STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265532	A. Building B. Wing	10/23/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to ensure the residents' personal possessions were maintained and failed to ensure the residents' dignity when having to wear clothes that didn't fit or were not in good repair for five sampled residents (Residents #5, #41, #42, #43, and #10) and three supplemental residents (Residents #16, #21, and #50) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's policy, Dignity and Respect, dated 6/29/23 showed: -Every resident has a right to be treated with dignity and respect. -All the residents' possessions, regardless of their apparent value to others, must be treated with respect. -Residents have the right to retain and use personal possessions to assist each resident in maintaining their independence. 1. Review of Supplemental Resident #16's care plan dated 5/30/23 showed: -The resident: --Had impaired cognitive function. --Instructions to staff to encourage as much participation by the resident as possible during care activities. --Maintain consistency in timing of care activities as much as possible. -There were no details on how much assistance the resident needed for care activities including getting dressed. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 9/9/24 showed the following staff assessment of the resident: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Had clear speech. -Understood others and was understood by others. -Cognition was not assessed. -The resident's functional abilities (self-care abilities such as dressing, transferring from one surface to another, etc.) were not assessed. -The resident's diagnoses included dementia (a chronic condition that causes a person to lose the ability to think, remember, and reason to the point that it interferes with their daily life) and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). Review of the resident's inventory of personal effects dated 7/16/24 showed: -The resident had three pants and four shirts. -There were no updates to the resident's inventory. Observation on 10/18/24 at 6:23 A.M. showed: -The resident was wearing red sweatpants and a blue sweatshirt. -The sweatpants waist band was about twice the size of the resident's waist. -The resident was standing up in the dining room. -The sweatpants were down below the resident's brief. -The resident kept pulling up his/her sweatpants and trying to roll them up at the waist. Observation on 10/18/24 at 8:04 A.M. showed the resident's closet was completely empty. Observation on 10/21/24 at 2:11 P.M. showed: -The resident was standing in the dining room wearing plaid pajama pants that were too big around his/her waist. -The resident tried to pull his/her pants up to stay in place multiple times. During an interview on 10/23/24 at 10:01 A.M., Licensed Practical Nurse (LPN) B said the resident got into other residents' stuff and would put on layers of clothes that were not his/hers. 2. Review of Resident #43's care plan dated 8/8/24 showed: -The resident: --Had a diagnosis of schizophrenia. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Had cognitive deficits. -There were no details on how much assistance the resident needed for care activities including getting dressed. Review of the resident's quarterly MDS dated [DATE] showed: -The resident's speech was not assessed. -The resident's ability to understand others and to be understood by others was not assessed. -Cognition was not assessed. -The resident's functional abilities (self-care abilities such as dressing, transferring from one surface to another, etc.) were not assessed. Review of the resident's electronic health record showed no inventory of personal effects. The resident's inventory of personal effects was requested but not received. Observation on 10/21/24 at 1:48 P.M., showed: -The resident was in the dining room. -He/She was wearing blue sweatpants and a red sweatshirt. -The sweatshirt was above his/her stomach and his/her sweatpants were down to his/her hips, leaving the resident's stomach hanging out between the bottom of his/her sweatshirt and the top of the sweatpants. 3. Review of Supplemental Resident #21's care plan dated 7/12/21 showed the resident was independent with care activities. Review of the resident's inventory of personal effects dated 4/10/22 showed: -The resident had two comforters, 40 pairs of socks, and four sweat suits. -There were no updates to the resident's inventory. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Had clear speech. -Understood others and was understood by others. -Was severely cognitively impaired. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Was dependent upon staff for dressing and putting on footwear. -Some of his/her diagnoses included dementia and schizophrenia. Observation on 10/15/24 from 9:00 A.M. to 1:00 P.M. showed: -The resident's pants kept sliding down and staff pulled them up three times while the resident was in the dining room. -The resident's pants did not have a middle belt loop in the back. -When the resident would sit down, his/her pants would slide down. -At 10:30 A.M., the Director of Nursing (DON) came onto the unit. -The DON asked if the resident had a belt and staff said he/she did not. -The DON took a white plastic trash bag tied it to the resident's belt loops on the sides to keep his/her pants up. -The resident had the trash bag on until after lunch. Observation on 10/21/24 showed: -At 9:30 A.M., the resident walked out of the dining room while his/her pants were falling and he/she was trying to pull them up. -At 10:20 A.M., the resident was standing in front of the television in the dining room while his/her pants were falling and he/she was trying to pull them up. Review of the resident's trust fund current account balance dated 10/22/24 showed the resident had $893.71 in his/her account. Observation on 10/23/24 at 8:29 A.M. showed there were two shirts in the resident's closet. During an interview on 10/23/24 at 12:30 P.M., the DON said: -Using a trash bag to tie the resident's pants up was not an appropriate intervention. 4. Review of Resident #42's care plan dated 10/18/21 and 10/31/21 showed: -The resident had dementia. -The resident was independent with care activities except for needing cueing and supervision. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Had clear speech. -Understood others and was understood by others. -Was severely cognitively impaired. -Required partial assistance from staff for dressing and putting on footwear. -He/She had a diagnosis of dementia. Review of the resident's inventory of personal effects dated 10/16/24 showed the resident had one pullover, three t-shirts, three joggers, three polo shirts, one long-sleeve shirt, two sweatpants, two hoodies, two flannel pants, nine pairs of socks, five boxers, shoes, and one sweater. Observation on 10/18/24 showed: -At 7:14 A.M., a dietary staff member asked the resident, Why don't you tie your pants up? as the resident was walking down the hall wearing light blue pajama pants that were falling off. -At 7:15 A.M., the resident came back down the hall with the draw string tied on the blue pajama pants. -At 7:23 A.M., the resident was in the dining room while holding his/her pants up using his/her left hand on his/her left hip. -At 8:04 A.M., there was one black shirt in the resident's closet, and it had Resident #15's name on the inside tag. Observation on 10/23/24 at 8:33 A.M., the resident had two pants in his/her closet. 5. Review of Resident #10's incident note dated 9/12/24 showed: -The resident saw another resident sitting in the chair with his/her pants on. -The resident approached the other resident saying, You took my pants! -The nurse separated the residents. Review of the resident's care plan dated 9/29/22 and 1/9/23 showed: -The resident had a diagnosis of schizophrenia, psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions), and dementia. -The resident required assistance of one person for getting dressed. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Had clear speech. -Understood others and was understood by others. -Was severely cognitively impaired. -Required substantial/maximum assistance with dressing. -Did not walk. -Some of his/her diagnoses included dementia, and schizophrenia. Review of the resident's undated inventory of personal effects showed the resident had one coat, seven shirts, one hoodie, two [NAME], one pair of shorts, three pairs of jeans, two pajamas, and one pair of sweatpants. During an interview on 10/16/24 at 9:25 A.M., the resident's responsible party said: -He/She thought the resident had so many clothes he/she couldn't even begin to describe them all. -He/She brought him/her jogging suits. -The resident's name was on his/her clothes. -The resident told him/her on Saturday, 10/12/24 that another resident recently broke his/her television. -The resident's television was brand new. -The staff did not talk to him/her about the resident's television being broken. Observation on 10/16/24 at 10:11 A.M. showed: -The resident had 12 short-sleeve tops, one pair of shorts, two pairs of pants, one jacket, one sweatshirt, one sweat suit, and one coat. -Of the items in the resident's closet, the resident's name was on seven shirts, one pair of shorts and one coat but another resident's name was written in black marker on the front right side of the coat that was clearly visible. Observation on 10/21/24 at 9:42 A.M. showed: -There was a television on the resident's overbed tray. -The screen was cracked and shattered and had multi-color lines going across the television on the top half. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's trust fund current account balance dated 10/22/24 showed the resident had $4,951. 26 in his/her account. During an interview on 10/23/24 at 8:55 A.M., the Social Service Director said: -He/She worked at the facility for six weeks. -He/She was told yesterday that the resident's television was broken. -A solution for that would be to have the family replace the television because stuff like that happened in the facility. -Another option might be that there might be an extra television in the one in the attic or somewhere else. During an interview on 10/23/24 at 10:29 A.M., LPN B said he/she was not aware of the resident's television being broken. During an interview on 10/23/24 at 10:30 A.M., Certified Nursing Assistant (CNA) C said he/she saw the resident's television was broken but he/she didn't know how or when it got broken. During an interview on 10/23/24 at 12:30 P.M. the DON said: -He/She had not heard about the resident's television being broken. -The resident's television should be replaced and the family should be notified. 6. Review of supplement Resident #50's inventory of personal effects dated 8/23 showed: -The resident had four pairs of pants, four shirts, one pair of shoes and six pairs of socks. -There were no updates to the resident's inventory. Review of the resident's care plan dated 7/3/24 showed: -The resident had cognitive impairment with a communication deficit. -The care plan did not address the level of assistance required for the resident's care activities such as getting dressed. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Had clear speech. -Understood others and was understood by others. -Was severely cognitively impaired. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Some of his/her diagnoses included dementia and schizophrenia. Observation on 10/21/24 at 2:07 P.M. showed: -The resident walked through the dining room wearing gray sweatpants that kept falling. -The resident's brief was visible. -The resident was holding his/her pants at the waist, trying to keep them up. Review of the resident's trust fund current account balance dated 10/22/24 showed the resident had $118.73 in his/her account. Observation on 10/23/24 at 8:29 A.M. showed the resident had six shirts in his/her closet. 39469 7. Review of Resident #5's annual MDS dated [DATE] showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Diabetes (a disease in which the body ' s ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). -Dementia. -Parkinson's (a disorder of the central nervous system that affects movement often including tremors). -Depression. -Bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to maniac highs). -Psychotic Disorder (a mental disorder characterized by a disconnection from reality). -Schizophrenia. -It was somewhat important to choose the clothing he/she wore. -It was somewhat important to take care of his/her personal belongings. -The resident resided on a locked Memory Care unit. Observation on 10/18/24 at 7:42 A.M. with CNA C showed: -The resident had one shirt hanging in his/her closet. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There were no belongings in his/her dresser. -The resident was dressed with high top tennis shoes that did not have shoe laces in them. -The resident did not have socks on. Observation on 10/18/24 at 9:28 A.M. with LPN B showed: -The resident was complaining about a sore on his/her foot. -The resident was wearing high top tennis shoes that did not have shoe laces in them. -The resident had a new blister on his/her left great toe. -He/She cleansed the area and applied a Band-Aid to it. During an interview on 10/18/24 at 9:28 A.M. LPN B said: -The high top tennis shoes belonged to the resident. -If the resident had shoe strings in the tennis shoes and wore socks he/she would not have developed a blister. -Most of the residents do not have much clothing. -The CNA's should have ensured the resident had socks and his/her shoes were tied correctly. -Many of the residents on the unit went shopping going into other resident's closets and take their clothes to wear. -Sometimes it would lead to a fight if a resident saw someone else wearing his/her clothing. Review of the resident's Resident Trust Fund account on 10/22/24 showed he/she had a balance of $978.16. 8. Review of Resident #41's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Dementia. -Cognitive communication deficit. -Need for assistance with personal cares. Review of the resident's Care plan dated 10/8/21 showed: -He/She had a history of wondering throughout the unit, could become intrusive into peers personal space. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff was to monitor if he/she was looking for something. Review of the resident's undated inventory list showed the following clothing: -One pair of pants. -One sweater. -One coat. -One cut up shirt. -One arm sling. -One pair of shoes. -The inventory list was not signed. Review of the resident's inventory list dated 6/3/22 showed the following clothing: -One pair of blue and gray pajamas. -One pair of green pants. -One blue suit. -One jogging set. -One blue jacket. Observation on 10/16/24 at 9:45 A.M. showed: -The resident had on black boots that were several sizes too big. -There were no shoe laces in the left boot. During an interview on 10/16/24 at 9:45 A.M. LPN A said: -The boots the resident was wearing were not his/hers. -The resident had a communication problem, he/she understood most English but would only answer with a single word. -He/She did not know where the resident was from or which language he/she spoke. -The residents would go shopping in each others room all the time. -He/She did not know if the resident had any shoes of his/her own. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/16/24 at 9:50 A.M. Certified Medication Technician (CMT) C said: -There was one shirt and one pair of pants in the resident's closet. -The resident was wearing black boots that were many sizes too large. -One boot did not have any shoe strings. -The resident would put on other people's clothes and shoes. -Those were not the resident's shoes. -The residents go shopping in each others closet. -They have tried to redirect him/her but there was a language barrier with him/her. -The residents should have their names written in their clothing. -The Social Worker or nurse would have put their name on their clothing. -The residents should have their belongings such as clothing listed on an inventory sheet when they first come into the facility. -All the residents clothes were put in one or two closets. -Staff would look for the resident's clothes but end up using whatever they think would fit him/her. -There was a cardboard box full of clean socks which they pulled out a pair and put on the residents. -There were hospital gowns for the residents to wear to bed but usually they slept in their clothes. -The residents should have had their own clothing and belongings in their own closet but it was too hard to keep up with. -Most of the residents were incontinent of bowel and bladder and they would wear disposable briefs. -He/She did not know about the residents who wore underwear where they got those. Review of the residents Resident Trust Fund account showed he/she had a balance of $1106.04. 9. During an interview on 10/21/24 at 9:10 A.M. the facility's Physician said: -He/She would expect the residents to wear their own clothes and they should fit them. -The facility should have provided clothing if the residents did not have enough. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/22/24 at 10:00 A.M. the Social Service Director said: -The residents should have had an inventory list made of their belongings upon admission. -The inventory list should have been accurate, dated, and signed by the person who had completed it. -Environmental Services brought personal items into his/her office and they put the resident's name on the belonging. -He/She documented the belongings in the computer system. -If the residents did not have enough clothing there were extra clothing in the attic that had been donated. -Some of the residents had money in their resident account that could have been used to purchase needed clothing. -Some of the residents had family that would purchase needed items for the resident. -The residents should have had enough pants or shorts to cover their briefs. -It was not acceptable to use others clothing. -Staff should have taken the resident back to their room and redressed them in their own clothing if they had been observed with someone else's clothing on. -It was the CNA's responsibility to keep the resident's belongings in their own closet or dresser. During an interview on 10/23/24 at 8:55 A.M., The Social Services Director said: -He/She worked at the facility for six weeks. -He/She was aware of only one resident missing clothes and that resident no longer lived at the facility. -The facility and the family were responsible for residents' clothes. -The facility could help shop for clothing. -It should be reported by the unit staff to him/her that when a resident didn't have any clothes that fit. -He/She has seen that residents are wearing clothes that don't fit. During in interview on 10/23/24 at 9:00 A.M. LPN B said: -The CNA's were responsible for the resident's clothing. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff should privately take the resident to get something that fits if their pants are falling down or change out of the clothing if it was not theirs. -The residents on the locked unit seemed to frequently loose belts. -They should try to keep extra belts around. -They could try sweat pants if the resident's clothes don't fit. -The resident's clothing should have fit well and been kept in good repair. -Staff should notify the Social Services Director if the resident had no clothes. -Residents should wear their own clothing. -The resident's shoes should have had shoe laces.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Care Center	2323 Swope Parkway 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #41) who was identified as a person with limited English proficiency was provided with a means of translating into his/her language so the resident could have been fully evaluated and participated in activities on his/her unit out of 12 sampled residents. The facility census was 50 residents. 