCl10 mg Tablet, give 10 mg by mouth at bedtime for dementia. This resident did not receive this medication 10 out of 31 opportunities.<br><br>-Invega Sustenna IM Suspension Prefilled Syringe 234 mg/1.5ml, inject 1.5 ml IM in the afternoon every 28 days for schizoaffective disorder, bipolar type. The resident did not receive this medication one out of one opportunities. The administration note dated 3/22/25 showed the medication was on order.<br><br>-Levoxyl 88 mcg Tablet, give 88 mcg by mouth in the morning on an empty stomach without other medications for hypothyroidism (low thyroid). This resident did not receive this medication 26 out of 31 opportunities.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Melatonin 10 mg Tablet, give 10 mg by mouth at bedtime for insomnia. This resident did not receive this medication eight out of 31 opportunities.<br><br>-Trazodone HCl 50 mg Tablet, give 50 mg by mouth at bedtime for insomnia secondary to mood disorder. This resident did not receive this medication six out of 26 opportunities.<br><br>Review of the resident's MAR and TAR dated April 2025 showed:<br><br>-Buspirone HCl 10 mg Tablet, give 10 mg by mouth three times a day for anxiety disorder. This resident did not receive this medication one out of 48 opportunities.<br><br>-Levoxyl 88 mcg Tablet, give 88 mcg by mouth in the morning on an empty stomach without other medications for hypothyroidism. This resident did not receive this medication 11 out of 16 opportunities.<br><br>6. Review of Resident #11's admission Record showed the resident was admitted on [DATE], readmitted on [DATE] with the following diagnosis:<br><br>-Diabetes Mellitus Type II (a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).<br><br>-Coronary Artery Disease (CAD-narrowing of the coronary arteries due to build up of plaque).<br><br>-Chronic Systolic (Congestive) Heart Failure (CHF-heart failure in which the heart is unable to maintain adequate circulation of blood in the tissue of the body or to pump out the venous blood returned to it by the venous circulation).<br><br>-Hyperlipidemia (HDL-high levels of lipids (fats) in the blood).<br><br>-Thrombophilia (is a condition that increases the likelihoodof blood clots forming).<br><br>-Bipolar Disorder (is a mental illness that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks).<br><br>-Depression.<br><br>-High blood pressure.<br><br>-Anxiety.<br><br>Review of the resident's Quarterly MDS dated [DATE] showed the resident was cognitively intact.<br><br>Review of the resident's MAR & TAR dated March 2025 showed:<br><br>-Gabapentin 100 mg Capsule, give 400 mg by mouth three times a day for polyneuropathy. The resident did not receive this medication four out of 57 opportunities.<br><br>-Loratadine 10 mg Tablet, give 10 mg by mouth at bedtime for Prophylaxis related to CHF. The resident did not receive this medication three out of 19 opportunities.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Melatonin 3 mg Tablet, give 3 mg by mouth at bedtime for insomnia. The resident did not receive this medication three out of 19 opportunities.<br><br>-Mirtazapine 15 mg Tablet, give 15 mg by mouth at bedtime related to mild cognitive impairment. The resident did not receive this medication three out of 19 opportunities.<br><br>-Oxycodone 5 mg Tablet, give 5 mg by mouth every 12 hours for pain. The resident did not receive this medication four out of 38 opportunities.<br><br>-Omeprazole 40 mg Capsule, give 40 mg by mouth in the morning for GERD. The resident did not receive this medication nine out of 19 opportunities.<br><br>-Seroquel 200 mg Tablet, give 200 mg by mouth at bedtime for bipolar disorder. The resident did not receive this medication three out of 19 opportunities.<br><br>-Seroquel 50 mg Tablet, give 50 mg by mouth at bedtime for bipolar disorder. The resident did not receive this medication three out of 19 opportunities.<br><br>-Trazodone HCl 50 mg Tablet, give 50 mg by mouth at bedtime for insomnia secondary to depression. The resident did not receive this medication three out of 19 opportunities.<br><br>-Accuchecks before meals and at bedtime for diabetes. The resident did not receive accuchecks eight out of 76 opportunities.<br><br>-Lantus SoloStar Subcutaneously Solution Pen-Injector 100 unit/ml, inject 30 units subcutaneously at bedtime for diabetes. The resident did not receive this medication three out of 19 opportunities.<br><br>-Lantus SoloStar Subcutaneously Solution Pen-Injector 100 unit/ml, inject 8 units subcutaneously in the afternoon for lunch for diabetes. Do not hold unless blood sugar (BS) is 70 or below. The resident did not receive this medication six out of 19 opportunities.<br><br>--Four missed doses at 12:00 P.M. were coded 4 (vitals outside of parameters for administration) on 3/23/25 BS was 88, 3/26/25 BS was 110, 3/27/25 BS was 140, and 3/30/25 BS was 158.<br><br>-Novolog Injection Solution (Insulin Aspart), inject 10 units subcutaneously in the afternoon for diabetes. The resident did not receive this medication five out of 19 opportunities.<br><br>--Three missed doses at 12:00 P.M. were coded 4 (vitals outside of parameters for administration) on 3/23/25 BS was 88, 3/26/25 BS was 110, and 3/27/25 BS was 134, no parameters for this order.<br><br>-Novolog Injection Solution (Insulin Aspart), inject 10 units subcutaneously in the evening for diabetes. The resident did not receive this medication four out of 19 opportunities.<br><br>--Two missed doses at 4:00 P.M. were coded 4 (vitals outside of parameters for administration) on 3/22/25 BS was 102 and 3/23/25 BS was 244, no parameters for this order.<br><br>Review of the resident's MAR & TAR dated April 2025 showed:<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Eliquis 5 mg Tablet, give 5 mg by mouth two times a day for CAD. The resident did not receive this medication five out of 32 opportunities.<br><br>--All five missed doses were blank and had no administration notes.<br><br>-Glyburide 5 mg Tablet by mouth two times a day for diabetes. The resident did not receive this medication five out of 32 opportunities.<br><br>-Gabapentin 100 mg Capsule, give 400 mg by mouth three times a day for polyneuropathy. The resident did not receive this medication seven out of 48 opportunities.<br><br>-Melatonin 3 mg Tablet, give 3 mg by mouth at bedtime for insomnia. The resident did not receive this medication three out of 16 opportunities.<br><br>-Mirtazapine 15 mg Tablet, give 15 mg by mouth at bedtime related to mild cognitive impairment. The resident did not receive this medication two out of 16 opportunities.<br><br>-Oxycodone 5 mg Tablet, give 5 mg by mouth every 12 hours for pain. The resident did not receive this medication six out of 32 opportunities.<br><br>-Omeprazole 40 mg Capsule, give 40 mg by mouth in the morning for GERD. The resident did not receive this medication eight out of 17 opportunities.<br><br>-Omeprazole 40 mg Capsule, give 40 mg by mouth in evening for GERD. The resident did not receive this medication four out of 16 opportunities.<br><br>-Seroquel 200 mg Tablet, give 200 mg by mouth at bedtime for bipolar disorder. The resident did not receive this medication two out of 16 opportunities.<br><br>-Seroquel 50 mg Tablet, give 50 mg by mouth at bedtime for bipolar disorder. The resident did not receive this medication two out of 16 opportunities.<br><br>-Trazodone HCl 50 mg Tablet, give 50 mg by mouth at bedtime for insomnia secondary to depression. The resident did not receive this medication two out of 16 opportunities.<br><br>-Accuchecks before meals and at bedtime for diabetes. The resident did not receive accuchecks 14 out of 64 opportunities.<br><br>-Lantus SoloStar Subcutaneously Solution Pen-Injector 100 unit/ml, inject 30 units subcutaneously at bedtime for diabetes. The resident did not receive this medication five out of 16 opportunities.<br><br>-Lantus SoloStar Subcutaneously Solution Pen-Injector 100 unit/ml, inject 8 units subcutaneously in the afternoon for lunch for diabetes. Do not hold unless blood sugar (BS) is 70 or below. The resident did not receive this medication seven out of 16 opportunities.<br><br>--Three missed doses at 12:00 P.M. were coded 4 (vitals outside of parameters for administration) on 4/1/25 BS was 168, 4/5/25 BS was 169, and 4/8/25 BS was 184.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Novolog Injection Solution (Insulin Aspart), inject 10 units subcutaneously in the afternoon for diabetes. The resident did not receive this medication five out of 16 opportunities.