1. Review of Resident #41's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Dementia (a group of thinking and social symptoms that interferes with daily functioning). -Cognitive communication deficit (a communication impairment that was caused by an underlying cognitive deficit, rather than a speech or language deficit). -Need for assistance with personal care. -The resident had a guardian. -The resident resided on a locked Memory Care unit. Review of the resident's care plan dated 6/26/24 showed: -He/She was at risk for impaired communication due to language barrier. -Staff was to incorporate alternate means of communication such as music, song or visual demonstration, dated 10/18/23. -Staff was to incorporate visual prompting, cues or gestures. -Staff was to offer alternative communication needs by offering language cards or translating system, dated 10/18/23. -Staff was to give the resident as many choices as possible about care and activities, dated 7/8/21. -Staff was to identify pattern of wandering; was wandering purposeful, aimless, or escapist. Was he/she looking for something, did he/she need more exercise. -Staff was to provide positive feedback, stop and talk with him/her when walking by, dated 5/30/24. -Explain all procedures to the resident before starting, dated 5/30/24. -Provide a program of activities that was of interest and accommodated the residents status, dated 5/30/24. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's notes on 8/14/24 showed: -Unable to fully assess. -He/She had difficulty responding to generalized and or open-ended questions. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 9/18/24 showed: -The Brief Interview for Mental Status (BIMS) was blank, the area was checked that it should have been completed. -He/She never had anyone read instructions or other written material from the physician or pharmacy. -Assessment for memory area was blank. -Cognitive skills for daily decisions was blank. -Interview for daily and activity preferences was blank. -Dementia was not checked. -Pain assessment was checked that it should be done. -No pain was checked. -Current smoker not checked. Observation on 10/15/24 at 9:55 A.M. showed: -The resident laying in bed fully clothed. -He/She appeared to be of Asian descent. -He/She declined to be interviewed. During an interview on 10/15/24 at 1:35 P.M. the resident's guardian said: -He/She did not know where the resident was from or what language he/she spoke. -When he/she had talked to the resident he/she would just grunt. During an interview on 10/16/24 at 10:30 A.M. agency Licensed Practical Nurse (LPN) A said: -He/She did not know where the resident was from or what language he/she spoke. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If he/she knew which language the resident spoke he/she would have used the translator on his/her phone. -The resident understood some English and would respond with one word answers. During an interview on 10/18/24 at 6:20 A.M. Registered Nurse (RN) A said: -He/She did not know what language the resident spoke. -He/She had tried to use Spanish and French on his/her phone translator which did not work. -The resident had been at the facility for a couple of years and which language he/she spoke should have been in his/her care plan and it was not. -He/She could not find any documentation in the resident's chart of where he/she was from or what language he/she spoke. -The resident did understand some English but usually only grunted for an answer when asked a question. -Staff would make gestures to the resident but could not ask him/her questions. During an interview on 10/18/24 at 8:10 A.M. LPN B said: -The resident had been at the facility for a couple of years. -He/She could understand English but did not know what language the resident spoke. -The staff would gesture to the resident about food usually and he/she seemed to understand that. -The Social Service Director should have assessed the resident for his/her primary language upon admission. -The resident's care plan should have showed his/her preferences but those areas were blank. During an interview on 10/21/24 at 9:10 A.M. the facility physician said: -He/She was new to the facility and had not evaluated the resident. -He/She was not aware English was not the resident's primary language. -He/She would have expected the staff to have known which language the resident spoke and had a means of translation in place such as the translator on the phone or a sheet with pictures on it. During an interview on 10/21/24 at 9:50 A.M. Certified Medication Technician (CMT) C said: -He/She did not know where the resident was from or the language he/she spoke. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was hard to communicate with the resident. -The facility did not have a translation/picture sheet, a translator phone, or translator available. -They could not get the resident to join in activities. During an interview on 10/22/24 at 10:30 A.M. agency LPN A said: -The resident would put on another resident's clothes and the staff had a hard time redirecting him/her related to the problem with communication. -The resident had never had any visitors to help with his/her history. During an interview on 10/22/24 at 1:00 P.M. the Social Service Director said: -He/She did not know where the resident was from or which dialect he/she spoke. -The resident's background should have been in his/her medical chart, it was not. -He/She did not know how the resident could have been evaluated if staff could not speak to him/her in a language he/she could fully understand. -No family was listed on the resident's chart. During an interview on 10/22/24 at 2:30 P.M. the Social Service Director said: -He/She had called the guardian who had family phone numbers so he/she could speak to them. -The family said the resident was from Korea and was able to understand some English. -The family said the resident had been abusive to them so they had distanced themselves from him/her and would not be involved with his/her cares. -Staff should have had a picture gram to communicate basic needs with the resident, they did not have one. -Staff had told him/her it was hard to toilet or shower the resident related to the communication difficulties. -The resident should have been evaluated upon admission which would have included which language he/she spoke and that should have been documented in his/her care plan. -The resident did not have a Brief Interview for Mental Status (BIMS -a test which showed if he/she was cognitively intact), which should have been completed upon admission. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident should have had a Pre Admission Screening and Resident review (PASRR - a federally mandated program that requires all states to prescreen all people regardless of payer source or age seeking admission to a Medicaid certified nursing facility) done before admission, it was not done. -The facility needed to break the communication barrier. -The resident would need to see a Psychologist that had access to a translator to adequately evaluate the resident. -The facility would need to obtain a translator phone line, they do not have one at this time. -The facility did not know if the resident even had any form of identification. During an interview on 10/23/24 at 12:30 P.M. the Director of Nursing said: -If a resident's primary language was not English, the staff were expected to look at the care plan to know how to communicate with the resident. -Staff should have had a visual picture board, a translation phone or through pictures to communicate with this resident. -He/She was not sure if the facility had a contract with a translation company. -An activity and interest assessment should have been completed upon admission and documented in the computer on the resident's medical chart. -When the resident first came to the facility they were using paper charts and his/her language was on the paper chart but had not transferred to the computer chart. -There should have been a process in place to communicate with the resident in his/her own language.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on interview and record review, the facility failed to ensure a Notice of Medicare Provider Non-Coverage (NOMNC) ((Centers for Medicare and Medicaid Services (CMS) form CMS-10123) and a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form (CMS)-10055) was provided to the resident or their representative for two sampled residents (Residents #2 and #19) out of two sampled residents who were discharged from Medicare part A (insurance that covers inpatient hospital care, skilled nursing facility, lab tests, surgery, home health care for individuals who are [AGE] years of age and above or disabled). The facility census was 50 residents. Review of the undated Form Instructions for the NOMNC CMS-10123 form showed the NOMNC must be delivered at least two calendar days before Medicare coverage services end. Review of the CMS memo (S&C-09-20), dated 1/9/09, showed: -The NOMNC, form CMS-10123 is issued when all covered Medicare services end for coverage reasons. -If the SNF believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled using the SNF ABN (form CMS-10055). -The SNF ABN provides an estimated cost of items or services in case the beneficiary had to pay for them him/herself or through other insurance they may have. -If the SNF provides the beneficiary with either the SNF ABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination. Review of the facility policy titled Resident's Rights dated as revised 7/5/23 showed the facility must inform the resident periodically during the resident's stay of services available and of charges for those services, including any charges for services not covered under Medicare. 1. Review of the facility's Beneficiary Notice - Residents discharged within the last six months form showed: -Two residents were discharged off Medicare Part A benefits in the facility over the last six months. -Resident #19 was discharged off Medicare Part A benefits on 9/17/24 and remained in the facility. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #2 was discharged off Medicare Part A benefits on 10/10/24 and remained in the facility. Review of the residents' medical records showed there were no SNF ABNs and no NOMNCs for Residents #19 and #2. During an interview on 10/22/24 at 9:18 A.M., the Director of Nursing (DON) said: -The Social Services Director was the person responsible for providing the SNF ABNs and NOMNCs to the residents and/or their responsible parties. -The previous Social Services Director just quit and walked out of the facility so there was a period where they did not have a Social Services Director. -They also had a time period before the previous Social Services Director was hired where they did not have a Social Services Director. -They have a new Social Services Director now. -No one had sent the notices to Residents #2 and #19 and/or their responsible parties. -He/She just sent Resident #2's notice to his/her Public Administrator (a county official with the responsibility to handle the affairs of someone who has no known or available relative, friend, guardian, or executor). -Resident #19's notice was not done yet. During an interview on 10/23/24 at 8:55 A.M., the Social Services Director said: -He/She had been working at the facility for six weeks. -He/She just learned he/she was responsible for the sending the residents and/or their responsible parties the beneficiary notices. -They were supposed to give the beneficiary notices a couple days prior to services ending.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation, interview, and record review, the facility failed to provide a safe, clean, homelike environment for residents in the resident rooms and shared bathrooms. Specifically, resident rooms on the locked dementia unit #104, #105, #102, #106, #103, #101 and #207 had no toilet paper, paper towels, or soap for the residents to utilize after toileting, resident rooms on the locked dementia unit #104, #102, #106, and #105 had broken toilet paper holders, broken or missing baseboards, broken drywall, broken or dirty door vents, missing molding, and resident rooms #104 and #207 were dirty with feces and a dark brown/blackish mold-like substance on the floors and walls. The facility census was 50 residents. Review of the facility's Safe and Homelike Environment policy dated 6/5/24 showed: -Housekeeping and maintenance services will be provided as necessary to maintain a sanitary and comfortable environment. -The facility will maintain bed and bath linens that are clean and in good condition. -Report any furniture disrepair to Maintenance promptly. 1. Observation on 10/15/24 at 12:50 P.M. of resident room [ROOM NUMBER] showed: -The room was equipped for three residents. -There were two residents that shared the room. -The mattress on bed 3 was ripped up and not in an easily cleanable condition, the privacy curtain was ripped, and the blinds were broken. -The toilet was missing a toilet bowl lid. -The bathroom did not have paper towels, toilet paper/toilet paper holder, or soap in the soap dispenser. -There was a large hole in the floor underneath the sink. -The walls were covered in a dark brown/black mold-like substance. -The floor vent was covered in a dark brown/black mold-like substance. -The bathroom had feces on the floor and wall, 2. Observation on 10/16/24 at 1:00 P.M. showed the resident's bathroom in room [ROOM NUMBER] there was no paper towels, soap, or toilet paper. There were four residents that shared the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was feces on the floor and dirty underwear. -Feces was smeared on the stool. During an interview on 10/16/24 at 1:05 P.M., Housekeeper A said he/she had just finished cleaning the resident's room. 3. Observation on 10/18/24 at 9:00 A.M. showed resident rooms on the locked dementia unit: -Resident room [ROOM NUMBER] which housed four residents did not have paper towels, toilet paper/toilet paper holder, or soap in the soap dispenser. -Resident room [ROOM NUMBER] which housed four residents did not have paper towels, toilet paper/toilet paper holder, or soap in the soap dispenser. -Resident room [ROOM NUMBER] which housed four residents did not have paper towels, toilet paper/toilet paper holder, or soap in the soap dispenser. Observation on 10/18/24 between 12:59 P.M. and 1:41 P.M. on the locked dementia unit showed the following: -In resident room [ROOM NUMBER] the wall-mounted toilet paper holder holder only had one side present and there was no toilet paper present in the bathroom. -The resident room [ROOM NUMBER] bathroom had baseboard on the left wall left of the toilet coming off which revealed the broken drywall underneath and there were two pieces of dried shriveled food in the under-sink cabinet with one broken door hinge. -There was a dirty toilet paper roll on the back of the toilet in resident room [ROOM NUMBER] and inside the double closets most of the baseboards were missing. -In resident room [ROOM NUMBER] the outside bathroom door vent on its lower quarter was askew and the inside door vent of the other door to an adjoining room was the same way; the wall-mounted toilet paper holder bar was missing. Observation on 10/21/24 at 10:20 A.M. on the locked dementia unit showed resident rooms #101, #102, and #105 did not have toilet paper, paper towels, or hand soap in their rooms. Observation on 10/21/24 between 10:29 A.M. and 10:41 A.M. on the locked dementia showed the following: -In resident room [ROOM NUMBER] the south door jamb to a double closet had its left side molding missing approximately (app.) 18 inches (in.) from the floor up and the right side was completely gone. -The southeast upper wall vent in resident room [ROOM NUMBER] had excessive lint on its louvers (a set of angled slats or flat strips fixed at regular intervals in a vent, shutter, or screen to allow air to pass through). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The northeast upper wall vent in resident room [ROOM NUMBER] had excessive lint on its louvers. 4. During an interview on 10/18/24 at 10:10 A.M., Certified Medication Technician (CMT) B said: -Staff did not put paper towels or soap in the resident bathrooms on the locked dementia unit because the residents would eat the soap or flush the paper towels down the toilet. -There should be toilet paper in the rooms. During an interview on 10/21/24 at 9:50 A.M., CMT C said: -Staff did not put paper towels in the resident's restrooms on the locked dementia unit as they would flush them down the toilet and it would stop it up. -The rooms on the locked dementia unit should have toilet paper but they usually did not. -They did not stock hand soap in the resident rooms on the locked dementia unit as the residents would eat it. -He/She did not know how or when the residents cleaned their hands. During an interview on 10/21/24 at 10:30 A.M., Agency Licensed Practical Nurse (LPN) A said: -The residents on the locked dementia unit would get into everything so they could not put soap, paper towels, or toilet paper in the rooms as they flush it down the toilet or eat the soap. -He/She did not know if the residents cleaned their hands. -Most of the residents wore disposable briefs. -Staff should help them cleanse their hands before meals. During an interview on 10/23/24 at 12:30 P.M., the Director of Nursing (DON) said: -There should be toilet paper, paper towels and soap in each resident's bathroom. -He/She had not seen bathrooms with no paper towels. -If an item, such as a chemical, had not have around children, then he/she had told staff to use that same decision-making process and not let those items around residents. -The rooms should have trash cans. -Staff should do constant rounds and should assist residents with hand hygiene, including before the residents eat. -He/She would expect the resident beds to at least have a bedspread. The Certified Nursing Assistants (CNA) were responsible to ensure beds were made. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All walls should be cleaned, they should not have rust or red stuff on it. During an interview on 10/23/24 at 2:03 P.M. the Administrator said the following: -There were plans to fix any broken baseboards, doors, and jambs. -He/She had sent requests to their corporate office to finish renovations on occupied rooms. -He/She would expect bathroom fixtures and any vents to be complete, intact, and clean. MO00243433

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42955 Based on interview and record review, the facility failed to ensure that an alleged allegation of abuse was reported to the state agency within the required time frame of no later than two hours after the allegation was made for one sampled resident (Resident #23) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's Abuse and Neglect Policy, dated 6/12/24, showed: -The facility reported all allegation of abuse/neglect/exploitation or mistreatment were reported immediately to the Administrator of the facility and other appropriate agencies in accordance with current state and federal regulations. -Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. -Instances of abuse that caused physical harm, pain, or mental anguish. -This included verbal abuse, sexual abuse, physical abuse, and mental abuse. -Sexual abuse was defined as non-consensual touching of any kind. -Each resident had the right to personal privacy of not only his/her own physical body, but also his/her personal space. -When a suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the facility followed the following procedures: --Respond to the needs of the resident. --The administrator completed an investigation. --Notify the state survey agency a soon as possible, but no later than 24 hours after discovery of the incident. 1. Review of Resident #23's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 8/8/24 showed: -The resident was severely cognitively impaired. -The resident was diagnosed with dementia (loss of memory, language, problem-solving and other thinking abilities), anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), and a stroke (something blocks blood supply to part of the brain or when a blood vessel in the brain bursts). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Electronic Health Record (EHR) progress notes dated 9/19/24 showed: -The resident's guardian reported that the resident stated another resident had been touching him/her. -The guardian was assured that the facility would take the matter seriously and do an investigation and take actions to remediate any concerns. Review of the ASPEN Complaints/Incidents Tracking System (ACTS-an automated computer system utilized by the state agency to track complaints and self-reports of abuse, neglect, and/or exploitation) showed no self-reports were called into the state from the facility regarding an incident with the resident on 9/19/24. During an interview on 10/18/24 at 9:05 A.M., the Administrator said: -There was a self-report complaint on 9/26/24. -There were no previous incidents regarding the resident. -The reason it was not reported was because the resident was unable to confirm what the guardian told the Director of Nursing (DON). During an interview on 10/18/24 at 10:41 A.M., the DON said: -He/She called the guardian back to review his/her concerns. -The guardian wasn't sure if what the resident said was true or not, regarding the other resident who came in the resident's room and touched him/her. -Conversations with the resident were vague. -He/She completed an investigation in a notebook. During a follow up interview on 10/23/24 at 12:32 P.M., the DON said: -No report was made to the state due to the resident not specifying any details of the incident. -There were no indications of being harmed. -All information was inconclusive.

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Parkway Health Care Center	2323 Swope Parkway Kansas City, MO 64130

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative(s) of a transfer to a hospital, including the reasons for the transfer in writing for three sampled residents (Residents #14, #60, and #10) out of 13 sampled residents. The facility census was 50 residents. Review of the Facility's Notification of Changes Policy dated 5/14/2024 showed: -The purpose of the policy was to ensure that the facility promptly informed the resident, consulted the resident's physician; and notified, consistent with his/her authority, the resident's representative when there was a change requiring notifications. -The facility must have informed the resident, consulted with the resident's physician, and/or notified the resident's family member or legal representative when there was a change that required such notification. -Circumstances that required notification were a significant change in the resident's physical, mental, or psychosocial condition, such as deterioration in health, mental, or psychosocial status. -Circumstances that required notification were a transfer or discharge of the resident from the facility. 1. Review of Resident #14's discharge Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 3/12/24, showed: -The resident was discharged to a hospital with his/her return anticipated. Review of the resident's discharge MDS dated [DATE], showed: -The resident was discharged to a hospital with his/her return anticipated. Review of the resident's quarterly MDS dated [DATE], showed: -The resident was moderately cognitively impaired. Review of the resident's admission record dated 10/18/24, showed: -The resident was his/her own responsible party. -The resident's original admitted was 9/8/16. -The resident's re-admitted was 6/12/24. Review of the resident's medical record on 10/21/24 at 11:30 A.M., showed: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No discharge notice dated 3/12/24. -No discharge notice dated 6/12/24. 2. Review of Resident #60's discharge MDS dated [DATE], showed the resident was discharged to a hospital with his/her return anticipated. Review of the resident's quarterly MDS dated [DATE], showed the resident was cognitively impaired. Review of resident's discharge MDS dated [DATE], showed the resident was discharged to a hospital with his/her return not anticipated. Review of the resident's medical record on 10/18/24 at 6:40 A.M., showed: -No discharge notice dated 6/30/24. -No discharge notice dated 8/13/24. 3. During an interview on 10/21/24 at 11:56 A.M., the Director of Nursing (DON) said: -A notice of transfer should have been given to a resident in writing when the resident was sent out to the hospital. -A notice of transfer was not given to Resident #14 at either time of the resident's hospital transfers. -He/she had no information on Resident #60's transfer notice and was not sure if it was done. -He/she was working on a plan to prevent this from happening in the future. During an interview on 10/23/24 at 11:38 A.M., Licensed Practical Nurse (LPN) B said: -The nurses were responsible for sending the transfer notices when a resident was transferred to the hospital. -The DON had been stepping in and helping with the transfer notices. -He/she was unsure why the transfer notices were not given to Resident's #14 and #60 and/or the resident's guardian's. 22727 4. Review of Resident #10's discharge assessment with return-anticipated dated 1/2/24 showed the resident discharged to an acute hospital. Review of the resident's entry tracking forms showed the resident returned to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's discharge assessment with return-anticipated dated 1/16/24 showed the resident discharged to an acute hospital. Review of the resident's entry tracking forms showed the resident returned to the facility on [DATE]. Review of the resident's medical record showed no transfer/discharge notice for 1/2/24 or 1/16/24. The transfer/discharge notices for 1/2/24 and 1/16/24 were requested on 10/21/24 but were not received. During an interview on 10/21/24 at 10:07 A.M., LPN A said the nurses were supposed to send the transfer/discharge notice when a resident was being discharged to the hospital. During an interview on 10/23/24 at 12:30 P.M., the DON said the nurses were responsible for sending the transfer/discharge notice when a resident was being discharged to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on interview and record review, the facility failed to provide a bed hold notification to a resident or resident representative upon transfer or discharge for three sampled residents (Resident #14, #60, and #10) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's Bed Hold Policy, date 11/6/23, showed: -When a resident was admitted to the facility, they received a copy of the bed hold policy from the Admission Packet. -When a resident was discharged to the hospital or went on therapeutic leave, the facility provided a copy of the Bed Hold Policy to the resident or resident representative. -When a resident was admitted following a hospitalization or therapeutic leave, the resident will be admitted to the facility if they continue to require services from the facility and was eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 1. Review of the facility's resident discharge list dated March 2024, showed: -Resident #14 was discharged on [DATE] to the emergency room (ER). -There was no bed hold documentation in the resident's medical record. Review of the facility's resident discharge list dated June 2024, showed: -The resident was discharged on [DATE] to the ER. -There was no bed hold documentation in the resident's medical record. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 9/16/24, showed the resident was moderately cognitively impaired. Review of the resident's admission record dated 10/18/24, showed: -The resident was his/her own responsible party. -The resident's original admitted was 9/8/16. -The resident's re-admitted was 6/12/24. 2. Review of the facility's resident discharge list dated June 2024, showed: -Resident #60 was discharged on [DATE] to the ER. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no bed hold documentation in the resident's medical record. Review of the resident's discharge MDS dated [DATE], showed: -The resident was discharged return anticipated. -There was no bed hold documentation in the resident's medical record. Review of the resident's quarterly MDS dated [DATE], showed the resident was cognitively impaired. Review of the resident's nursing note dated 8/13/24, showed: -Emergency Medical Services (EMS) was called and the resident was sent to the ER. -There was no bed hold documentation in the resident's medical record. 3. During an interview on 10/21/24 at 11:56 A.M., the Director of Nursing (DON) said: -A bed hold notice was not given to Resident #14 at either time of the resident's hospital stay. -A bed hold notice was not given to Resident #60 at either time of the resident's hospital stay. During an interview on 10/23/24 at 11:38 A.M., Licensed Practical Nurse (LPN) B said: -The nurses were responsible for the bed hold policies when a resident is transferred to the hospital. -He/she was unsure why the bed hold notices were not given to Resident's #14 and #60. 22727 4. Review of Resident #10's discharge assessment with return-anticipated dated 1/2/24 showed the resident discharged to an acute hospital. Review of the resident's entry tracking forms showed the resident returned to the facility on [DATE]. Review of the resident's discharge assessment with return-anticipated dated 1/16/24 showed the resident discharged to an acute hospital. Review of the resident's entry tracking forms showed the resident returned to the facility on [DATE]. Review of the resident's medical record showed no bed hold documentation for 1/2/24 or 1/16/24. The bed hold policy notifications for 1/2/24 and 1/16/24 were requested on 10/21/24 but were not received. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/21/24 at 10:07 A.M., LPN A said the nurses were supposed to send the bed hold policy when a resident was being discharged to the hospital. During an interview on 10/23/24 at 12:30 P.M., the DON said the nurses were responsible for sending the bed hold policy when a resident was being discharged to the hospital.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on interview and record review, the facility failed to ensure the comprehensive Minimum Data Set (MDS-a federally mandated assessment instrument completed by the facility staff for care planning) was accurate for one sampled resident (Resident #46) out of 13 sampled residents. The facility census was 50 residents. 1. Review of Resident #46's Annual MDS, dated [DATE] showed: -His/Her Brief Interview for Mental Status (BIMS) should have been assessed. -The BIMS summary score for level of cognition was not scored. -He/She had the following diagnoses: --Anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus). --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). During an interview on 10/23/24 at 9:24 A.M., the MDS Coordinator said: -He/She was the temporary MDS Coordinator at this facility. -He/She covered two facilities and started doing this facility on 6/6/24. -The comprehensive MDS should be done on admission, annually, and when a significant change was identified. -All questions/areas should have been addressed if the section was marked that it needed to be assessed. During an interview on 10/23/24 at 12:32 P.M., the Director of Nursing said: -The MDS Coordinator was responsible for completing the MDS. -The comprehensive MDS was to be completed on admission, annually and when a significant change was identified. -A resident's level of cognition should have been addressed in the comprehensive MDS.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 22727 Based on interview and record review, the facility failed to complete a significant change comprehensive assessment within 14 days after the resident was placed on hospice (end of life care) for one sampled resident (Resident #45) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's policy titled Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) 3.0 Care Assessment Summary and Individualized Care Plans dated 11/6/23 showed it did not include any instructions related to a significant change. 1. Review of Resident #45's MDS showed a quarterly MDS was completed on 1/24/24. Review of the resident's current physician's order sheet showed the resident admitted to hospice on 2/16/24. Review of the resident's care plan dated 3/8/24 showed: -The resident had a terminal prognosis. -Hospice services/interventions were not included in the care plan. Review of the resident's MDS showed a quarterly MDS was completed on 4/25/24. Review of the resident's MDS showed a quarterly MDS was completed on 7/26/24. Review of the resident's MDS showed an annual MDS was completed on 10/24/24. During an interview on 10/23/24 at 9:34 A.M., the MDS Coordinator said: -He/She took over the MDS Coordinator position on 6/6/24. -A significant change MDS should have been done when the resident went on hospice. During an interview on 10/23/24 at 12:30 P.M. the Director of Nursing said a significant change MDS should have been completed within 14 days of the resident being placed on hospice.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to accurately complete the residents' Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) for six sampled residents (Residents #10, #43, #45, #51, #9, and #41) and one supplemental resident (Resident #16) out of 13 sampled residents. The facility census was 50 residents. Review of the facility policy titled MDS 3.0 Care Assessment Summary and Individualized Care Plans, revised 11/6/23, showed: -The purpose of the MDS policy was to ensure that the MDS 3.0 sections were completed accurately and in a timely manner by the responsible parties. -Section F was to be completed by the activity director. -Section F allowed the resident to determine his/her own preferences for daily activities. -Section L was to be completed by the nursing staff. -Section L was used to document any dental problems. -The MDS defined the dental health of the resident and included an assessment of mouth and facial pain. -The focus of section L was the relationship between poor oral health, the quality of life, and the nutritional status of the resident. -MDS's must be kept current and up to date. 1. Review of Resident #10's annual MDS dated [DATE] showed the activities section (section F) was left blank for resident and facility staff assessment. Review of the resident's care plan dated 1/19/24 showed: -The resident had a diagnosis of dementia (a decline in mental ability that affects a person's daily life). -The resident had little activity participation due to dementia. Review of the resident's annual MDS dated [DATE] showed the cognitive assessment interview was marked to be completed with the resident, but it was not assessed, and the facility staff assessment of the resident's cognition was not completed. During an interview on 10/15/24 at 10:06 A.M. the resident was able to engage in conversation. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 10/22/24 at 10:43 A.M. showed the resident was singing along to music being played in the dining room. During an interview on 10/23/24 at 9:34 A.M., the MDS Coordinator said: -He/She took over the position of MDS Coordinator on 6/6/24. -The Activity Director should complete the activity section with the MDS Coordinator as back-up. -The MDS Coordinator was responsible for the cognition assessment. -When residents couldn't answer questions about their preferences or to complete the cognition assessment, the staff should complete the staff questions/assessments of those sections. 2. Review of Resident #16's care plan dated 2/3/23 showed: -The resident had impaired cognition due to diagnosis of dementia. -The care plan did not include what assistance the resident required for care activities. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Cognition was not assessed. -The resident's functional abilities (self-care abilities such as dressing, transferring from one surface to another, etc.) were not assessed. Observation on 10/18/24 at 6:23 A.M. showed the resident was standing in the dining room. During an interview on 10/23/24 at 9:34 A.M., the MDS Coordinator said: -He/She took over the position of MDS Coordinator on 6/6/24. -The MDS Coordinator was responsible for the cogitation assessment. -All sections should have been completed on the MDS. 3. Review of Resident #43's quarterly MDS dated [DATE] showed: -The resident's speech was not assessed. -The resident's ability to understand others and to be understood by others was not assessed. -Cognition was not assessed. -The resident's functional abilities were not assessed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/23/24 at 9:34 A.M., the MDS Coordinator said: -When residents couldn't answer questions to complete the cognition assessment, the staff should complete the staff questions/assessments of those sections. -All sections should have been completed on the MDS and should have been accurate. 4. Review of Resident #45's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Had clear speech. -Understood others and was usually understood by others. -Could not participate in the cognitive assessment because he/she was rarely understood. During an interview on 10/23/24 at 9:34 A.M., the MDS Coordinator said all sections should have been completed on the MDS and should have been accurate. 5. Review of Resident #51's care plan showed: -On 3/18/24 the resident was independent with bed mobility, eating, locomotion, personal hygiene, toilet use, transferring, and walking. -On 4/2/24 the resident received anti-depressant medication for depression. -On 4/30/24 the resident had impaired cognitive impairment due to dementia. -On 9/18/24 instructions to staff were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. -On 9/18/24 instructions to staff were to provide structured activities such as walking inside and outside, reorientation strategies included signs, pictures, and memory boxes. 6. During an interview on 10/23/24 at 8:55 A.M., the Social Services Director said: -He/She's worked at the facility for six weeks. -He/She did section C and one or two other sections, he/she would have to look to see what they were. -He/She didn't know if it was his/her responsibility to answer the employee section of section C if the resident couldn't answer the questions. -He/She thought the Director of Nursing (DON) did the employee answers section of section C if the resident couldn't answer the questions. During an interview on 10/23/24 at 12:30 P.M., the DON said: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-They currently do not have an Activity Director to complete the activities section of the MDS. -The Social Services Director was responsible for completing the mood and behavior sections. -In the absence of a Social Services Director or an Activity Director, the MDS Coordinator was responsible for completing those sections of the MDS. -The MDS should be accurate. 51150 7. Review of Resident #9's admission MDS, dated [DATE] showed: -The resident was cognitively intact. -Section F was blank and not completed at the time of admission. -In section L, the resident did not have any dental problems upon admission to the facility. -In section L, the resident did not have any missing/broken teeth upon admission to the facility. Observation on 10/16/24 at 10:30 A.M., showed the resident had a broken tooth. During an interview on 10/22/24 at 1:00 P.M. the resident said: -He/she had a broken tooth upon admission to the facility. -He/she informed the facility staff of the broken tooth upon admission to the facility. 8. During an interview on 10/23/24 at 9:06 A.M., the MDS Coordinator said: -He/she was currently the one responsible for creating a resident's MDS assessment and care plan. -He/she was temporarily covering as the MDS Coordinator at this facility as they do not have a full time MDS Coordinator. -A MDS assessment should be completed upon a resident's admission to the facility and should have included a dental assessment. -He/she would expect a broken tooth to be reflected on a resident's MDS. -He/she would expect activity preferences to be assessed on a resident's initial MDS assessment. During an interview on 10/23/24 at 9:40 A.M., the Social Services Director said: -He/she worked as the Social Services director at this facility part time. -He/she worked on average 2-3 days per week at the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/she was not aware of the resident's broken tooth. -The admission nurse and the MDS Coordinator should have told the previous social worker about the resident having a broken tooth upon admission to the facility. -The broken tooth should have been documented in the resident's MDS assessment. -He/she was unaware that the resident's activities preferences on his/her initial MDS assessment were not completed. -He/she would expect that activity preferences be completed on a resident's initial MDS assessment. During an interview on 10/23/24 at 12:34 P.M., the DON said: -A resident who had a broken tooth on their initial assessment should have been addressed on the MDS and care plan. -A resident with a broken tooth on their initial assessment should have been communicated to the Social Services Director. -He/she was not aware of the resident having a broken tooth. -He/she was not aware of the resident's activity preferences not being completed on his/her initial MDS assessment. -The activity preferences on the initial MDS assessment were supposed to be completed by the Social Service Director. -He/she would expect the activity preference section to be completed when a resident was admitted into the facility. 