<br><br>--Two missed doses at 12:00 P.M. were coded 4 (vitals outside of parameters for administration) on 4/1/25 BS was 168 and 4/8/25 BS was 184, no parameter on this order.<br><br>-Novolog Injection Solution (Insulin Aspart), inject 10 units subcutaneously in the evening for diabetes. The resident did not receive this medication eight out of 16 opportunities.<br><br>--Two missed doses at 4:00 P.M. were coded 4 (vitals outside of parameters for administration) on 4/6/25 BS was 104 and 4/8/25 BS was 94, and one was code 13 (blood sugar outside parameters) on 4/2/25 BS was 128. none of these doses were outside the parameter of 70 or below.<br><br>During an interview on 4/15/25 at 4:54 P.M., Resident #11 said sometime he/she does not get his/her bedtime medications.<br><br>7. During an interview on 4/15/25 at 1:24 P.M. CMT A said:<br><br>-Medications are to be administered to the residents as ordered by the physician.<br><br>-If residents refuse medications he/she notifies the charge nurse.<br><br>-Document why the medication was not given on the MAR & TAR and in the resident administration notes.<br><br>During an interview on 4/15/25 at 3:03 P.M., Licensed Practical Nurse (LPN) A said:<br><br>-If two CMTs are on shift they pass the medications and he/she does the nursing stuff like treatments.<br><br>-If one or no CMTs, then he/she is in charge of passing medications to the residents.<br><br>-Staff are to document why the medications was not given and notify the physician.<br><br>During an interview on 4/17/25 at 4:18 P.M. the Director of Nursing (DON) said:<br><br>-He/She was not aware there were medications that did not get passed, notified the NP or documented.<br><br>-He/She expected the nurse and/or CMT to pass medication as ordered by the physician.<br><br>During an interview on 4/18/25 at 11:45 A.M. Nurse Practitioner B said:<br><br>-He/She was not aware medications were not being administered for any reason.<br><br>-He/She expects staff to ensure medications are administered and if not administered to be notified as part of the resident's plan of care for mental health and behavioral disorders is medication management.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/21/25 at 5:58 P.M. the Administrator in Training (AIT) said:<br><br>-He/she would expect medications to be given as ordered and document the medication was given or not given.<br><br>-He/she would notify the physician or Nurse Practitioner of the missed medications.<br><br>MO00252031<br><br>MO00252201 |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a broken window on a locked behavioral and mental health unit from 3/22/25 to 4/16/25 was replaced and cleaned up. Broken glass shards were left on the unit and accessible to all residents on the unit. All resident on the unit had the potential for harm with broken glass left unattended. The facility census was 49 residents.<br><br>Review of the facility Incidents and Accidents Policy dated 5/18/24 showed:<br><br>-It is the policy of this facility for staff to utilize Point Click Care Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident.<br><br>-Accident refer to any unexpected or unintentional incident, which results or may result in injury or illness to a resident.<br><br>-Incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization.<br><br>-Purpose of incident reporting can include:<br><br>--Assuring the appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care.<br><br>--Conducting root cause analysis to ascertain causative and contributing factors to avoid further occurrences.<br><br>--Alert risk management and or administration of occurrences that could result in claims or further reporting requirements.<br><br>--Meeting regulatory requirement for analysis and reporting of incidents and accidents.<br><br>-Incidents that rise to the level of abuse, misappropriation or neglect will be managed and reported according to the facility's abuse prevention policy.<br><br>-Incidents include but are not limited to falls, observed accident/incidents, and unobserved injuries require an incident report.<br><br>-In the event of an incident or accident, immediate assistance will be provided or securement of the area will be initiated unless it places one at risk for harm.<br><br>-Any injuries will be assessed by the license nurse or practitioner and the affected individual will not be moved until safe to do so.<br><br>-First aid will be given for minor injuries such a as cuts or abrasions.<br><br>(continued on next page) |

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|---|---|---|---|
| | 265532 | A. Building<br>B. Wing | 04/22/2025 |

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The supervisor or other designee will be notified of the incident/accident.<br><br>-The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or there findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of injury.<br><br>-In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks per protocol and document on the neurological flow sheet.<br><br>-The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information.<br><br>-Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions.<br><br>-If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or Administrator.<br><br>1. Review of Resident #3's admission Record showed the resident admitted on [DATE] with diagnoses including diffuse traumatic brain injury with loss of consciousness of unspecified duration sequela and paranoid schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others).<br><br>Review of Resident #3's Comprehensive Discharge Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 3/10/24 showed the resident was severely cognitively impaired.<br><br>Review of Resident #3's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid) dated 3/12/24 showed the resident:<br><br>-Had diagnoses including paranoid schizophrenia, personality disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems) , borderline intellectual functioning (a categorization of intelligence wherein a person has below average cognitive ability (generally an IQ of 70-85), but the deficit is not as severe as intellectual disability (below 70) and polysubstance dependence (condition where an individual meets the diagnostic criteria for substance use disorder (SUD) on two or more different classes of substances simultaneously and exhibit significant problems and impairments in their lives due to their use of multiple substances, such as alcohol, stimulants, opioids, or sedatives).<br><br>-Recent physical altercation with another resident where he punched another resident in the face while out smoking on 2/19/24.<br><br>-Recent multiple falls.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -History of having a guardian.<br><br>-Had chronic medical and psychological condition requires around the clock medical care and oversight.<br><br>-Had multiple comorbidities requiring skilled care.<br><br>-Had resided in a skilled facility for many years.<br><br>-At that time he remained safest in a skilled nursing facility.<br><br>-Behaviors to be addressed were aggression, mood liability, and impulsivity.<br><br>-Required medication therapy and monitoring, structured environment for history of aggression towards other and high fall risk, and crisis intervention plan recommended due to aggression towards others.<br><br>During an observation and interview with Administrator in Training (AIT) on 4/16/25 at 12:04 P.M. said:<br><br>-room [ROOM NUMBER] had a broken window with glass shards on the windowsill.<br><br>-He/she was not sure how long the window had been broken.<br><br>-He/she noticed the window was broken about two weeks ago.<br><br>-The Maintenance Director left last week and there have been Maintenance workers from sister facilities assisting.<br><br>Review of Resident #13's Quarterly MDS dated [DATE] showed the resident was mildly cognitively impaired with no mood or behavior concerns documented.<br><br>During an interview on 4/16/25 at 4:46 P.M. Resident #13 said:<br><br>-He/She moved into room [ROOM NUMBER] about three to four weeks ago.<br><br>-The window was broken after he/she moved in by his/her roommate, Resident #3.<br><br>-Resident #3 broke the window in the afternoon before he/she was sent to the hospital the last time on 3/22/25.<br><br>-He/She saw Resident #3 break the window.<br><br>-The Administrator knew about the broken window and tried to blame him/her.