39469 9. Review of Resident #41's face sheet showed he/she was admitted to the facility with the following diagnoses: -Dementia. -Cognitive communication deficit. -Need for assistance with personal cares. -The resident had a guardian. Review of the resident's Quarterly MDS dated [DATE] showed: -The resident resided on a locked Memory Care Unit. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Section C: Cognitive Patterns was not completed. During an interview on 10/22/24 at 11:00 A.M. the Social Service Director said: -The MDS should have been completed upon admission. -Section C: Cognitive Patterns should have been completed upon admission and updated quarterly. -Resident #41 was missed. During an interview on 10/23/24 at 12:30 P.M. the DON said: -Every resident should have been evaluated in Section C: Cognitive Patterns upon admission and quarterly. -Resident #41 was missed. -The Social Service Director was responsible for ensuring Section C was completed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on interview and record review, the facility failed to ensure residents with a mental disorder and individuals with intellectual disabilities had a DA-124 level I screen (used to evaluate for the presence of psychiatric conditions to determine if a Preadmission Screening/Resident Review ((PASRR-a federal program implemented in 1987 to: Prevent individuals with mental illness (MI), intellectual disability (ID) or related conditions (RC) from being inappropriately placed in a Medicaid certified nursing facility (NF) for long-term care)) level II screen is required) and failed to ensure the follow-through of the PASRR recommendations and failed to integrate the recommendations into the care plan for two sampled residents (Resident #9 and #41) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's PASRR Assessments & DA-124 A&B policy updated 7/9/2021, showed: -The purpose of this policy is to utilize the PASRR assessment to develop a plan of care that shows continuity from previous history of behaviors and placement. -Upon the resident's admission to the facility and upon the facility receiving the PASRR, the customer service consultant will make a copy of the PASRR with the clinical history of the previous behaviors and the services provided. -The Director of Nursing (DON), Social Services Director (SSD), and Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning)/Care plan Coordinator will meet and develop a plan of care that shows continuity from previous history of behaviors and placements. -The PASRR will be utilized as an instrument to assist the facility in maintaining as much as possible, previous treatment modalities that were effective in the resident's life prior to placement at this facility. -The PASRR will be a guide in developing an assessment that will assist in the continuity of care and services in the best interest of the resident. 1. Review of Resident #9's PASRR dated 3/31/10 showed the resident had the following diagnoses: -Antisocial personality disorder (Sometimes called sociopathy, is a mental health condition in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others). -Depressive disorder (a mental disorder characterized by a feeling of profound and persistent sadness or despair and is frequently accompanied by a loss of interest in things that were once pleasurable). -Bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Schizophrenia (a mental condition that causes both psychosis (a loss of contact with reality) and mood problems). -Mild mental retardation (mild intellectual disability (previously known as mild mental retardation) refers to deficits in intellectual functions pertaining to abstract/theoretical thinking). -Multiple suicidal attempts (when someone harms themselves with any intent to end their life, but they do not die as a result of their actions). -Self mutilation (self-harm/self-injury). -History: Multiple suicide attempts, 1st at the age of [AGE] years old by hanging. History of cutting self after mothers' death at the age of 25. The resident had history of abuse and trauma at the age of 3 years old. The resident was placed in foster care as a child and had been in institutions ever since. The resident's mother was diagnoses with schizophrenia when the resident was a child. The resident had a history of sexual assault of female RCF resident where probation was given to the resident and completed in 11/2008. -Current psychiatric treatment: Medication therapy, administration, and monitoring, inpatient psychiatric treatment, and group therapy/counseling. -Nursing home service needs: Implementation of systemic plans to change inappropriate behavior, provisions of a structured environment, medication therapy monitoring, implementation of Activity of Daily Living (ADL-bathing, dressing, grooming) programs, and development of personal support networks. -Resident may benefit from the following additional services: Community psychiatric rehabilitation program, guardianship, secured unit/facility, recreational therapy/activities evaluation, skills training, vocational rehabilitation, social services evaluation, and community resources. -NOTE: The facility did not have the resident's PASRR on site or in the resident's medical record until after the survey entrance and it was requested from the surveyor. Review of the resident's admission MDS dated [DATE] showed the resident: -Was admitted to the facility on [DATE]. -Was cognitively intact. -Had a PASRR completed and it was determined the resident had a serious mental illness condition. -Had no psychosis. -Was not assessed for customary routine and activities. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had a diagnosis of Traumatic Brain Injury (TBI-happens when a sudden, external, physical assault damages the brain). -Had a diagnosis of depression. -Was taking an anti-depressant (a prescription medications that can help treat depression and other mental health conditions). -NOTE: The MDS did not reflect a diagnosis of bipolar, schizophrenia, mild mental retardation, or suicidal attempts, all of which were reflected in the resident's PASRR. Review of the resident's undated Care Plan showed the resident: -Was admitted to the facility on [DATE]. -Had a diagnosis of TBI with loss of consciousness of unspecified duration. -Had a diagnosis of antisocial personality disorder. -Had a diagnosis of major depressive disorder. -Had a diagnosis of Borderline Personality Disorder (BPD-a personality disorder characterized by severe mood swings, impulsive behavior, and difficulty forming stable personal relationships). -Had a diagnosis of intellectual disabilities. -NOTE: The resident's care plan did not reflect a diagnosis of bipolar, schizophrenia, or suicidal attempts, all of which were reflected in the resident's PASRR. -NOTE: The resident's care plan did not include any of the resident's mental health diagnosis as a problem. Nor did the resident's care plan include desired outcomes or interventions for any of the resident's mental health diagnosis as indicated on the resident's PASRR or on the resident's list of diagnosis on his/her care plan. Review of the resident's Electronic Medical Record (EMR) on 10/18/24 at 8:30 A.M., showed the resident did not have a DA-124 level 1 screen or a PASRR level II screen in his/her medical record. During an interview on 10/18/24 at 8:42 A.M., the Director of Nursing (DON) said: -The facility had not received the resident's PASRR screening from his/her previous facility. -NOTE: The DON provided the PASRR to this surveyor on 10/18/24 at 10:27 A.M. During an interview on 10/22/24 at 1:00 P.M. the resident said: -He/she was molested as a child at the age of 3 years old. -His/her mother placed him/her in a mental facility at the age of 6 years old. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she felt neglected when his/her mom placed him/her in a mental facility and he/she did not know how to handle his/her emotions, so he/her started acting out. -He/she had been in and out of mental facilities and group homes from the age of 6. -His/her mother and brothers were emotionally abusive to him/her. -He/she had a mental breakdown in second grade and lost his/her ability to read. -He/she last attempted suicide after his/her mother passed away when he/she was [AGE] years old. -He/she lost contact with all his/her family when his/her mom passed away. -He/she had requested mental health therapy at the facility. -He/she had not received the requested mental health therapy since being at the facility. -He/she would greatly benefit from having mental health therapy. During an interview on 10/23/24 at 9:06 A.M., the MDS Coordinator said: -He/she was currently the one responsible for creating a resident's MDS assessment and care plan. -He/she was temporarily covering as the MDS Coordinator at this facility as they did not have a full time MDS Coordinator. -A MDS assessment should be completed upon a resident's admission to the facility and should have included information from a previous PASRR. -A baseline admission care plan should be created for each resident with 48 hours of admission into the facility and should have included information from a previous PASRR . -He/she would have expected that a resident's PASRR be utilized when creating a MDS assessment and care plan for a newly admitted resident. -He/she would expect all mental health diagnoses listed on a resident's PASRR to be reflected on a resident's MDS and care plan. -He/she would expect previous suicide attempts listed in a resident's PASRR to be reflected in a resident's care plan. -Social services would be responsible for getting a resident who had a PASRR upon admission the therapy and other services that the resident needed at the facility. -If a resident was admitted with a previous PASRR that stated the resident had past suicide attempts, then the resident's physician should have been notified by the MDS Coordinator. During an interview on 10/23/24 at 9:40 A.M., the Social Services Director said: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she worked as the Social Services Director at this facility part time. -He/she worked on average 2-3 days per week at the facility. -He/she was not aware of the resident's mental health diagnoses. -He/she was not aware of the resident's past trauma. -He/she was not aware of any of the resident's past suicidal attempts. -He/she would expect mental health diagnoses, past trauma, or suicidal attempts to be a part of the resident's care planning. -He/she would expect to have been notified by the MDS Coordinator or the DON about a newly admitted residents mental health conditions, trauma, and past suicidal attempts. -He/she was unsure the facility's process for identifying residents with a possible mental and/or intellectual disorder but he/she would assume that this would be the MDS Coordinators job. -He/she had never seen the resident's PASRR and did not know what was on it but stated that he/she would have suggested a different facility for the resident if he/she would have had the information from the resident's PASRR prior to admission to the facility. -There was currently no therapy being offered to the resident. -There was currently no process in place at the facility to help the resident. -He/she believed that the resident would benefit from being moved to a different facility that could accommodate his/her needs. During an interview on 10/23/24 at 12:34 P.M., the DON said: -The Social Services Director was responsible for setting up needed counseling and other mental health services for residents upon admission, if needed. -The MDS Coordinator was responsible for obtaining a residents PASRR and implementing the PASRR to create an initial MDS assessment and care plan. -He/she was unaware of the mental health diagnoses that were on the resident's PASRR. -He/she was unaware of the resident's past suicide attempts. -He/she would expect information from a residents PASRR be used when creating a MDS assessment and care plan for a newly admitted resident. -He/she would expect past suicide attempts to be on a residents care plan. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she would expect that every resident in the facility have a PASRR in their medical record, if warranted. 39469 2. Review of Resident #41's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Dementia (a group of thinking and social symptoms that interferes with daily functioning). -Cognitive communication deficit. -The resident had a guardian. During an interview on 10/22/24 at 11:00 A.M. the Social Service Director said: -A PASRR should have been completed for the resident. -This resident's PASRR was missed. During an interview on 10/23/24 at 12:30 P.M. the DON said: -Every resident should have had a PASRR before they came to the facility or immediately upon admission. -This resident was missed. -He/She and the Social Service Director were responsible for ensuring the PASRR was completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan for three sampled residents (Residents #14, #9, and #41) out of 13 sampled residents. The facility census was 50 residents. Review of the facility policy titled Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) 3.0 Care Assessment Summary and Individualized Care Plans, revised 11/6/23, showed there were twenty (20) areas that could become triggered areas for concern and must be addressed with individualized interventions on the plan of care for the resident. Review of the facility's policy titled Comprehensive Care Plans dated as revised on 6/26/24 showed: -The facility staff would develop and implement a comprehensive, person-centered care plan for each resident to meet the resident's medical, nursing, mental, and psychosocial needs. -The care plan would include resident-specific objectives and time frames to meet the residents needs. 1. Review of Resident #14's care plan, initiated 3/19/24, showed no activity preferences. Review of the residents annual MDS dated [DATE], showed: -The resident was moderately cognitively impaired. -The resident was his/her own responsible party. -It was somewhat important to the resident to have material to read. -It was somewhat important to the resident to listen to music. -It was somewhat important to the resident to keep up with the news. -It was somewhat important to the resident to do things with groups of people. -It was somewhat important to the resident to go outside and get fresh air. -It was somewhat important to the resident to do his/her favorite activities. -It was somewhat important to the resident to participate in religious services and practices. Review of the resident's Activity Interest Survey, dated 7/5/24, showed: -The resident was interested in spades (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was interested in table games. -The resident was interested in dominoes. -The resident was interested in rock collecting. -The resident was interested in reading. -The resident was interested in bird watching. -The resident was interested in socials. -The resident was interested in going to the movie theater. 2. Review of Resident #9's concerns questionnaire dated 5/31/24 showed: -Dental services were needed. -The resident had a broken tooth. -The resident requested to see a dentist and to have his/her broken tooth pulled. Review of the resident's history and physical transfer note dated 6/5/24, showed: -The resident had a broken tooth. -The resident needed to see a dentist. Review of the resident's admission MDS dated [DATE], showed: -The resident was cognitively intact. -No activities preferences assessed. -No teeth problems assessed. Review of the resident's progress note dated 7/22/24, showed a dental referral was ordered on admission to the facility and was never completed. Review of the resident's undated care plan showed: -No activity preferences, -No broken teeth or any other dental issues. Observation on 10/16/24 at 10:30 A.M., showed the resident had a broken tooth. During an interview on 10/22/24 at 1:00 P.M., the resident said: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she had a broken tooth upon admission to the facility. -He/she informed the facility staff of the broken tooth upon admission to the facility. 3. During an interview on 10/23/24 at 9:06 A.M., the MDS Coordinator said: -He/she was currently the one responsible for creating a resident's MDS assessment and care plan. -He/she was temporarily covering as the MDS Coordinator at this facility as they do not have a full time MDS Coordinator. -He/she was unaware that Resident #14's activity preferences were not on his/her care plan. -He/she would expect activity preferences to be assessed on a resident's initial MDS assessment and transferred to the resident's care plan. -He/she would expect a broken tooth to be reflected on Resident #9's care plan. During an interview on 10/23/24 at 9:40 A.M., the Social Services Director said: -He/she worked as the Social Services Director at this facility part time. -He/she worked on average 2-3 days per week at the facility. -He/she was unaware that Resident #14's activities preferences were not on the resident's care plan. -He/she would expect that activity preferences be completed on Resident #14's care plan. -He/she was not aware of Resident #9's broken tooth. -He/she has not seen Resident #9's care plan. During an interview on 10/23/24 at 12:34 P.M., the DON said: -He/she was not aware of Resident #14's activity preferences not being completed on his/her care plan. -The activity preferences on the initial MDS assessment were supposed to be completed by the Social Service Director and transferred to the care plan. -A resident who had a broken tooth on their initial assessment should have been addressed on the care plan. -He/she was not aware of Resident #9 having a broken tooth. 