<br><br>Review of facility incident report dated 3/27/25 showed:<br><br>-AIT noticed a broken window next to an empty bed in Resident #13's room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Resident #13 denied breaking window.<br><br>-No action required, waiting for window to be repaired.<br><br>During an interview on 4/16/25 at 5:01 P.M. the AIT said:<br><br>-He/She was working as a direct care staff nurse about two weeks ago when he/she noticed the window was broken in room [ROOM NUMBER].<br><br>-The Administrator advised him/her the window was being repaired.<br><br>-He/She started on the investigation on 3/27/25 but had not completed it.<br><br>During an interview on 4/17/25 at 10:56 A.M. the Regional Maintenance Director said:<br><br>-He/She repaired the window, cleaned up the glass shards off the windowsill, and replaced the window shade in room [ROOM NUMBER] on 4/16/25.<br><br>-He/She was not informed when the window was broken in room [ROOM NUMBER] until he/she came to the facility on 4/16/25.<br><br>-There is a maintenance thread for all department heads, however, there was no information related to the broken window in room [ROOM NUMBER] sent in the thread.<br><br>-He/She does not know how staff are communicating maintenance needs within the facility.<br><br>-If he/she had been aware of the broken window when the AIT noticed it was broken on 3/27/25, the window would have been repaired immediately due to the broken glass being dangerous.<br><br>During an interview on 4/17/25 at 4:18 P.M. the former Director of Nurses (DON) said:<br><br>-He/She recalled the window in room [ROOM NUMBER] being broken about 3/25/25.<br><br>-Resident #13 said the window was broken, but he/she could not recall when.<br><br>-The Administrator and AIT had a conversation about the broken window in room [ROOM NUMBER], but he/she was not a part of that conversation.<br><br>-He/She did not know if Resident #3 broke the window, however there were concerns about his/her behaviors.<br><br>During an interview on 4/18/25 at 11:45 A.M. Nurse Practitioner (NP) B said:<br><br>-He/She was not informed of the resident kicking or breaking any windows in the facility.<br><br>-He/She was concerned about the broken window in room [ROOM NUMBER] left in disrepair for over twenty-one or more days.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The broken window was located in a locked facility with behavioral and mental health residents and any resident could use the broken glass for self-harm, harm to others or attempt to elope from the broken window which could result in serious injury.<br><br>During an interview on 4/21/25 at 6:30 P.M. the AIT said:<br><br>-He/She knew the window in room [ROOM NUMBER] was broken and the previous Administrator reported the window was fixed on 3/26/25.<br><br>-He/she never followed up.<br><br>-It was the Administrator's responsibility to ensure the window was repaired.<br><br>MO00252201 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to ensure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident. The facility assigned one nurse to be on a locked memory care unit and the Transitional Unit at the same time to pass medications, monitor resident behaviors and document such behaviors, leaving one other staff member on each unit, as a result medications were not given to the residents. The facility census was 49 residents.<br><br>Review of the facility's Sufficient Staff Policy dated 5/18/24 showed:<br><br>-It was the policy of the facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.<br><br>-The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment.<br><br>-Must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>-Was required to provide licensed nursing staff 24 hours a day, seven days a week.<br><br>-Must ensure that licensed nurses have the specific competencies and skill set necessary to care for resident's needs as identified through resident assessments and described in the plan of care.<br><br>-Providing care includes, but was not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>-Must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the care plan.<br><br>-Except when waived, the facility must use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week.<br><br>-The Director of Nursing (DON) may serve as a charge nurse only when the facility had an average daily occupancy of 60 or fewer residents.<br><br>Review of the Facility assessment dated [DATE] showed:<br><br>-The facility was licensed for 97 residents.<br><br>-The average number of occupied beds during 1/2024 to 10/2024 was 48 residents.<br><br>-The facility was a locked facility with two locked Specialty Unit inside the locked facility.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Skilled Acuity:<br><br>--Four with extensive services.<br><br>--Twenty-eight residents with high special care.<br><br>--Thirty-two residents with behavioral symptoms and cognitive performance.<br><br>-Resident acuity affecting licensed nurses:<br><br>--Ninety-seven residents with Behavioral/Mental health.<br><br>--Twenty residents' high risk or Intravenous (IV - in the vein)/intramuscular (IM - in the muscle) medications/infusions.<br><br>--Two hospice residents.<br><br>--Four wound care residents.<br><br>-Resident acuity affecting Nurse Aides:<br><br>--Twelve residents need assistance with dressing.<br><br>--Sixteen residents need assistance with baths.<br><br>--Five residents need assistance with transferring and mobility.<br><br>--Four residents need assistance with eating.<br><br>--Thirteen residents need assistance with toileting.<br><br>--Forty-one residents need assistance with behavioral symptoms.<br><br>-Staffing needs as per shift (adjust as needed).<br><br>--Day Shift 7:00 A.M. to 7:00 P.M., one RN for 97 residents, one Licensed Practical Nurse (LPN) per 50 residents, One Certified Nursing Assistant (CNA) per 24 residents, and one Certified Medication Technicians (CMT) per 35 residents.<br><br>--Night Shift 7:00 P.M. to 7:00 A.M., one RN for 97 residents, one LPN per 50 residents, one CNA per 12 residents and one CMT per 35 residents.<br><br>1. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/13/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN and two CNAs.<br><br>-The facility census was not provided as requested.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. medications and 5:00 A.M. medications on 3/14/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>2. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/15/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One LPN, and two CNAs.<br><br>-The facility census was not provided as requested.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. and 9:00 P.M. medications and 5:00 A.M. medications on 3/16/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>3. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/17/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN and two CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 5:00 A.M. medications on 3/18/25 for the 13 sampled out of 29 residents who resided on the Transition Unit. residents who resided on the Transition Unit.<br><br>4. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/22/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN and one CNA from 7:00 P.M. to 10:45 P.M A second CNA clocked in at 10:45 P.M.<br><br>-The facility census was 50 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. medications and 5:00 A.M. medications on 3/23/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>5. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/23/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN and two CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. medications and 5:00 A.M. medications on 3/24/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>6. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/26/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -One RN, one LPN (until 11:36 P.M.), and three CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. medications and 5:00 A.M. medications on 3/27/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>7. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/27/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN and three CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 5:00 A.M. medications on 3/28/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>8. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/29/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One LPN and two CNAs.<br><br>-The facility census was 48 residents.<br><br>NOTE: 7:00 A.M. to 7:00 P.M. nurse did not administer 7:00 A.M., 8:00 A.M., 9:00 A.M., 2:00 P.M., and 4:00 P.M. medications on 3/29/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>9. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/30/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One LPN and two CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. medications for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>10. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 3/31/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN and two CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. medications and 5:00 A.M. medications on 4/1/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 11. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 4/4/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One LPN and two CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 A.M. to 7:00 P.M. nurse did not administer 12:00 P.M. and 4:00 P.M. medications for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>12. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 4/5/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN and three CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 5:00 A.M. medications on 4/6/25 medications for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>13. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 4/6/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-7:00 P.M. to 7:00 A.M.<br><br>-One RN and three CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. and 9:00 P.M. medications and 5:00 A.M. medications on 4 /7/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>14. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 4/7/25 showed:<br><br>-One LPN and three CNAs from 7:00 A.M. to 7:00 P.M.<br><br>NOTE: 7:00 A.M. to 7:00 P.M. nurse did not administer 7:00 A.M., 9:00 A.M., 12:00 P.M., 4:00 P.M., and 5:00 P.M. medications for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>-One LPN, one CMT, and three CNAs 7:00 P.M. to 7:00 A.M.<br><br>-The facility census was 49 residents.<br><br>NOTE: The 7:00 P.M. to 7:00 A.M. nurse did not administer 5:00 A.M. medications on 4/8/25 medications for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 15. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 4/9/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN, one CMT, and two CNAs.<br><br>-The facility census was 48 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. 9:00 P.M. medications and 5:00 A.M. medications on 4/10/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>16. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 4/10/25 showed:<br><br>-One RN, one CMT, one CNA 7:00 P.M. to 7:00 A.M. and one LPN from 7:00 P.M. to 10:00 P.M.<br><br>-The facility census was 48 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. 9:00 P.M. medications and 5:00 A.M. medications on 4/11/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>17. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 4/13/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One CMT and two CNAs.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 8:00 P.M. 9:00 P.M. medications and 5:00 A.M. medications on 4/14/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>18. Review of the facility's Daily Staffing Sheet and Daily Punch In and Out for 4/14/25 from 7:00 P.M. to 7:00 A.M. showed:<br><br>-One RN, and three CNAs 7:00 P.M. to 7:00 A.M.<br><br>-The facility census was 49 residents.<br><br>NOTE: 7:00 P.M. to 7:00 A.M. nurse did not administer 5:00 A.M. medications on 4/15/25 for the 13 sampled out of 29 residents who resided on the Transition Unit.<br><br>19. Review of Resident #13's admission Record showed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, insomnia, and anxiety.<br><br>Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) MDS dated [DATE] showed the resident was mildly cognitively impaired with no mood or behavior concerns documented.<br><br>During an interview on 4/16/25 at 4:46 P.M. Resident #13 said:<br><br>(continued on next page) |

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| | 265532 | A. Building<br>B. Wing | 04/22/2025 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Sometimes he/she and the other residents do not get their medications because there is no nurse.<br><br>-Although there have been staff in the facility, there were no staff on Transition Unit.<br><br>20, During an interview on 4/16/25 at 8:01 A.M. CNA C said:<br><br>-He/She was not responsible for checking residents on the other hall (Transition Unit).<br><br>-Residents should be checked every hour.<br><br>-Everybody should be checked at least every two hours.<br><br>-There have been times when there was no staff on the other hall (Transition Unit), once or twice per month.<br><br>-Sometimes there was only one nurse and one CNA for the night shift.<br><br>-Most of the time it was one CNA on the Transition Unit.<br><br>During an interview on 4/16/25 at 8:37 A.M. CNA D said:<br><br>-He/She does not usually work the Transition Unit.<br><br>-CNA E would come to the memory care side to assist the staff in the early morning hours, leaving the Transition Unit unattended.<br><br>-His/Her concerns were there was no staff on the Transition Unit.<br><br>During an interview on 4/17/25 at 4:18 P.M. the DON said:<br><br>-He/She was out of the facility from 3/12/25 to 3/25/25 on personal leave.<br><br>-He/She expected there to be six direct care staff during the day shift including one nurse, two CMTs, and three CNAs.<br><br>-He/She expected there to be four to five direct care staff during the night shift including one nurse, one CMT, and three CNAs.<br><br>-He/She was aware there were medications that did not get passed, notified the Nurse Practitioner (NP) and not documented.<br><br>-He/She expected staff to check residents hourly and document in the resident chart the face checks.<br><br>During an interview on 4/18/25 at 9:41 A.M. CNA E said:<br><br>-He/She is usually the only staff on the hall during the last smoke time for the residents at 9:00 P.M.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Most of the time he/she is the only staff and cannot allow the residents to use the microwave or vending machines.<br><br>-There are times when there is a CNA for the Transitional Unit and a nurse on the memory care for the entire shift.<br><br>-He/She goes to the memory care unit at around 4:00 A.M. to help get residents up and will return to the Transition Unit at 6:00 A.M. to smoke the residents.<br><br>-There had never been a Code [NAME] (when a resident is having behavioral issues and need more staff support) called, but there would not have been enough staff to call a Code Green.<br><br>-Residents should be checked every two hours.<br><br>-There are about seven to eight residents who do not sleep through the night.<br><br>During an interview on 4/18/25 at 10:53 A.M. CNA F said:<br><br>-He/She has always worked on the Transition Unit and sometimes the whole facility by him/herself.<br><br>-Residents should be checked every two hours, every hour and some are every 15 minutes.<br><br>-Many times he/she was the only staff on the hall as the CMT leaves once they are done passing medications.<br><br>-He/She sat in the hall where he/she could see everything as there were some residents that were out a lot.<br><br>-There have been times when residents did not get their medications because there was no CMT or nurse for the Transition Unit.<br><br>-Sometimes the nurse would not come in at all or come in late.<br><br>-He/She would always go to the memory care side to help in the mornings until 6:00 A.M. when it was time to take the Transition Unit residents out to smoke.<br><br>During an interview on 4/18/25 at 11:45 A.M. NP B said:<br><br>-There are staffing concerns and not enough staff to manage the behaviors of the behavioral and mental health side of the Transition Unit.<br><br>-He/She was not aware medications were not being administered for any reason.<br><br>-There was not enough staff to do one on one supervision for residents who may need that kind of supervision.<br><br>During an interview on 4/21/25 at 3:25 P.M. CNA G said:<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -He/She changed positions to activities but has not been able to perform that job due to not enough staff to work the floor.<br><br>-He/She works on the floor as an CNA two to five days per week due to the lack of staff.<br><br>During an interview on 4/21/25 at 5:58 P.M. the Administrator in Training (AIT) said:<br><br>-When he/she started working in the facility, he/she was a weekend supervisor.