39469 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #41's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Dementia (a group of thinking and social symptoms that interferes with daily functioning). -Cognitive communication deficit. -Need for assistance with personal cares. -The resident had a guardian. Review of the resident's Quarterly MDS dated [DATE] showed: -A Brief Interview for Mental Status (BIMS-a test which showed if he/she was cognitively intact) should have been completed. -BIMS score was blank. -The resident resided on a locked Memory Care Unit. Review of the resident's care plan dated 10/18/23 showed: -He/She was at risk for impaired communication due to language barrier. -Staff were to offer alternative communication needs by offering language cards and/or translating system. -The care plan did not reflect which country the resident was from or which language he/she spoke. Observation on 10/15/24 at 11:06 A.M. showed: -The resident appeared to have been of Asian descent. -The resident declined to be interviewed. -There was no translation phone number on the unit. -There were no language cards on the unit or in the resident's room. During an interview on 10/15/24 at 1:30 P.M. the guardian said: -He/She did not know where the resident was from or which language he/she spoke. -He/She said the resident only responded to questions with a grunt. -He/She seemed to understand what you asked him/her. -He/She did not know if the staff had a way to interact with the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had talked with the resident's children as they spoke English. -They do not interact with the resident. During an interview on 10/22/24 at 1:00 P.M. the Social Service Director said: -He/She did not know where the resident was from or which dialect he/she spoke. -The resident's background should have been in his/her medical chart and on the care plan, it was not. -He/She did not know how the resident could have been evaluated if staff could not speak to him/her in a language he/she could fully understand. -No family was listed on the resident's chart. During an interview on 10/22/24 at 2:30 P.M. the Social Service Director said: -He/She had called the guardian who had family phone numbers so he/she could speak to them. -The family said the resident was from Korea and was able to understand some English. -The family said the resident had been abusive to them so they had distanced themselves from him/her and would not be involved with his/her cares. -Staff should have had a picture gram to communicate basic needs with the resident, they did not have one. -Staff had told him/her it was hard to toilet or shower the resident related to the communication difficulties. -The resident should have been evaluated upon admission which would have included which language he/she spoke and that should have been documented in his/her care plan. -The resident did not have a BIMS, which should have been completed upon admission. -The facility needed to break the communication barrier. -The facility would need to obtain a translator phone line, they do not have one at this time. During an interview on 10/23/24 at 12:30 P.M. the DON said: -If a resident's primary language was not English, the staff were expected to look at the care plan to know how to communicate with the resident. -Staff should have had a visual picture board, a translation phone or picture cards to communicate with the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was not sure if the facility had a contract with a translation company. -An activity and interest assessment should have been completed upon admission and documented in the computer on the resident's care plan. -When the resident first came to the facility they were using paper charts and his/her language was on the paper chart but had not transferred to the computer chart. -There should have been a process in place to communicate with the resident in his/her own language and it should have been documented on the care plan for staff to use.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on interview and record review, the facility failed to notify the resident or the resident's representative of meetings for care plan (a document that specified health care and supported needs and outlined how the facility met resident requirements) development, review, and revision, for seven sampled residents (Resident #47, #41, #17, #46, #33, #10, and #51) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's policy titled Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) 3.0 Care Assessment Summary and Individualized Care Plans dated 11/6/23 showed it did not include any instructions related to inviting the resident and/or their responsible party to participate in care plan meetings. Review of the facility's Comprehensive Care Plans policy, dated 6/26/24 showed: -The purpose of the policy was to develop a comprehensive person-centered care plan for each resident. -It addressed measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs. -Person Centered was defined as the resident being in control of the support the resident needed to make their own choices and have control over their daily lives. -The care planning process included an assessment of the resident's strengths and needs and incorporated the resident' s personal and cultural preferences in developing goals of care. -The comprehensive care plan was prepared by multiple staff as well as the resident or the resident's representative. 1. Review of Resident #47's annual MDS dated [DATE], showed: -The resident was cognitively intact. -The resident's diagnoses included anxiety disorder (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), depression (a low mood or loss of pleasure or interest in activities for long periods of time), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). During an interview on 10/15/24 at 10:03 A.M. the resident said: -He/She had not been to a care plan meeting. -He/She had no recollection of having been invited to a care plan meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's Electronic Health Record (EHR) on 10/18/24, showed no information was found showing the resident was invited to or present at a care plan meeting. 2. Review of Resident #41's quarterly MDS dated [DATE], showed the resident was severely cognitively impaired. Review of the resident's EHR progress notes showed no entries for care plan meeting contacts to the guardian. During an interview on 10/15/24 at 11:43 A.M., the guardian for Resident #41 said: -He/She had not been to see the resident for a while. -He/She was unsure when the last care plan meeting was. -The care plan was overdue. 3. During an interview on 10/21/24 at 8:56 A.M., Certified Nursing Assistant (CNA) A said: -Resident's were invited to care plan meetings. -He/She thought they came to the room of the resident. During an interview on 10/21/24 at 9:20 A.M., CNA B said: -He/She looked on the care plan for information regarding the resident. -Resident's were supposed to go their care plan meeting. During an interview on 10/21/24 at 9:32 A.M., Agency Licensed Practical Nurse (LPN) A said: -Resident' s were invited to care plan meetings. -He/She was not sure of the process. During an interview on 10/21/24 at 9:49 A.M., the Human Resource (HR) director said: -He/She was unaware if residents were invited to care plan meetings. -He/She believed they should be. During an interview on 10/21/24 at 10:11 A.M., Certified Medication Technician (CMT) A said: -Residents were invited to care plan meetings -The Social Services Director (SSD) and the Director of Nursing (DON) got together with the resident or the resident's representative to discuss any changes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	37576 4. Review of Resident #17's Admission record showed he/she was admitted on [DATE] and readmitted on [DATE] with the following diagnoses: -Dementia (a general term for a decline in mental ability resulting in memory loss, and other mental abilities severe enough to interfere with daily functioning). -Anxiety. -Psychotic Disturbance (also known as Psychosis is a severe mental disorder that causes a person to lose touch with reality and have abnormal perceptions and thoughts). -Schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms). Review of the last care plan meeting dated 7/20/23 at 12:18 P.M., showed: -Care plan meeting held with the Interdisciplinary Team (IDT-usually the DON, Nursing, MDS, SSD, Physician and other ancillary disciplines involved with care). -The resident's guardian was present by phone. -Did not indicate that the resident attended. During an interview on 10/15/24 at 11:18 A.M., the resident said: -He/She did not know what a care plan meeting was. -He/She did not remember ever being invited to a care plan meeting. Review of the resident's EHR on 10/21/24, showed: -No other care plan meeting records were found. -No other documentation that the resident, his/her family or representative were notified or invited to a care plan meeting. 5. Review of Resident #46's Admission record showed he/she was admitted on [DATE] with the following diagnoses: -Diabetes Mellitus II [DM-condition that affects the way the body processes blood sugar (glucose)]. -Anxiety. -Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the last care plan meeting dated 3/30/23 at 12:16 P.M., showed: -Care plan meeting was held with the IDT team. -Did not indicate that the resident attended. -Did not indicate that the resident, his/her family or representative were notified or invited to the care plan meeting. During an interview on 10/15/24 at 11:35 A.M., the resident said: -He/She did not know what a care plan meeting was. -He/She could not recall ever being invited to a care plan meeting. Review of the resident's EHR on 10/21/24, showed: -No other care plan meeting records were found. -No other documentation that the resident, his/her family or representative were notified or invited to a care plan meeting. 6. Review of Resident #33's Admission record showed he/she was admitted [DATE] with the following diagnoses: -Spina Bifida (birth defect in which a developing baby's spinal cord fails to develop or close properly while in the womb). -Anxiety. -Diabetes Mellitus II During an interview on 10/15/24 at 1:49 P.M. the resident said: -He/She had not been to a care plan meeting. -He/She did not remember ever having been invited to a care plan meeting. Review of the resident's EHR on 10/21/24, showed no documentation that the resident, his/her family or representative were notified or invited to a care plan meeting. During an interview on 10/23/24 at 10:43 A.M., the SSD said: -He/She was uncertain if the MDS Coordinator set up the care plan meetings. -Residents and family received invites either by phone or email. -He/She believed care plan meetings were held quarterly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	22727 8. Review of Resident #51's care plan showed the resident's care plan was most recently updated on 6/26/24. Review of the resident's MDS showed the resident's most recent MDS was an annual dated 9/18/24. During an interview on 10/16/24 at 11:49 A.M., the resident's responsible party said he/she did not get invited to care plan meetings. 9. Review of Resident #10's care plan showed the resident's care plan was most recently updated on 4/2/24. Review of the resident's MDS showed the resident's most recent MDS was an annual dated 10/2/24. During an interview on 10/16/24 at 9:25 A.M., the resident's responsible party said no one had called or mailed him/her a care plan meeting invitation. 10. During an interview on 10/23/24 at 8:55 A.M., the Social Services Director said: -He/She's worked at the facility for six weeks (which was the week of 9/16/24). -He/She let the MDS Coordinator know when the guardians were available for care plan meetings and then they invited them. -He/She called family members to invite them. -There have not been care plan meetings for Residents #51 or #10 since he/she had been at the facility. During an interview on 10/23/24 at 9:34 A.M., the MDS Coordinator said: -He/She became the MDS Coordinator on 6/6/24. -He/She and the Social Services Director were responsible for inviting family members to care plan meetings. -He/She and the Social Services Director were supposed to communicate with each other to determine who would mail out the invitations. -They hand deliver care plan meeting invitations to residents who were their own responsible party. -If the resident had a responsible party/guardian, they emailed or called with a follow-up email or call. -They usually mailed the care plan invitations a month in advance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Not sure if Residents #47, #41, #17, #46, #33, #10, and #51 were invited to or had a care plan meeting. During an interview on 10/23/24 at 12:30 P.M., the DON said: -Family members should have been notified by a phone call or email of care plan meetings. -Care plan meetings should be held quarterly. -They have a letter to follow-up on the schedule of the care plan meeting that could be mailed or emailed. -Residents and family or representative should attend.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation and interview, the facility failed to ensure three sampled residents (Resident #5, #41, and #43) had assistance by the staff for oral cares, out of 13 sampled residents. The facility census was 50 residents. Review of the facility's policy, Activies of Daily Living, dated 5/18/24 showed: -Care and services would have been provided for the following activities of daily living; -Bathing, dressing, grooming, and oral care. -A resident who was unable to carry out activities of daily living would have received the necessary services to maintain good oral hygiene. 1. Review of Resident #5's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 7/14/24 showed: -He/She was severely cognitively impaired. -He/She had Dementia (a group of thinking and social symptoms that interferes with daily functioning). -He/She had Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). -He/She had Schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly). -He/She was totally dependent on staff to do all of his/her oral cares. During an interview on 10/23/24 at 9:48 A.M. Licensed Practical Nurse (LPN) B said: -He/She did not know who was responsible for ensuring the residents brushed their teeth. -He/She thought that who ever helped the resident get dressed maybe would have brushed their teeth. -The residents on the locked memory care unit could not keep the toothpaste in their room, as some of them would have eaten it. -He/She did not know who was responsible to ensure teeth brushing was done, where the oral care/dental supplies were kept or where brushing teeth was documented. 2. Review of Resident #41's quarterly MDS dated [DATE] showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-His/Her Brief Interview for Mental Status (BIMS) was blank. -He/She had Dementia. -He/She needed substantial help from staff with oral cares, dated 11/15/22. Observation and interview on 10/23/24 at 10:26 A.M. showed there was no toothbrush or toothpaste in the resident's room. During an interview on 10/23/24 at 10:26 A.M. LPN B and Certified Nursing Assistant (CNA) D said: -The resident should have been able to brush his/her teeth with direction from the staff. -It was unknown if the resident had a tooth brush or tooth paste in his/her room. -Both thought the resident's toothbrush should have been in his/her dresser. -Neither had not helped the resident with oral cares. 3. Review of resident #43's quarterly MDS, dated [DATE] showed: -He/She was moderately cognitively impaired. -He/She had Schizophrenia. -He/She needed supervision and assistance to complete oral hygiene. Observation on 10/23/24 at 11:00 A.M. with LPN B showed there was no toothbrush or toothpaste in residents room or bathroom. During an interview on 10/23/24 at 11:00 A.M. LPN B said: -Staff did not need to help the resident brush his/her teeth. -The resident could do it if he/she had a toothbrush and toothpaste but they were locked up. -He/She did not know where oral cares would have been documented. 4. Observation on 10/23/24 at 10:00 A.M. showed: -One unidentified resident in room [ROOM NUMBER] had an electric toothbrush and toothpaste in his/her drawers. -None of the other residents on the locked unit had a toothbrush or toothpaste. -There were 20 residents on the locked unit. 5. During an interview on 10/23/24 at 10:22 A.M. CNA D said: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The residents on the locked unit could not keep the toothpaste in their rooms as they would have eaten it. -He/She thought the residents had their name on the toothbrushes. -He/She could not find any toothbrushes that had the residents name on them or toothpaste. -In a locked closet there was a box of toothpaste and toothbrushes, still in their packaging. -He/She did not know if brushing teeth was documented anywhere when they performed oral cares with the residents. -He/She had worked at the facility for two years and had not helped any of the residents brush their teeth. During an interview on 10/23/24 at 12:30 P.M. the Director of Nursing (DON) said: -It should have been documented on the care plan if the resident needed assistance with oral cares. -All residents should have had their name on their own toothbrushes. -Tooth brushes and toothpaste should have been in the resident's bathroom. -Most of the residents needed at least prompting to do oral cares by the staff. -The staff should have documented when they assisted the residents with oral cares on the computer under Activities of Daily living.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities to meet the interests as well as the physical, mental, and psychosocial well-being for four sampled residents (Residents #8, #14, #9, and #41) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's Activities policy, dated 7/19/23, showed: -The purpose of the policy was to ensure that all residents were provided an ongoing program of activities designed to meet their interests and their physical, mental, and psychosocial well-being. -The activities calendar was posted on each unit and included activities that were appropriate for the general population that met the specific needs, interests, and supported the quality of life. -The activities director documented each resident's activity within the facility daily. -Documentation noted each resident's participation in activities. 1. Review of Resident #8's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 7/9/24, showed the resident was moderately cognitively impaired. Review of the resident's Group Activity Participation Log dated August 2024, showed: -The resident participated in activities five out of 31 days. -There was an x on every Saturday and Sunday. -The remaining 26 days were blank. Review of the resident's Group Activity Participation Log dated September 2024 showed: -The resident participated in activities six out of 30 days. -There was an x on every Saturday and Sunday. -The remaining 24 days were blank. Review of the resident's Group Activity Participation Log dated October 2024 showed: -The resident participated in activities one day out of 23 days (day of exit). -There was an x on every day from the third to the 31st. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's activities calendar dated October 2024 showed no activities scheduled for Saturdays and Sundays. Review of the resident's Activity Interest Survey, dated 10/4/24, showed: -The resident was interested in blues type music. -The resident was interested in going to parties. Observation on 10/16/24 to 10/23/24 showed: -The resident to be up and walking the halls. -The resident was not engaged in any activities. Observation on 10/16/24 to 10/22/24 showed no activities scheduled or being conducted. During an interview on 10/21/24 at 9:20 A.M., Certified Nursing Assistant (CNA) B said: -The resident came to activities. -The resident let him/her know what his/her needs were. -The resident walked around the halls a lot. -The Activities Director quit a few weeks ago. -No one was doing activities with the residents. During an interview on 10/21/24 at 9:32 A.M., agency Licensed Practical Nurse (LPN) A said: -The resident liked activities when food was served. -He/She was unsure who the activities director was. During an interview on 10/21/24 at 9:49 A.M., the Human Resources (HR) Director said: -There was no activities director at the facility. -All department heads pitched in and did what they could. -The administrator assigned staff to the activities on the halls. -The resident liked to draw and go to bingo. During an interview on 10/21/24 at 10:11 A.M., Certified Medication Technician (CMT) A said: -The activities director was no longer at the facility. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's liked a routine. During an interview on 10/22/24 at 9:05 A.M., the Director of Nursing (DON) said: -The x on the Activity Participation Log meant nothing was planned. -The blank spaces meant there was no documentation. -Initials of the person conducting the activity meant the resident was there and participated. 