<br><br>-On or about 3/30/25 he/she became the AIT.<br><br>-On 4/3/25 he/she came to the facility at 4:00 A.M. to pass the 5:00 A.M. and 6:00 A.M. medications and left the facility before 7:00 A.M.<br><br>-He/She was the Administrator on 4/15/25.<br><br>-The DON was off from 3/12/25 to 3/25/25.<br><br>-The DONs last day in the facility was 4/11/25.<br><br>-He/She was covering the DON position while he/she was off work.<br><br>-He/She was the AIT, RN coverage and floor nurse on 4/12/25 and 4/13/25.<br><br>-Interim DON started on 4/15/25.<br><br>-Staffing for each shift should be one nurse, one CMT and three CNAs. One nurse and two CNAs for the Memory Care Unit and one CMT and one CNA for the transition Unit. If no CMT then two CNAs for the Transition Unit.<br><br>-Memory Care CNAs take all residents who smoke out for smoke breaks.<br><br>-He/She had worked when only three staff to help with coverage.<br><br>-There should be two staff on the Transition Unit at all times to manage behaviors and ensure safety.<br><br>MO00252031<br><br>MO00252201 |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized service care plan that identified resident triggers and de-escalation needs to maintain the resident's highest physical, mental and psychosocial well being for one sampled resident (Resident #3) out of 13 sampled residents. The facility census was 49 residents.<br><br>Review of the facility Behavioral Contracts Policy dated 4/30/24 showed:<br><br>-Residents who exhibit behaviors which could endanger themselves, other residents, or staff may benefit from a behavioral contract to ensure they are receiving appropriate services and interventions to meet their needs.<br><br>-Mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in a psychological, biological, or developmental processes underlying mental functioning.<br><br>-Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.<br><br>-Substance use disorder is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.<br><br>-The interdisciplinary team, including the resident, and as appropriate the resident's family, should develop a behavioral contract with identified behaviors.<br><br>-Behaviors should be documented clearly and concisely by facility staff.<br><br>-Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and the outcomes of the interventions.<br><br>-Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care.<br><br>-The plan of care and behavioral contract should be reviewed at least quarterly for continued need of behavior management and appropriate interventions.<br><br>-A contract will only be used as a method of encouraging the resident to follow their plan of care, and not as a system of reward and punishment.<br><br>-The contract will not conflict with resident rights or other requirements of participation.<br><br>-The contract should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet his/her highest practicable well-being.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Review of Resident #3's admission Record showed the resident admitted on [DATE] with diagnoses including diffuse traumatic brain injury with loss of consciousness of unspecified duration sequela define and paranoid schizophrenia (a form of schizophrenia [a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others] characterized by persistent preoccupation with illogical, absurd, and changeable delusions, usually of a persecutory, grandiose, or jealous nature, accompanied by related hallucinations).<br><br>Review of the resident's Pre-admission Screening Resident Review (PASRR) dated 3/12/24 showed the resident:<br><br>-Had diagnoses including paranoid schizophrenia , personality disorder (mental health condition characterized by persistent, inflexible patterns of thinking, feeling, and behaving that deviate significantly from cultural expectations and cause significant distress or impairment in daily life), borderline intellectual functioning (a categorization of intelligence wherein a person has below average cognitive ability (generally an IQ of 70-85), but the deficit is not as severe as intellectual disability (below 70) and polysubstance dependence (condition where an individual meets the diagnostic criteria for substance use disorder (SUD) on two or more different classes of substances simultaneously, exhibiting significant problems and impairments in their lives due to their use of multiple substances, such as alcohol, stimulants, opioids, or sedatives).<br><br>-Recent physical altercation with another resident where he/she punched another resident in the face while out smoking on 2/19/24.<br><br>-Recent multiple falls.<br><br>-History of having a guardian.<br><br>-Had chronic medical and psychological condition requires around the clock medical care and oversight.<br><br>-Had multiple comorbidities requiring skilled care.<br><br>-Had resided in a skilled facility for many years.<br><br>-At that time he remained safest in a skilled nursing facility.<br><br>-Behaviors to be addressed were aggression, mood liability, and impulsivity.<br><br>-Required medication therapy and monitoring, structured environment for history of aggression towards other and high fall risk, and crisis intervention plan recommended due to aggression towards others.<br><br>Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 12/17/24 showed the resident was moderately cognitively impaired.<br><br>Review of the resident's Progress Note dated 3/1/25 at 6:32 P.M. showed:<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The resident came out of room multiple times disrobed and had to be redirected multiple times.<br><br>-The resident yelled and screamed at staff and other residents.<br><br>-The resident was redirected and educated on the importance of being polite and respectful.<br><br>-The resident attempted multiple times to get off the unit when others were trying to leave the unit.<br><br>-The resident attempted multiple times to go on the smoke porch partially disrobed.<br><br>-When asked if he needed any assistance the resident would try to manipulate the situation and had to be redirected.<br><br>Review of the resident's Progress Note dated 3/2/25 at 3:30 A.M. showed:<br><br>-The resident's peer came running out of his/her room to CNA hall monitor, that Resident #3 was naked in his/her bed.<br><br>-The CNA assisted Resident #3 out of his/her peer's bed helped him/her to get dressed and placed back in his/her bed.<br><br>-Called the DON to give report of resident's demeanor stated to send him/her out to ER for behavioral and undressing issues.<br><br>Review of the resident's Care plan dated 3/2/25 showed the resident:<br><br>-Had been disrobing and coming out of his/her room or going into other resident's rooms naked.<br><br>-Staff were to ensure protective oversight was provided.<br><br>-Interventions included:<br><br>--Administering medications as ordered.<br><br>--Education and re-education on the importance of dressing.<br><br>--Staff were to intervene as necessary to protect the rights and safety of others.<br><br>--He/she was sent to the ER for evaluation and treatment.<br><br>Note: No triggers for the behavior of disrobing were identified.<br><br>Note: No instruction for staff on how to redirect the resident's behavior of disrobing.<br><br>Review of the resident's Progress Note dated 3/9/25 showed:<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -At 7:19 A.M. he/she did not want to put his/her pants on, he/she had defecated in another resident's room, put his/her urinal full of urine at the nursing station, was cursing at staff, and was difficult to redirect.<br><br>-At 10:41 A.M. he/she was witnessed defecating and urinating on another resident's bed and on the floor of another resident's room. Nurse Practitioner A was notified and ordered the resident to be sent to ER for evaluation and treatment.<br><br>Review of the resident's Hospital Record dated 3/9/25 showed:<br><br>-The resident was given a laxative while at the facility and was throwing feces at the facility staff. The nursing facility had said the past four days the resident had been more aggressive, difficult to redirect, up urinating and defecating on the other residents' property in the facility.<br><br>-He/she presented to the ED for altered mental status and abnormal behaviors and rapid heart rate.<br><br>-He/she was admitted for medicine management of altered mental status.<br><br>-He/she had a low lithium blood level, his/her thyroid stimulating hormone (TSH) was high 16.5, it was unclear if he/she was taking the levothyroxine appropriately or an insufficient dose.<br><br>-He/she needed a sitter (one to one protective oversight) while in the hospital<br><br>Review of the resident's Comprehensive Discharge MDS dated [DATE] showed the resident was severely cognitively impaired.<br><br>Review of the resident's Hospital Discharge summary dated [DATE] showed:<br><br>-On 3/10/25 hospital staff spoke with the facility staff and it was reported one of the Nurse Practitioners (PA) had stopped Haloperidol (medication for agitation related to paranoid schizophrenia and schizoaffective disorder) 5 mg twice daily, risperidone (medication for schizophrenia) 2 mg twice daily, lorazepam (medication for anxiety disorder ) 0.5 mg twice daily and citalopram (medication for major depressive disorder) 30 mg daily, and replaced with olanzapine (medication for paranoid schizophrenia) 5 mg in the morning and 10 mg at bedtime on 3/5/25 and this was when the behavioral disturbances started for the resident.<br><br>-The hospital placed several calls to the facility to ascertain why the changes were made in the resident's psychiatric care. The staff at the facility mentioned there was concern about polypharmacy (the simultaneous use of multiple medications by a patient, often defined as five or more drugs) the resident was provided.<br><br>-At that time the decompensation correlated with medication changes made on 3/5/25 could explain the sudden change in his/her presentation.<br><br>-Hospital psychiatry recommended an increase in Olanzapine 10mg BID (twice a day) and ordered oral haloperidol 2mg every four hours with an IV as needed for acute agitation.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -He/she was discharged back to the facility with adjusted medication regimen after he/she was removed from restraints.<br><br>Review of the resident's medical record dated 3/14/25 showed:<br><br>-He/she had returned from the hospital. Immediately began behaviors such as throwing self on the floor and was unable to be redirected.<br><br>-The facility obtained an order for to the resident to go back to the hospital.<br><br>Note: There was no update to the resident care plan or update from the hospital admission with new interventions.<br><br>Review of the resident's Hospital Records dated 3/14/25 to 3/20/25 showed:<br><br>-The resident was discharged earlier today and was brought back from the facility due to combative behavior.<br><br>-During hospitalization 3/14/2025-3/20/2025, the patient continued to be managed on his/her mental health regimen.<br><br>-He/She was seen by the inpatient psychiatric team who commented that the patient likely had a acute decompensation of his/her chronic mental illnesses.<br><br>-There was no infectious or metabolic etiology identified for patient's increasing agitation.<br><br>-Patient had presented multiple times to hospital for behavior related concerns recently, i.e. throwing feces in the room of his/her nursing facility.<br><br>-Medical workup up complete and no reversible etiologies identified.<br><br>-Psychiatry had evaluated the patient, no medication changes.<br><br>-Patient was at baseline.<br><br>-Waxing and waning mentation at times.<br><br>-If nursing home unable to care for him/her, recommend they initiate placement to another facility.<br><br>-No medications were changed at discharge.<br><br>-On 3/20/2025 the patient was discharged in stable condition back to his facility.<br><br>Review of the resident's Progress Note dated 3/20/25 showed the resident returned to the facility.<br><br>Review of the resident's Progress Note dated 3/21/25 showed:<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Clinical team met to review new orders from hospital including how and when to administer as needed (PRN) medications for behaviors to avoid re-hospitalization.<br><br>-Discussed mild to moderate behaviors resistance to redirect and administer Haldol 2 mg po PRN and where behaviors have the potential for harm to self or others to use the Haldol IM.<br><br>-Discussed plan with NP B who is in agreement and will be in to see resident.<br><br>Note:There was no update to the resident care plan or update from the hospital admission with new interventions.<br><br>Review of the resident's Hospital Records dated 3/22/25 showed:<br><br>-He/she was brought to the emergency department due to multiple falls in his/her nursing home.<br><br>-Assessment trauma activation status post fall at his/her nursing facility.<br><br>-Reportedly, patient fell from his wheelchair, but he/she did not hit his/her head and there was no loss of consciousness.<br><br>-He/She had a history of a traumatic brain injury and per emergency services has difficulty speaking.<br><br>-He/She had a superficial abrasion beneath his/her left eye and above his/her left eyebrow but per nursing facility said these were present prior to this fall.<br><br>-CT scan of the face showed acute fractures involving bilateral distal nasal bones, with moderate fragment displacement.<br><br>Review of the resident's Care Plan dated 12/20/23 showed:<br><br>-The resident was a moderate risk for falls related to psychoactive drug use.<br><br>-Outcomes were the resident:<br><br>--Would not sustain serious injury.<br><br>--Would be free of falls.<br><br>--Would keep his/her bed in low position to maintain accessibility in and out of bed.<br><br>-Interventions included:<br><br>--Anticipate and meet resident needs.<br><br>--Review information on past falls and attempt to determine cause of falls.<br><br>--Remove any potential causes and educate as to causes.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | --The resident needs a safe environment including even floors free from spills and/or clutter and glare free light.<br><br>Review of the resident's Care Plan dated 2/15/25 showed:<br><br>-The resident noted to be laying on the floor of room.<br><br>-Resident to resume usual activities without further incident.<br><br>-Interventions included:<br><br>--For no apparent acute injury, determine and address causative factors of the fall.<br><br>--Monitor, document, and report as needed for 72 hours to physician for signs and symptoms of pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture or agitation.<br><br>Review of the resident's incident report dated 3/27/25 showed:<br><br>-The Administrator in Training (AIT) noticed a broken window next to an empty bed in Resident #13's room.<br><br>-Resident #13 denied breaking window.<br><br>Review of the resident's Hospital Records dated 4/16/25 showed he/she has been rejected from his/her facility for re-admission and psychiatry was consulted due to concern for his/her continued agitation and for assistance with medications.<br><br>During an interview on 4/10/25 at 3:03 P.M. the DON said:<br><br>-He/She did not feel the facility would be able to meet the resident's needs.<br><br>Note: Fall investigations for the resident were requested and not received.<br><br>-Resident discharged on 3/22/25 and had not returned, there were no updates to the care plan after 3/22/25.<br><br>Review of the resident's incident report dated 4/10/25 showed:<br><br>-Physician was notified of the resident's fall on 3/22/25 at 1:00 A.M.<br><br>-Disciplinary action required for nurse related to physician notification and fall protocol.<br><br>-Resident was found on the floor by the nurse sitting on the floor in front of his/her wheelchair.<br><br>-Full range of motion and appeared in no acute distress.<br><br>-Resident assisted to wheelchair.<br><br>(continued on next page) |

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|---|---|---|---|
| | 265532 | A. Building<br>B. Wing | 04/22/2025 |

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