51150 2. Review of Resident #14's Activity Interest Survey, dated 7/5/24, showed: -The resident was interested in spades -The resident was interested in table games. -The resident was interested in dominoes. -The resident was interested in rock collecting. -The resident was interested in reading. -The resident was interested in bird watching. -The resident was interested in socials. -The resident was interested in going to the movie theater. Review of the resident's Group Activity Participation Log dated August 2024, showed: -The resident participated in activities 0 out of 31 days. -31 days were blank. Review of the facility's August 2024 activities calendar showed no activities scheduled for Saturdays and Sundays. An activity log for September 2024 was requested from the facility and not provided. An activities calendar for September 2024 was requested and not provided. Review of the resident's quarterly MDS dated [DATE], showed the resident was moderately cognitively impaired. Review of the resident's Group Activity Participation Log dated October 2024, showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident participated in activities 0 out of 21 days. -21 days were blank. Review of the facility's October 2024 activities calendar showed no activities scheduled for Saturdays and Sundays. Observation on 10/16/24 at 9:04 A.M., showed: -The resident was laying in his/her bed. -The resident did not participate in any activities. Observation on 10/18/24 at 6:23 A.M., showed: -The resident was laying in his/her bed. -The resident did not participate in any activities. Observation on 10/18/24 at 8:16 A.M., showed: -The resident went to the dining room to eat breakfast and went back to his/her room and laid in his/her bed after breakfast. -The resident did not participate in any activities. During an interview on 10/23/24 at 9:25 A.M., CNA D said: -He/she did not see Resident #14 participate in activities much. -He/she was unaware of why Resident #14 did not participate in activities. -He/she was unaware that the facility did not have an activities director. -He/she was unaware of who oversaw facilitating the resident's activities. 3. Review of Resident #9's admission MDS dated [DATE], showed the resident was cognitively intact. Review of the resident's Activity Interest Survey, dated 7/5/24, showed: -The resident was interested in rummy. -The resident was interested in deal or no deal. -The resident was interested in bingo. -The resident was interested in board games. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was interested in table games. -The resident was interested in pool. -The resident was interested in dominoes. -The resident was interested in sports. -The resident was interested in playing video games. -The resident was interested in helping others. -The resident was interested in going to the movie theater. -The resident was interested in listening to music. -The resident was interested in exercising. -The resident was interested in bible studies. -The resident was interested in learning to read. -The resident was interested in social events. -The resident was interested in bird watching. Review of the facility's August 2024 activities calendar showed no activities scheduled for Saturdays and Sundays. An activity log for August 2024 was requested from the facility and not provided. An activities calendar for September 2024 was requested and not provided. An activity log for September 2024 was requested from the facility and not provided. Review of the resident's Group Activity Participation Log for October 2024, showed: -The resident participated in activities 5 out of 21 days. -21 days were blank. -Saturdays and Sundays were marked out. Review of the facility's October 2024 activities calendar showed no activities scheduled for Saturdays and Sundays. Observation on 10/16/24 to 10/23/24 showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident to be in his/her room most of the time, playing his/her video game. -The resident did not participate in any activities. During an interview on 10/22/24 at 1:00 P.M. the resident said: -He/she did not participate in many activities due to the activities not being things he/she enjoyed. -The only thing he/she did was sit in his/her room most days, playing his/her video games. -He/she felt that he/she would benefit from more outdoor activities. During an interview on 10/23/24 at 9:25 A.M., CNA D said: -He/she did not see Resident #9 participate in activities much. -He/she was unaware of why #9 did not participate in activities. -He/she was unaware that the facility did not have an activities director. -He/she was unaware of who oversaw facilitating the resident's activities. During an interview on 10/23/24 at 9:30 A.M., CMT D said: -Resident #9 stayed in his/her room most of the time. -The activities director had been gone from the facility for a while now. -He/she and the rest of the staff were all pitching in and helping with activities. -He/she was unaware of the plans for an activity's director for the facility. During an interview on 10/23/24 at 12:34 P.M., The DON said: -There was no activities director for the facility. -He/she would expect activity calendars to be kept up to date and posted on all the units in the facility. -Since the last activities director walked out, activities have not been consistent for the residents. 39469 4. Review of resident #41's quarterly MDS dated [DATE] showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had Dementia (a group of thinking and social symptoms that interferes with daily functioning). -BIMS score was blank. -Assistance for memory was blank. -Interview for daily and activity preferences was blank. -The resident resided on the locked memory care unit. Review of the resident's undated Activity Evaluation showed: -He/She was admitted on [DATE]. -Interview for Daily Preferences was blank. -Interview for Activity Preferences was blank. -In the past the resident like music (did not specify what kind). -In the past the resident liked to attend social events. -The form was not dated or signed by a staff member. Review of the resident's participation in activities on the computer showed: -He/she had attended on 12/8/22, 12/2/22, and 3/5/22. -There was no documentation since then. Review of the resident's care plan dated 6/6/24 showed: -He/She had been admitted to the facility for long term care. -Staff were to encourage the resident to become engaged in facility life through group activities. -Staff were to give the resident as many choices as possible about care and activities. -Staff were to provide a program of activities that were of interest and accommodated the residents status. -He/She had a communication problem related to head injury and language barrier. Observation on 10/15/24 at 11:01 A.M. showed: -The resident was sitting in his/her room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no communication board in his/her room. -The resident declined to be interviewed. Observation on 10/15/24 at 2:00 P.M. showed: -The resident was sitting in the dining room. -He/She was not interacting with other residents. -There was no activity calendar on the unit. Continuous observation on 10/15/24 from 10:00 A.M. to 2:00 P.M. showed: -There were no activities on the unit for the residents to be involved in. -At 2:30 P.M. a staff member brought out a large deck of cards and large sized dominos, which he/she handed out to the residents. -The residents picked up the cards but did not do anything with them and there was no one who lead the activity. Observation on 10/16/24 at 11:00 A.M. showed there was no activity calendar on the bulletin board. During an interview on 10/18/24 at 7:10 A.M. Registered Nurse (RN A) said: -It was hard to communicate with the resident. -The resident was able to understand some English. -He/She had tried to use his/her translator application on his/her phone. -He/She had tried French and Spanish and the resident had not responded. -He/She did not know the resident was Korean. -The facility did not have a picture board or translation phone line to communicate with the resident. -The resident had been in the facility a couple of years. -The facility has not had an Activity Director for a couple of weeks. -There should have been an Activity Calendar on the bulletin board but there had not been one for a month or so. -It was hard to communicate with the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-They did not have any kind of picture board or translation to use with the resident. -They did not have scheduled activities currently as there was no Activity Director. During an interview on 10/18/24 at 7:42 A.M. CNA C said: -He/she did not know what language the resident spoke. -The resident could understand some English. -He/She did not know what kind of things the resident liked to do. -The Activity Director would put the activity schedule up on the board. -Currently there was no schedule. -There was no Activity Director. -He/She did not know if the resident did activities. -The resident had been at the facility a couple of years. -When the resident first came they should have done an assessment for activities that he/she would have liked to do. -He/She had no idea who was responsible for doing an activity assessment or where it would have been charted. -There have not have not been any activities on the weekends for a long time and the residents got bored and would fuss with each other. Observation on 10/18/24 at 8:00 A.M. showed there was no activity calendar on the bulletin board. During an interview on 10/18/24 at 8:06 A.M. Licensed Practical Nurse (LPN) B said; -There should have been a schedule of activities on the bulletin board in the hall way. -There was not one for this month. -There was no Activity Director currently. -The CNA's were doing activities with the residents the other day. -The resident liked to play balloon ball. -The resident had not done any activities recently. -He/She did not know where activities would have been documented. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not know what language the resident spoke so he/she was not able to ask what the resident liked to do for an activity. -The resident understood some English. -There was no communication board on the unit to communicate with the resident. -They have not had any activities on the weekends for a while. During an interview on 10/18/24 at 1:00 P.M. the Social Services Director (SSD) said: -It was not listed on the resident's chart where he/she was from or which language he/she spoke and it should have been documented. -A quarterly assessment should have been completed to assist with the care plan which should have addressed the activities the resident was interested in. -The Activity Director had quit a few weeks ago and a couple of the staff have been trying to do a couple of things with the residents when they could. -Activities should have been documented in the computer. -The facility should have had a translation line to call so the staff could have talked with the resident. -The resident should have had a picture board to help communicate with the resident, they did not have that either. During an interview on 10/18/24 at 2:30 P.M. the SSD said: -He/She had called the resident's guardian who gave him/her the phone number for the resident's family member. -He/She had talked to a couple of the resident's children who said the resident understood some English but his/her primary language was Korean. -This should have been listed on the resident's face sheet when he/she was admitted . -The admitting nurse should have been responsible for ensuring the information was on his/her chart. Continuous observation on 10/21/24 from 9:00 A.M. to 12:00 P.M. showed no activities on the unit. During an interview on 10/21/24 at 8:50 A.M. the facility physician said: -The facility had recently switched practices and he/she was new to the facility. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She would have expected the facility to have known before they accepted the resident as a resident that English was not his/her first language and made accommodations for him/her such as a translation line and a picture gram. -He/She had not been aware the resident spoke Korean. Review of the resident's October 2024 Activity schedule showed: -He/She had attended seven activities. -There were no activities on Saturday or Sundays. -NOTE: Requested the resident's activity log to see what activities the resident had attended, it was not provided. During an interview on 10/23/24 at 12:30 P.M. the DON said: -The Activity Director was responsible for assessing the resident's interest in activities. -They have not had a Activity Director continuously since April. -The department heads were taking turns doing activities with the residents. -Residents should have been assessed quarterly for activities. -Residents should have been assessed for their interests in activities upon admission, quarterly, and if they had a significant change. -There should have been an activity calendar but it has not been done consistently. -If the resident was not able to answer then the SSD should have called the family for the information. -They had not known the resident was Korean.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 22727 Based on interview and record review, the facility failed to follow-up regarding the resident's responsible party's request for monitoring after chemotherapy and radiation treatment for cancer and failed to clarify the resident's related diagnoses for one sampled resident (Resident #10) out of 13 sampled residents. The facility census was 50 residents. The facility did not have a policy related to this care area. 1. Review of Resident #10's census showed he/she admitted to the facility in January 2023. Review of the hospital emergency department provider note dated 1/16/24 showed the resident had a past medical history of liver cancer. Review of the resident's nurse's note dated 9/12/24 written by Licensed Practical Nurse (LPN) A showed the resident's responsible party had questions about an oncologist visit and prostate (a small gland in men that helps make semen) exam. Review of the resident's history and physical by the facility's physician dated 9/26/24 showed no diagnosis of cancer included. Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 10/2/24 showed the following staff assessment of the resident: -The cognitive assessment interview was to be completed with the resident, but it was not assessed, and the facility staff assessment of the resident's cognition was not completed. -Some of the resident's diagnoses included benign prostatic hyperplasia (BPH-a non-cancerous condition that causes the prostate gland to enlarge), dementia (a progressive mental disorder characterized by memory problems, impaired reasoning and personality changes), 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) and cognitive communication deficits. Review of the resident's care plan updated 10/2/24 showed nothing regarding liver cancer, prostate cancer or BPH. Review of the resident's diagnoses section in the electronic health record showed: -No diagnosis of prostate or liver cancer. -A diagnosis of BPH. Review of the resident's electronic health record showed no Prostate-Specific Antigen lab results (PSA-a blood test that's used to screen for prostate cancer). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 9:25 A.M., the resident's responsible party said: -The resident had prostate cancer. -The resident had radiation and chemotherapy for prostate cancer. -He/She had tried to ask staff about the resident seeing the oncologist but no one had talked to him/her about it. -It had been two years since the resident had seen the oncologist. During an interview on 10/21/24 at 10:07 A.M., LPN A said he/she forwarded the resident's responsible party's questions about oncology on to the Director of Nursing (DON). During an interview on 10/22/24 at 9:18 A.M., the DON said: -He/She didn't remember anything about the oncologist and prostate exam. -He/She did see the nurse's note dated 9/12/24 but he/she was more focused on something else that was going on with the resident at that time. -They were having trouble with their phone system around that time. -He/She would have to pull up old encounters from previous physician(s) and contact them to get a follow-up. During an interview on 10/23/24 at 10:21 A.M., the Doctor of Nursing Practice (DNP) who was president of the medical group that serviced the facility said: -They just recently began seeing patients at the facility. -An initial visit with the resident occurred on 9/26/24. -They ordered labs on 9/26/24 including a PSA and were awaiting results. -He/She found the resident had a diagnosis of BPH, but he/she could not find a diagnosis of prostate cancer. -He/She would let the resident's provider know and establish a correct diagnosis.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to ensure two sampled residents (Resident #51 and #33) received a vision exam and glasses out of 13 sampled residents. The facility census was 50 residents. Review of the facility's Hearing and vision policy last revised on 6/26/24 showed: -Ensure all residents have access to vision services and receive adaptive equipment as indicated. -The facility will utilize the comprehensive assessment process for identifying and assessing a resident's vision abilities to provide person-centered care. -Employees should refer any identified need for vision services/appliances to the social worker/social service designee. -Once vision services have been identified, the social worker/social service designee will assist the resident by making appointments and arranging transportation. 1. Review of Resident #51's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 9/18/24 showed no vision impairment and no use of corrective lenses during the assessment. Review of the resident's care plan updated on 9/18/24 did not address the resident's vision. Observation on 10/15/24 at 10:17 A.M. showed: -The resident did not have on any glasses. -The resident was looking at large playing cards that were on the dining room table. During an interview on 10/16/24 at 11:49 A.M., the resident's responsible party said the resident needed an eye exam and a pair of glasses. Observation on 10/18/24 showed the resident was not wearing glasses at 6:31 A.M., 7:04 A.M., and 7:31 A.M. Observation on 10/21/24 showed the resident was not wearing glasses at 9:16 A.M., 9:31 A.M., 9:40 A.M., 10:18 A.M., 10:27 A.M., 10:38 A.M., 10:51 A.M. to 11:19 A.M., and 1:24 P.M. Observation on 10/22/24 at 10:20 A.M. showed the resident was not wearing glasses. Review of the resident's electronic health record on 10/22/24 showed no documentation regarding the resident's vision. During an interview on 10/23/24 at 8:55 A.M., the Social Services Director said: (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had been at the facility six weeks. -He/She was collecting a list of all the residents who had been seen by the eye doctor, a list from the clinic of who had been seen and who needed to be seen, and progress notes from the eye doctor since he/she started at the facility. -The eye doctor came to the facility on [DATE] and the resident was not seen. During an interview on 10/23/24 at 10:01 A.M., Licensed Practical Nurse (LPN) B said he/she had not seen that the resident had any glasses. Observation on 10/23/24 at 10:14 A.M. showed no glasses in the resident's room. During an interview on 10/23/24 at 12:30 P.M., the Director of Nursing (DON) said: -The Social Services Director should be told about any residents that needed to be seen by the eye doctor. -The Social Services Director should keep track of when residents were seen and when they needed to be seen by the eye doctor. 37576 2. Review of Resident #33's quarterly MDS dated [DATE] showed: -Vision adequate. -No use of corrective lenses during the assessment. Review of the resident's care plan updated on 8/7/24 did not show the resident wore glasses. Review of the resident's Physician Progress Note dated 9/3/2024 showed no vision changes. During an interview on 10/15/24 at 1:50 P.M., the resident said: -He/she wore glasses all the time. -He/she could see ok but not the best with the glasses he/she had. -He/she felt he/she needed new glasses. -He/she would like to see an eye doctor. -He/she had not told anyone at the facility that he/she needed new glasses. During an interview on 10/15/24 at 2:00 P.M., Certified Nursing Assistant (CNA) H said the resident wore glasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/24 at 1:00 P.M., LPN A said: -The resident wore glasses. -He/she had not heard the resident mention he/she needed or wanted new glasses. Requested from the facility on 10/18/24 at 12:46 P.M., any documentation of the resident having received an eye exam or a vision assessment. Had not received any documentation as of 10/21/24 at 1:32 P.M. During an interview on 10/23/24 at 9:24 A.M., the MDS Coordinator said if a resident wore glasses it should show in the MDS and on the care plan. During an interview on 10/23/24 at 9:51 A.M., the DON said: -He/she was unaware that the resident had any issues with his/her glasses. -The resident had not seen an eye doctor. -The vision company came every three months and was last at the facility on 10/9/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation and interview, and record review, the facility failed to maintain a safe, functional, and comfortable environment by allowing tripping hazards to be created in at least four locations throughout the facility. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. Additionally the facility failed to supervise residents in the dining room, failed to safely transfer the resident off the floor and failed to have an appropriate wheelchair for one sampled resident (Resident #45) out of 13 sampled residents. The facility had a census of 50 residents with a licensed capacity of 97 residents at the time of the survey. 1. Observation on 10/18/24 between 12:59 P.M. and 1:41 P.M. showed the following: -In resident room [ROOM NUMBER] there were 6 laminate floor planks that were buckling up in an approximate (app.) 36 inch (in.) diameter bubble-like bump raised up to app. 1.5 in. in height located app. 54 in. inside the corridor door. -The bathroom floor linoleum in room [ROOM NUMBER] was ripped up leaving over half the bare floor visible. -The door to resident room [ROOM NUMBER] dragged heavily on the floor making it difficult to open and the bathroom floor was sticky to the point of ones' shoes continuing to be sticky when the room was left. -There was an unexpected sudden rise in the hallway flooring by resident rooms #203/204. Review of the Safe and Homelike Environment Policy, last reviewed 6/5/24 and provided by the Administrator, under Purpose, read, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. During an interview on 10/23/24 at 2:03 P.M. the Administrator said the facility should be free from tripping hazards. 22727 2. Review of the facility's policy titled Safety Program Policy dated 7/31/23 showed they would provide mechanical and physical safeguards to the maximum extent possible. Review of the facility's policy titled Safe Resident Handling Transfers Policy dated 5/14/24 showed: -All residents required safe handling when transferred to prevent or minimize the risk for injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts were a safer alternative and should be used. Review of the facility's policy titled Use of assistive devices dated 5/18/24 showed: -Assistive devices were tools that helped performance of tasks and activities. -The used of assistive devices would be based on the resident's comprehensive assessment, in accordance with the resident's plan of care. -The facility would provide assistive devices for residents who needed them. -The interdisciplinary team or designee would evaluate and assess each resident's individual mobility needs, considering other factors as well, such as weight and cognitive status. -It was the policy of the facility to use gait belts with residents that could not independently ambulate or transfer for the purpose of safety. Review of Resident #45's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 7/26/24 showed the following staff assessment: -Had clear speech. -Understood others and was usually understood by others. -Could not participate in the cognitive assessment because he/she was rarely understood. -Had short-term and long-term memory impairment. -Had severely impaired cognitive skills for decision-making. -Was independent when going from lying down to sitting up. -Required partial/moderate assistance with going from sitting to standing. -Did not walk. -Used a wheelchair. -Some of his/her diagnoses included dementia (a progressive mental disorder characterized by memory problems, impaired reasoning, and personality changes) and psychotic disorder (severe mental disorder that cause abnormal thinking and perceptions). -Had one non-injury fall since his/her last assessment. Review of the resident's care plan showed: -A fall care plan dated 6/25/24 that the resident was at risk for falls. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A care activities care plan updated 8/1/24 that the resident was independent with transferring. -A behavior care plan updated 8/1/24 that the resident had a behavior of lying on the floor with no instructions on how to assist the resident up off the floor. Review of the resident's health status note written by the Director of Nursing (DON) dated 9/10/24 showed: -The resident's wheelchair was broken on the right armrest. -Hospice (end of life care) was notified regarding the need to switch out wheelchairs because of safety. -Requested hospice to provide a full body mechanical lift and care planned for full body mechanical lift transfer. Observation and interview on 10/18/24 showed: -At 6:33 A.M., --The resident was sitting in a regular wheelchair on the scale in the dining room. --The resident kept leaning forward, trying to push himself/herself up out of the wheelchair. --There were no staff in the dining room. -At 6:38 A.M., due to the fear of the resident falling, the state surveyor went and found staff and informed him/her that the resident was trying to stand up. -At 6:41 A.M., --Registered Nurse (RN) A told Certified Nursing Assistant (CNA) J they couldn't have the resident in the wheelchair he/she was in because he/she needed to be in his/her bigger high-back chair. --Observation showed the resident's high-back wheelchair was missing the handrail/arm rest on the right side. --CNA J asked the surveyors what they should do because the nurse said the resident shouldn't be in the chair he/she's in but his/her bigger wheelchair was broken. --The surveyors responded that they should do what they would normally do without surveyor presence. --RN A said if the surveyors were not here, he/she would put the resident in the bigger chair (without the right-side armrest and rail) and put a belt around him/her but he/she didn't think that would be a restraint because the resident would be able to release it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--RN A said he/she didn't know the arm was broken off the resident's wheelchair and that the resident kept breaking things. --RN A said he/she would report the broken wheelchair to hospice. --RN A said he/she thought someone already reported the broken wheelchair. -At 6:49 A.M., CNA J said: --The resident's high-back wheelchair had been broken a couple of months. --He/She just now reported the high-back wheelchair was broken to RN A. --He/She was going to put the resident in his/her regular wheelchair and keep one-on-one observation of him/her until the next shift got there because the resident was difficult to get out of bed. --The resident tensed up during transfers sometimes and the resident won't sit in a sit to stand lift to transfer. -At 6:48 A.M., the resident was in his/her room in his/her wheelchair. -At 6:52 A.M., CNA J pushed the resident in his/her wheelchair out of his/her room and into the hall at the edge of the hall and the dining room. -At 6:56 A.M., CNA J put socks on the resident, then took the resident into his/her room and closed the door. -At 7:01 A.M., CNA J brought the resident out of his/her room and to the edge of the dining room in his/her regular wheelchair. -At 7:02 A.M., CNA J told the two oncoming CNA's that the resident's high-back wheelchair was broken so he/she suggested keeping the resident on one-on-one supervision for now. Observation on 10/21/24 showed: -From 9:19 A.M. to 9:33 A.M.: --The resident was sitting in the dining room in his/her regular wheelchair. --The resident was turning himself in his/her wheelchair with his/her feet. --The resident started to propel himself/herself forward. --Then the resident fell asleep sitting in his/her wheelchair in the dining room. -At 10:03 A.M.: --The resident was lying on his/her back on the floor in the dining room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Licensed Practical Nurse (LPN) A and CNA J lifted the resident up off the floor without a gait belt, with each one of them with their hands under his/her armpits, one on each side and placed him/her in his/her wheelchair. --LPN A told the resident they would take him/her to bed. --CNA J took the resident to his/her room and closed the door. -At 10:07 A.M., LPN A said: --The resident liked to lie on the floor. --The resident got himself/herself out of his/her wheelchair and put himself/herself on the floor. --The resident could stand up but he/she didn't want to this time. --Normally they should use a gait belt but he/she she didn't think they would be able to get the resident up with a gait belt. During an interview on 10/23/24 at 10:01 A.M., LPN B said: -When transferring the resident off the floor, they had to let him/her lie there until he/she relaxed, and then get him/her up. -They had to get his/her wheelchair behind him/her, get their arm under his/her armpit and one hand on his/her pants and slide him/her back in the wheelchair. -The resident was strong. -He/She hadn't seen the resident stand up straight, he/she had only seen him/her stand up halfway. During an interview on 10/23/24 at 12:30 P.M., the DON said: -The nurse should be out on the floor directing care. -The staff should not put the resident in a restraint in his/her wheelchair. -The way to transfer the resident depended on how much he/she was processing and following directions. -Sometimes they had to use a full body mechanical lift or sometimes a gait belt to transfer the resident. -There were times when the resident could get himself/herself up off the floor. -They should not have picked him/her up off the floor the way they did. -They should have called him/her to assist with getting the resident up off the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's high-back wheelchair had been broken for over a month. -The steel rod of the arm of the resident's wheelchair was broken and could not be repaired. -It was a hospice wheelchair. -Hospice was notified about the wheelchair.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on observation, interview and record review, the facility failed to ensure staffing was posted correctly at the beginning of each shift where residents and visitors could easily see it. The facility census was 50 residents. The facility staffing policy was requested and not received at the time of exit. 1. Review of the Facility assessment dated [DATE] showed the required daily nursing services was: -1 Registered Nurse (RN). -1 Licensed Practical Nurse (LPN). -4 Certified Medication Technician (CMT)'s. -13 Certified Nursing Assistant (CNA)'s. Observation on 10/15/24 at 8:30 A.M., showed: -No posted staffing sheet at the entrance reception desk and glass case near the door to the [NAME] hall. -No posted staffing sheet on the [NAME] or Cherry halls. Observation on 10/16/24 at 11:18 A.M., showed: -No posted staffing sheet at the entrance reception desk and glass case near the door to the [NAME] hall. -No posted staffing sheet on the [NAME] or Cherry halls. During an interview on 10/16/24 at 11:18 A.M., CMT A said: -There was no staffing sheet located at the [NAME] nurse's station. -Sometimes in the past it would be on the board that was now behind the construction plastic that was covering that wall. Observation on 10/18/24 at 6:16 A.M., showed: -A staffing sheet on the back wall at the receptionist desk. -This was not in a location that was visible for visitors. During an interview on 10/18/24 at 6:23 A.M., LPN C said: (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was not aware if staffing was posted up front at the entrance reception area. -Staffing was not posted at either of the two nurse's stations. During an interview on 10/18/24 at 7:04 A.M., CNA H said: -Staffing was at the reception desk. -Staffing was not posted at either of the two nurse's stations. Observation on 10/18/24 at 7:41 A.M., with the Director of Nursing (DON) showed: -The glass case near the door to the [NAME] hall did not have a posted staffing sheet. Observation on 10/21/24, 10/22/24 and 10/23/24 showed no posted staffing sheets at either of the two nurse's stations. During an interview on 10/23/24 at 11:46 A.M., the Staffing Coordinator said: -Posted staffing was in the glass case in the front by the entrance to [NAME] hall. -Hours for each position were listed. -Posted staffing was not on the units. During an interview on 10/23/24 at 12:32 P.M., the DON said staffing sheets: -Should be posted in the front entrance in the glass case. -Were not posted on each unit. -Should be posted up front and on each unit where residents and visitors could easily see them.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on observation, interview, and record review, the facility failed to ensure the oncoming and off going nursing staff counted the narcotics at the same time, failed to ensure the nursing staff did not pre-sign the narcotic count sheets, failed to ensure the count was correct by totaling the narcotic cards daily, failed to ensure all nursing staff was counting the narcotics, and failed to ensure the narcotic count sheets were accurate for three sampled residents (Resident #24, #2, and #11) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's Controlled Substance Administration and Accountability policy dated 5/14/24 showed: -The facility will have safeguards in place in order to prevent loss or diversion. -Controlled substances (medications that can cause physical and mental dependence) are stored in a separate compartment of a locked storage unit (medication cart or cabinet) with access limited to approved personnel. -Controlled substances are recorded on the designated usage form. -Written documentation must be clearly legible with all applicable information provided. -The dose noted on the usage form must match the dose recorded on the Medication Administration Record (MAR), the Controlled Drug Record, or other facility specified form. -The Controlled Drug Record serves the dual purpose of recording both the narcotic disposition and the patient administration. -The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient specific narcotic dispensed from the pharmacy. -The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. -Spot checks are performed to verify: --Controlled substances that are destroyed are appropriately documented. --Medications had a physician's order. -Two licensed nurses account for all controlled substances and access keys at the end of each shift. Review of the facility's Medication Storage policy, dated 5/18/24 showed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All drugs and biologicals (therapeutic substance, such as a vaccine or drug) will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. -During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. -Any discrepancies (in the count) which cannot be resolved must be reported immediately as follows: --Notify the Director of Nursing (DON), charge nurse, and the pharmacy. --Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted. --The DON, charge nurse or designee must also report any loss of controlled substances where theft was suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators. -Staff may not leave the area until discrepancies were resolved or reported as unresolved discrepancies. 1. Observation on 10/18/24 at 6:28 A.M., of the [NAME] nurse medication cart narcotic count sheet dated 9/7/24 to 10/18/24 for the A.M., and the P.M., shifts showed: -A total of 81 slots to record the total number of narcotic cards in the cart. --A total of 35 slots were left blank. -A total of 81 slots to record on coming nurse signatures. --A total of 13 slots were left blank. -A total of 81 slots to record off going nurse signatures. --A total of 15 slots were left blank. -On 9/10/24 and 9/15/24 for the 7:00 A.M., shift showed no on coming or off going signatures. Observation on 10/18/24 at 6:35 A.M., of the [NAME] Certified Medication Technician (CMT) medication cart narcotic count sheet dated 9/12/24 to 10/18/24 for the A.M. and the P.M. shifts showed: -No narcotic count sheet dated 9/20/24 to 10/3/24 shifts for a total of 18 shifts each for the A.M., and the P.M. , shifts. -A total of 59 slots to record the total number of narcotic cards in the cart. --A total of 34 slots were left blank. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A total of 59 slots to record on coming nurse signatures. --A total of 14 slots were left blank. -A total of 59 slots to record off going nurse signatures. --A total of 17 slots were left blank. -On 9/13/24, 9/14/24, and 10/4/24 for the 7:00 A.M. and the 7:00 P.M. shifts showed no on coming or off going signatures. -On 9/15/24, 9/23/24, and 10/7/24 for the 7:00 A.M., shift showed no on coming or off going signatures. Observation on 10/18/24 at 6:40 A.M., of the Cherry Lane non locked unit CMT medication cart narcotic count sheet dated 9/27/24 to 10/18/24 for the A.M. and the P.M. shifts showed: -A total of 44 slots to record the total number of narcotic cards in the cart. --A total of 25 slots were left blank. -A total of 44 slots to record on coming nurse signatures. --A total of 14 slots were left blank. -A total of 44 slots to record off going nurse signatures. --A total of 9 slots were left blank. -On 9/27/24 and 10/4/24, for the 7:00 A.M. and the 7:00 P.M. shifts showed no on coming or off going signatures. -On 9/28/24, 10/7/24, and 10/11/24 for the 7:00 A.M. shift showed no on coming or off going signatures. -On 10/10/24 for the 7:00 P.M. shift showed no on coming or off going signatures. During an interview on 10/18/24 at 7:17 A.M., Licensed Practical Nurse (LPN) A said: -He/she signed off going slots for all three of the medication carts for this side of facility when he/she signed on for the shift. -He/she knew that he/she should not pre-sign the off going slot. -He/she should only sign off going after counting with the oncoming nurse. 39469 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the Nurses' Narcotic Count sheet on Cherry Lane dated August 2024 showed: -On August 31st there were two shifts per day with two places for staff signatures which equaled four opportunities. --Three out of four opportunities were blank. --Number of liquid narcotics two out of two opportunities were blank. --Number of narcotics two out of two opportunities were blank. --Number of total narcotics two out of two opportunities were blank. 3. Review of the Nurses' Narcotic Count sheet on Cherry Lane dated September 2024 showed: -There were two shifts per day with two places for staff signatures which equaled 120 opportunities. --22 out of 120 opportunities were blank. --Number of liquid narcotics 43 out of 60 were blank. --Number of narcotics 31 out of 60 were blank. --Number of total narcotics 30 out of 60 were blank. -Started with 14 cards added one, destroyed 9 should have equaled 6. --Narcotic count sheet showed it started with 14 ended with 10 there was no documentation of addition or subtraction of narcotics. 4. Review of the Nurses' Narcotic Count sheet on Cherry Lane dated October 2024 showed: -10/1/24 to 10/21/24 there were two shifts per day with two places for staff signatures which equaled 84 opportunities. --13 out of 84 opportunities were blank. --Number of liquid narcotics 38 out of 42 were blank. --Number of narcotics 33 out of 42 were blank. --Number of total narcotics 7 out of 42 were blank. -Started with 10 cards added one liquid, should have equaled 11. --Narcotic count sheet showed it started with 10 added one liquid ended with 9. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 10/3/24 showed a total of 10 cards. -On 10/4/24 showed a total of 6 cards no documentation of of subtraction of cards. -On 10/18/24 showed addition of one liquid which equaled 8 cards no documentation of an additional 2 cards. -On 10/20/24 showed 9 cards with addition of one liquid which should have equaled 10. -On 10/21/24 showed the nurse had presigned the narcotic count sheet. 