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Later in the day, the resident was observed while sitting in wheelchair on the patio getting fresh air.<br><br>-Reported that he/she fell forward to ground from his/her wheelchair and landed on the left side of body, sustaining two abrasions to his/her the left knee and hematoma to left side of his/her forehead.<br><br>-Staff was within reach and could not get to the resident to stop the fall.<br><br>-The resident appeared to be drowsy per staff report.<br><br>-Note changes to mental and physical condition.<br><br>-Resident was changing both cognitively and medically.<br><br>-Resident sent to the hospital.<br><br>During an interview on 4/15/25 at 11:55 A.M. CNA A said:<br><br>-If a resident was to have behaviors he/she would tell the charge nurse and the nurse will come do his/her part.<br><br>-His/Her first action would be to stop the residents from fighting, then get the charge nurse and the nurse does the rest.<br><br>-Training for behavior management was done about a year ago, CPI (Crisis Prevention Institute) training in mental health equips staff with skills to prevent, de-escalate, and respond to crisis situations, prioritizing safety and well-being for both individuals and staff) and how to throw (put them down on the ground) them when having behaviors.<br><br>-He/She would go to the charge nurse to know how to work with the resident.<br><br>During an interview on 4/15/25 at 12:43 P.M. CNA B<br><br>-He/She had not had any behavior management training in the facility.<br><br>-If a resident was having behaviors, he/she would walk away, report to charge nurse, wait for the resident to calm down to revisit, and if the resident is out of control let the nurse handle it.<br><br>-He/She was not aware of any place to find information related to the resident's behaviors, triggers or interventions.<br><br>-If there is anything available for information related to resident specific behaviors, triggers and interventions, he/she had not seen it.<br><br>-Sometimes when the CNAs have asked about behavior information for the residents, the nurses have said the aides need to stay in their lane.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -All training he/she has received has been generalized training.<br><br>-He/She would go to the charge nurse to know how to work with the resident.<br><br>During an interview on 4/15/25 at 1:24 P.M. CMT A said:<br><br>-He/She used to run the behavior unit that was closed for remodel.<br><br>-He/She has not had any behavior specific training.<br><br>-There were some dementia training's last year sometime.<br><br>-The residents from the behavior unit have done okay, but some were out of control.<br><br>-In order to know what he/she was supposed to do for a resident having behaviors, he/she must discuss with the charge nurse.<br><br>-He/She can access the care plan for information, but the CNAs do not have that access.<br><br>-He/She worked with the resident downstairs.<br><br>-The resident's behavior was different since the move to the Transition Unit.<br><br>-The change had been gradual.<br><br>-The resident struggled with communication, which had gotten worse over time.<br><br>-De-robe was a new behavior over the last three months and he/she was very difficult to redirect.<br><br>-The resident was getting into other resident's bed's naked, upsetting those residents and putting him/her at risk to be harmed.<br><br>-The resident started getting weak and really wasn't the same person.<br><br>During an interview on 4/15/25 at 3:03 P.M. LPN A said:<br><br>-He/She has not had any behavior management training in the facility since he/she started about two months ago.<br><br>-He/She was trained on the job and had some behavior training the last time he/she worked in the facility.<br><br>-Knowing about the residents and observing residents was how he/she knew resident triggers.<br><br>-The licensed nurses had access to a [NAME] (a system for organizing and accessing information, used in nursing for quick patient-specific information, and by businesses for data storage and retrieval) for resident interventions for behaviors, the direct care staff do not have access.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -He/She has been showing the CNAs interventions for resident triggers.<br><br>During an interview on 4/15/25 at 5:08 P.M. LPN B said:<br><br>-He/She started working at the facility on 4/10/25.<br><br>-He/She did CALM and CPI training at orientation, but no other formal training for behavior management.<br><br>-Interventions for resident behaviors depends on the behavior, then after the behavior is identified he/she will determine the intervention.<br><br>-Sometimes information about the behavior, triggers and interventions were in the care plan or he/she would ask other staff.<br><br>-He/She had no training on how to access resident specific behavior information.<br><br>During an interview on 4/16/25 at 11:53 A.M. the SSD said:<br><br>-Care plans were behind and he/she had been trying to update the best he/she could.<br><br>-The regional care plan coordinator had been asked to come in to assist with updating care plans. There was not anyone in the facility to update the care plans.<br><br>During an interview on 4/16/25 at 2:32 P.M. Nurse Practitioner (NP) A said:<br><br>-Staff had reported a decline in the resident over the last few months.<br><br>-Resident needed assistance with decisions.<br><br>Review of Resident #13's Quarterly MDS dated [DATE] showed the resident was mildly cognitively impaired with no mood or behavior concerns documented.<br><br>During an interview on 4/16/25 at 4:46 P.M. Resident #13 said:<br><br>-He/She moved into room [ROOM NUMBER] about three to four weeks ago.<br><br>-The window was broken after he moved in by his/her roommate, Resident #3, who returned today.<br><br>-Resident #3 broke the window in the afternoon before he/she was sent to the hospital the last time on 3/22/25.<br><br>-He/She saw Resident #3 break the window.<br><br>-The Administrator knew about the broken window and tried to blame him/her.<br><br>-Although there have been staff in the facility, there were no staff on the Transition Unit.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/17/25 at 9:40 A.M. the AIT said:<br><br>-Resident #3 broke the window that was just repaired after returning from the hospital yesterday.<br><br>-Resident was placed on one-on-one supervision and relocated in room away from the window.<br><br>-He/She advised the resident's care plan was updated at admission.<br><br>Review of the resident's Care Plan for 4/17/25 showed:<br><br>-Problems listed on care plan include:<br><br>--At risk for COVID.<br><br>--admitted to facility for long term care.<br><br>--Facility would follow resident's advanced directive for code status.<br><br>--Had allergies that may put the resident at risk if used or given.<br><br>--PASRR evaluation Level II.<br><br>--Resident was on the stop program due to TBI and COPD.<br><br>---Approved five person CALM take down will not be used.<br><br>NOTE: No care plan for behaviors or falls.<br><br>During an interview on 4/17/25 at 4:18 P.M. the former DON said:<br><br>-The resident had a very odd and sudden decline and was exhibiting bizarre behaviors.<br><br>-There was indication of psychosis related to dementia and mental health diagnoses.<br><br>-Falls were new for the resident as well and they have been added to the resident medical record as a behavior.<br><br>-All of the residents medical records were in a box in the DON office.<br><br>-He/She did not know if Resident #3 broke the window, however there were concerns about his/her behaviors.<br><br>-Resident #3 was sent out initially for delirium and had a long hospital stay.<br><br>-Resident #3 had several emergency room visits with falls.<br><br>-There was discussion about medication changes and finding a good medication regimen for the resident.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -He/She noticed the resident's decline the first time the resident was sent out at the beginning of March. There was no identified plan for the decline.<br><br>-There resident was having bizarre behaviors and had several medications stopped and/or reduced.<br><br>-When the resident returned he/she did well for a couple of days and then continued to decline with motor ability, mobility and task management.<br><br>-The resident's decline was sudden and very odd.<br><br>-There was an indication of psychosis related to dementia and mental health diagnosis per the physician.<br><br>-The falls were new for the resident as well and had started laying on the floor prior to the delirium.<br><br>-Behavior management training was mandated at the first of the year online.<br><br>-CNAs were only able to observe and report behaviors. Direct care staff are to ask the nurses how to work with the residents behaviors.<br><br>-People that have been with the residents for a while would know what to do for behaviors.<br><br>-The nurse was responsible for relaying information to the staff on what to look for and what to do for each resident.<br><br>-Interventions were to be guided by the nurse.<br><br>During an interview on 4/18/25 at 9:41 A.M. CNA E said:<br><br>-He/She has been working at the facility since January 2024 and has not had any behavior management training.<br><br>-He/She has never seen anything for resident specific behaviors, triggers or interventions.<br><br>-All information related to the residents' behaviors was by word of mouth or the nurse would tell the staff.<br><br>During an interview on 4/18/25 at 10:53 A.M. CNA F said:<br><br>-He/She has always worked on the Transition Unit, at times worked the whole building by him/herself.<br><br>-He/She worked on the Transition Unit on 4/17/25 overnight when the resident had kicked the window out at around 10:00 P.M.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -There was no CNA from dayshift to give report and he/she realized the resident had returned to the facility after taking the residents out to smoke at 7:30 P.M. so he/she was not notified the resident had returned by a nurse.<br><br>-On 4/17/5 at 9:30 P.M. Resident #3 was beating the wall and yelling, the resident's roommate reported the resident had kicked out the window.<br><br>-He/She reported the broken window to the AIT between 5:00 A.M. and 6:00 A.M.<br><br>-Many times he/she was the only staff on the hall as the CMT leaves once they are done passing medications.<br><br>-There were some behavior management videos online, but they had been down and unable to access.<br><br>-Resident specific interventions have to be something that was written up, but he/she had not been trained on how to find that information.<br><br>During an interview on 4/18/25 at 11:45 A.M. NP B said:<br><br>-Around the beginning of March the resident was confused, was getting into things, there was not enough staff and he/she agreed to sent the resident out.<br><br>-He/She felt the facility did not have enough staff to manage the resident.<br><br>-There are staffing concerns that there was not enough staff to manage the behaviors of the behavioral and mental health side of the facility (Transition Unit).<br><br>-There was not enough staff to do one on one for residents who may need that kind of supervision.<br><br>-He/She was concerned there was not enough staff in the building to manage the behaviors for the residents on the Transition side who have histories of mental health and behavioral needs.<br><br>-There was not enough staff to have one to one supervision for a resident if needed.<br><br>-He/She was not aware of any behavior management training for the staff.<br><br>-He/She expected the staff to be able to find behaviors, triggers and interventions for the residents.<br><br>-He/She did not feel the PASRR was being utilized for all residents with mental health diagnoses.<br><br>Review of Resident #3's Progress Note dated 4/20/25 showed:<br><br>-6:06 A.M.<br><br>--Resident agitated and keeps yelling out nurse.<br><br>--Tried to change out dressings and resident refused said it could be done it tomorrow.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | --Residents and roommates keep getting into it with resident.<br><br>--He/she keeps going down on the floor, acting helpless and difficult to redirect.<br><br>--He/she keeps asking for water then spills it on the floor, snacks offered.<br><br>-2:01 P.M.<br><br>--Resident slid him/herself to the edge of wheelchair then slid to the floor landing on his/her buttock in the dining room.<br><br>--Staff witnessed, however was not close enough to intervene.<br><br>-There was no staff training, no additional information to the plan of care for the resident triggers or interventions.<br><br>During an interview on 4/21/25 at 3:56 P.M. CNA G said:<br><br>-He/She worked on the locked unit for the same gender before it closed due to flooding.<br><br>-The resident was moved to the Transition Unit and it had more stimulation, such as loud music.<br><br>-He/She had CPI training at the beginning of the year online, otherwise there was no other behavior management training.<br><br>-When residents have behaviors he/she will try to de-escalate and if unable to do so call a code for help.<br><br>-Resident specific behavior management information was shared by word of mouth.<br><br>-He/She was not aware of any source of information for resident specific behaviors, triggers and intervention.<br><br>During an interview on 4/21/25 at 6:30 P.M. the Administrator in Training (AIT) said:<br><br>-When he/she started working in the facility, he/she was a weekend supervisor.<br><br>-On or about 3/30/25 he/she became the AIT.<br><br>-He/She was unable to give an exact date of the prior administrator's last day.<br><br>-He/She was the administrator on 4/15/25.<br><br>-He/She was AIT and being trained by the Administrator to conduct an investigation on 3/31/25.<br><br>-Checks should have been done at 10:00 P.M., midnight and 2:00 A.M.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -If the nurse had completed checks like he/she was supposed to for the midnight census, the residents would have been observed no later than midnight.<br><br>-He/She expected the staff to do their checks and the charge nurse to ensure the checks were being done.<br><br>-He/She was aware of Resident #3's behavior becoming erratic at the beginning of the year.<br><br>-The resident was growling, yelling, screaming and putting self on the floor.<br><br>-The resident had been on the Transition Unit for approximately three months at that time.<br><br>-He/She noticed a rapid change in the resident from around Christmas to New Year.<br><br>-There had been some medications changes and psychiatric evaluations.<br><br>-By the beginning of March nothing was working and they were unable to manage the resident's behaviors no matter what they did.<br><br>-The resident was sent out on 3/10, 3/14, and again on 3/22.<br><br>-The resident returned to the facility on 4/16 and kicked out the window again that same day.<br><br>-When the resident is sent out the staff sends a medication list and the face sheet, the rest of the information related to the resident's transfer is given to the ambulance crew and the hospital verbally.<br><br>-The facility does not provide written documentation as to the change for which the resident was being transferred.<br><br>-When residents are transferred or admit/readmit to the facility he/she expects the nurses to document in the progress notes clear and concise information so the staff providing cares were able to identify behaviors, triggers and interventions for the resident.<br><br>-He/She knew the window in room [ROOM NUMBER] was broken and the Administrator reported the window was fixed on 3/26/25.<br><br>-He/She did not who would have fixed the window on that date as there was no in house maintenance person.<br><br>-It was the Administrator's responsibility to ensure the window was repaired, he/she was not the administrator until 4/15/25.<br><br>-The Regional Director of Operations was supposed to help him/her as he/she transitioned into the position.<br><br>-He/She was unable to identify the last day he/she worked for the Administrator.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The move to the memory care unit for Resident #3 was a great move as there was not as much chaos as the Transition Unit and more one-on-one engagement.<br><br>-The one-on-one supervision has been discontinued as there was more staff and extra oversight.<br><br>-Denied any knowledge of Resident #3 consuming chemicals on 3/14/25 resulting in his/her transfer to the hospital.<br><br>During an interview on 4/24/25 at 2:17 P.M. LPN C said:<br><br>-The resident was on the locked unit prior to moving to the Transition Unit.<br><br>-Over the last couple of months, he/she started noticing changes with the resident.<br><br>-The resident would not sleep at night, holler through the night, and would get into his/her wheelchair and argue with other residents.<br><br>-There was a new psych doctor that she thought was working with the resident.<br><br>-Since the resident was moved to the memory care unit on 4/21/25, the resident has done much better.<br><br>-He/She tried to get the administration to move the resident to the memory care unit, unfortunately it did not happen right away.<br><br>During an interview on 4/15/25 at 1:24 P.M. CMT A said:<br><br>-He/She has not had any behavior specific training.<br><br>-There were some dementia training's last year sometime.<br><br>-The residents from the behavior unit have done okay, but some are out of control.<br><br>-In order to know what he/she is supposed to do for a resident having behaviors, he/she must discuss with the charge nurse.<br><br>-He/She can access the care plan for information for the resident, but the CNAs do not have that access.<br><br>MO00252031<br><br>MO00252201 |