5. Observation and interview on 10/18/24 at 6:15 A.M. Men's locked unit with Registered Nurse (RN) A showed: -He/She had pre-signed the narcotic count for both the nurses' cart and CMT cart before the day shift arrived at the facility. -He/she had presigned the narcotic sheets as the day staff was always late. -There were many blanks on the narcotic count sheet. -He/She had not told anyone about the blanks on the count sheet he/she should have told the DON. -He/She did not know that staff were to count with the oncoming nurse/CMT and sign at the time of the count. -He/She had not had any education on narcotic count and signing. Observation and interview on 10/21/24 at 9:50 A.M. with CMT C showed: -He/She had pre-signed the narcotic count sheet for the next shift without the oncoming shift. -He/She always signed the oncoming shift and the off going shift at the same time when he/she came onto his/her shift -There were a lot of blank areas where one or two staff members had not signed verifying that the count was correct. -He/She probably should have reported the blanks to the DON but had not done that. -The night shift pre-signed the narcotic count sheet about 50% of the time. -He/She did not know that they were to count together with the oncoming shift and sign the count sheet at the same time. During an interview on 10/21/24 at 10:30 A.M. agency Licensed Practical Nurse (LPN) A said: -A second nurse did not always sign the narcotic sheet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She always pre-signed the narcotic count sheet. -He/She did not know that he/she was not supposed to do that. -There were a lot of blanks on the narcotic sign sheet which showed the count was correct. -He/She had never said anything to the DON about the blanks in the narcotic count sheet. 6. Review of Resident #24's face sheet showed he/she was admitted with the following diagnosis of Schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly). Review of the resident's Medication Administration Record (MAR) dated September 2024 showed: -He/She had a physician's order for Clonazepam (for Anxiety)1 milligram (mg) three times a day. -9/1/24 at 8:00 A.M. and 2:00 P.M. were blank. -9/5/24 at 2:00 P.M. were blank. -9/9/24 at 8:00 A.M. and 2:00 P.M. were blank. -9/14/24 at 8:00 A.M. and 2:00 P.M. were blank. -9/18/24 at 8:00 A.M. and 2:00 P.M. were blank. -Nine out of 90 opportunities were not signed out. Review of the resident's Narcotics count sheet dated September 2024 showed the medication, Clonazepam, was not signed out on the following times: -9/6/24 at 8:00 P.M. -9/10/24 at 8:00 A.M. and 2:00 P.M. -9/19/24 at 2:00 P.M. -9/23/24 at 8:00 A.M. -9/23/24 two pills were signed out at 4:00 P.M. -9/24/24 at 2:00 P.M. and 10:00 P.M. -9/27/24 at 10 P.M. Review of the resident's October 2024 POS showed the following order Clonazepam (medication used for Schizophrenia) one milligram (mg) three times a day, dated 5/30/24. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #2's face sheet showed he/she was readmitted to the facility on [DATE] with the following diagnosis of Anxiety. Review of the resident's POS dated September 2024 showed the following orders: -Lorazepam 0.5 mg two times a day for anxiety, dated 9/23/24. -Lorazepam 1.0 mg. once a day at bedtime for anxiety. Review of the resident's Narcotic Record from 10/12/24 to 10/20/24 showed: -The physician's order was for Lorazepam 1.0 mg tablet, one tablet by mouth at bedtime. -There was no second sheet for the Lorazepam 0.5 mg tablet twice a day. -On 10/13/24 the 8:00 A.M. dose and 4:00 P.M. dose should have been Lorazepam 0.5 mg not the Lorazepam 1.0 mg each time. -On 10/16/24 the 8:00 A.M. dose and 4:00 P.M. dose should have been Lorazepam 0.5 mg not the Lorazepam 1.0 mg each time. -On 10/17/24 the 8:00 A.M. dose and 4:00 P.M. dose should have been Lorazepam 0.5 mg not the Lorazepam 1.0 mg each time. No bedtime dose was given. -On 10/19/24 the bedtime dose of Lorazepam 1.0 mg was not given. -On 10/20/24 Lorazepam 0.5 mg was given not the ordered dose of Lorazepam 1.0 mg. -The count started at 30, nine whole pills (1.0 mg) were given, 12 half pills (0.5 mg) were given for a total of 15. The facility count showed 16 left. Review of the resident's MAR dated 10/12/24 to 10/20/24 showed: -The Lorazepam 0.5 mg dose should have been given 17 times. --There were two out of 17 opportunities the MAR was blank. -One half pill was not accounted for. -The Lorazepam 1.0 mg dose should have been given 9 times. 8. Review of Resident #11's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Low back pain. -Fracture of nasal (nose) bones. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Narcotic record showed the following order: -Tylenol with codeine (pain medication) every eight hours as needed. -From 9/22 to 10/4 the facility started with 60 pills. -30 pills were administered the ending count should have been 30. -The facility ending count was 28. 9. During an interview on 10/23/24 at 12:32 P.M., the DON said: -There should not be any blanks on the narcotic count sheet for the narcotic cards. -The narcotic card count should match the number of cards in the cart. -The count on the Narcotic Record should have been correct. -The nurses should not be pre-signing the on coming or the off going slots when they sign on for their shift. -Two nurses (on coming and off going) should have signed the narcotic sheets at the same time when they counted the narcotics. -If the count was not correct staff should have contacted him/her. -No staff should have left the facility until the error was found. -He/She had not been contacted about any discrepancies. -The MAR should have matched the amount that was given on the narcotic record. -The medication carts should have been locked if staff was not directly in front of it. -The charge nurse should have periodically looked at the narcotic count sheets to ensure they were accurate. -He/She was ultimately responsible to ensure the carts were locked when a staff member was not directly in front of it. -He/She was ultimately responsible for ensuring the narcotic count was completed by the on coming and off going nurses at the same time that they counted.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR) completed by the pharmacist was reviewed and responded to by the facility physician(s) and failed to monitor for side effects of anti-psychotic (the main class of drugs used to treat people with schizophrenia) medications for two sampled residents (Resident #47 and #51) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's Medication Regimen Review Policy, dated 6/26/24, showed: -Each resident was reviewed at least once a month by a licensed pharmacist. -The MRR was a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. -Review of the medical record was to prevent, identify, and resolve medication-related problems, medications errors and other recommendations. -The pharmacist communicated any irregularities to the facility physician, Director of Nursing (DON), or staff of any urgent needs. -The facility staff acted upon all recommendations according to procedure for addressing medication regimen review irregularities. Review of the facility's Use of Psychotropic Medication (used to treat mental health disorders) Policy, dated 6/26/24, showed: -A psychotropic drug was any drug that affected the brain activities associated with mental processes and behavior. -Psychotropic drugs included the following categories: anti-psychotics, anti-depressants, and anti-anxiety. -The effects of the psychotropic medications on the resident's physical, mental and psychosocial well-being will be evaluated on an ongoing basis: --Upon physician evaluation. --During the pharmacists monthly medication regimen review. --During Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--During nurse assessments and medication monitoring parameters consistent with the resident's care plan (a document created for a person that is receiving healthcare, personal care, or other forms of support). 1a. Review of Resident #47's annual MDS, dated [DATE], showed: -The resident's diagnoses included anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), depression (a low mood or loss of pleasure or interest in activities for long periods of time) and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). -The resident was cognitively intact. Review of the resident's Electronic Health Record (EHR) Progress Notes showed: -On 10/10/23 the resident had a Comprehensive Metabolic Panel (CMP-a blood test that gave doctors information about the body's fluid balance, levels of sodium and potassium, and how well the kidneys and liver are working). -On 1/11/24 the resident refused the blood test. Review of the resident's EHR Pharmacy Review Note, dated 8/17/24, showed the pharmacist recommended the resident have a blood draw for a current CMP. Review of the resident's EHR Pharmacy Review Note, dated 9/16/24, showed the pharmacist recommended to add current CMP (labs on file were past due). Review of the resident's Standing Order Daily Log, dated 10/23/24, showed the resident's blood for the CMP would be drawn in the morning. 1b. Review of the resident's annual MDS, dated [DATE], showed: -The resident's diagnoses included anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), depression (a low mood or loss of pleasure or interest in activities for long periods of time) and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). -The resident was cognitively intact. Review of the resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated August 2024 showed no monitoring for psychotropic medication side effects. Review of the resident's MAR/TAR dated September 2024 showed no monitoring for psychotropic medication side effects. Review of the resident's MAR/TAR dated October 2024 showed no monitoring for psychotropic medication side effects. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician Order Summary (POS) dated October 2024 showed the resident had the following ordered: -Risperdal (a type of antipsychotic medication that treated schizophrenia), --Give 1 milligram (mg) by mouth every morning and at bedtime related to schizophrenia. Start date 5/22/24 --Antipsychotic medication monitoring: dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, lethargy, drooling, tremors, disturbed gain, increased agitation, restlessness, involuntary movement of the mouth or tongue. --Document 'Y' on the MAR/TAR if monitored, every shift. -Hydroxyzine (a medication to help control anxiety) --Give 50 mg by mouth in the evening related to anxiety disorder. Start date 5/23/24. --Anxiety medication monitoring: drowsiness, slurred speech, dizziness, nausea aggressive/impulsive behavior. --Document 'Y' on the MAR/TAR if monitored, every shift. Start date 7/22/22. 2. During an interview on 10/21/24 at 9:32 A.M., Agency Licensed Practical Nurse (LPN) A said: -The pharmacist reviewed all resident's medications. -The pharmacist provided a list of recommendations for the physician and the nurse made sure the physician had them. -Nurses monitored for medication side effects and documented on the MAR/TAR. During an interview on 10/21/24 at 10:11 A.M., Certified Medication Technician (CMT) A said: -The pharmacist reviewed residents monthly. -The Director of Nursing (DON) gave the reviews to the physician to sign off on. -It should be in the resident's record. -He/She monitored the resident every day. -Residents were monitored after they took their medications and he/she checked on them several times a day, -Sometimes it was documented in the nurses notes. -The DON put it on the side notes. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she monitored for side effects every day, twice a day and documented on the MAR/TAR. During an interview on 10/23/24 at 9:03 A.M., the MDS Coordinator said: -The pharmacist reviewed resident's medication regimens monthly. -The DON received the pharmacists recommendations. -Physicians received a pile to look over and sign off. -The nurse would make a note in the chart that the physician wrote on the recommendation. -Resident labs were usually done after the physician signed off on it. -Pharmacist recommended labs should be done before the end of the month or before the next pharmacy review. During an interview on 10/23/24 at 12:32 P.M. the DON said: -The resident should have had labs drawn this morning. -Pharmacist orders were not being scanned in. -The resident did not have labs drawn according to the pharmacist's recommendations. -The resident should be assessed for side effects of anti-psychotic medications. -Monitoring was done by nursing staff. -The residents should be monitored according to the physician orders. -The MAR/TAR should have the order for monitoring on it. -If the monitoring was a physician order and it was not on the MAR/TAR then it was an error in transcription and did not get moved from the orders to the MAR/TAR. 22727 3. Review of Resident #51's pharmacy review note dated 8/17/24 showed: -Instructions to add a lipid panel (a blood test that measures the different types of cholesterol in the blood) for antipsychotic (class of medicines used to treat psychosis and other mental and emotional conditions) medication monitoring (individuals taking antipsychotic medications can be at higher risk for the development of lipid abnormalities). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Instructions to assess the medical risk versus benefit for elderly resident with dementia (a progressive mental disorder characterized by memory problems, impaired reasoning, and personality changes) with agitation and if the resident would benefit from a gradual dosage reduction of one or more therapy agents; or document that a change in the current therapy regimen was clinically contraindicated for: --Fluoxetine (an antidepressant) 20 milligrams (mg) every morning. --Trazodone (an antidepressant) 50 mg at bedtime. --Valproic acid (an anticonvulsant) 250 mg every six hours. Review of the resident's electronic health record (on 10/18/24) showed no response to the pharmacy review dated 8/17/24. Review of the pharmacy review notes dated 9/16/24 and 10/19/24 showed instructions to follow-up on the August 2024 recommendations. Review of the resident's annual MDS dated [DATE] showed the following staff assessment of the resident: -The mood section was not completed. -The resident had no behaviors. -Some of the resident's diagnoses included dementia, depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life), psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions), and insomnia (difficulty falling asleep or staying asleep). -The resident received antipsychotic medications on a routine basis with no gradual dose reduction and no documentation of clinical contraindication. -The resident received antidepressant medication., Review of the resident's care plan updated 9/18/24 showed: -The resident had mental illness with behaviors included yelling, combativeness, spitting at staff and refusal of cares. -Instructions for a pharmacy consultant to review medications monthly and as needed. Review of the resident's electronic health record (on 10/18/24) showed no response to the pharmacy review dated 8/17/24. Review of the resident's Physician's Order Sheet dated October 2024 showed the following physician's orders: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lipid panel dated 10/21/24 (six days after the facility survey began). -Fluoxetine 20 mg, give one capsule in the morning related to major depressive disorder. -Trazodone 50 mg, give one tablet at bedtime related to related to major depressive disorder and insomnia. -Valproic acid 250 mg every six hours related to psychosis. -Quetiapine 50 mg, give 1.5 tablet at bedtime related to psychosis. The responses to the pharmacist's recommendations were requested from the facility on 10/22/24 and none were provided. During an interview on 10/21/24 at 10:11 A.M., Certified Medication Technician (CMT) A said: -The pharmacist reviewed residents' medications monthly. -The Director of Nursing (DON) gave the reviews to the physician to sign off on. -It should be in the resident's record. During an interview on 10/23/24 at 9:03 A.M., the MDS Coordinator said: -The pharmacist reviewed residents' medication regimens monthly. -The DON received the pharmacist's recommendations. -Physicians received a pile to look over and sign off. -The nurse would make a note in the chart that the physician wrote on the recommendation. -Resident labs were usually done after the physician signed off on it. -Pharmacist recommended labs should be done before the end of the month or before the next pharmacy review. During an interview on 10/23/24 at 10:01 A.M., LPN B said the pharmacy recommendations and responses went to the DON. During an interview on 10/23/24 at 12:30 P.M., the DON said: -The pharmacist documents monthly medication review notes in the medical records. -The follow-up should be in a progress note in the medical records. -If there were no progress notes regarding follow-up on the pharmacist's recommendations, then the physician most likely did not respond. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She needed to refine their medication regimen review process.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on interview and record review, the facility failed to ensure a gradual dose reduction (GDR-tapering of a medication dose) of a psychotropic (a medication that affected mental activity, behavior, or perception) medication was attempted for two sampled residents (Residents #41 and #51) and failed to ensure labs were drawn as ordered to provide adequate monitoring for one sampled resident (Resident #14) out of 13 sampled residents. The facility census was 50 residents. Review of the facility's Gradual Dose Reduction of Psychotropic Drugs policy, dated 5/14/24, showed: -Residents who used psychotropic drugs received a gradual dose reduction and behavioral interventions, unless clinically contraindicated. -Dose reductions and behavioral interventions were part of the medication management. -Within the first year a resident was admitted to the facility on a psychotropic medication or after the prescribing practitioner indicated the medication, the facility attempted a GDR in two separate quarters. -GDR was documented in the electronic health record (EHR) -The physician documented the clinical rationale to contraindicate the GDR in the EHR. 1. Review of Resident #41's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/18/24, showed the resident was severely cognitively impaired. Review of the resident's Medication Regimen Review (MRR) completed by the pharmacist, dated 8/14/24, showed: -The pharmacist requested a GDR. -There was no physician response. Review of the resident's MRR completed by the pharmacist, dated 9/16/24, showed: -The pharmacist requested a GDR. -There was no physician response. Review of the resident's Physician Order Summary (POS) dated October 2024, showed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was diagnosed with vascular dementia (impaired supply of blood to the brain), anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), and psychotic disturbance (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). -The resident was ordered: --Depakote (medication used to treat certain psychiatric conditions), 250 milligrams (mg) by mouth in the mornings for dementia, anxiety, and psychotic disturbance. --Quetiapine Fumarate (an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder) 25 mg by mouth in the mornings. During an interview on 10/23/24 at 12:30 P.M. the Director of Nursing (DON) said: -GDR's should be completed quarterly. -If the physician agreed it would be documented in the progress notes. -If a physician disagreed with the pharmacy recommendation it would also be documented in the progress notes. -If neither was in the progress notes the physician would be notified via email. -He/She was responsible for ensuring the physician saw the pharmacy recommendations. -There was no note in the progress notes regarding a completed GDR for the resident. 51150 2. Review of the facility's use of psychotropic medication policy, dated 6/26/24, showed: -Residents were not given psychotropic drugs unless the medication was beneficial to the resident as demonstrated by monitoring and documentation of the resident's response. -The effects of a psychotropic medication on a resident's physical, mental, and psychosocial wellbeing, would be evaluated on an on-going basis, such as in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturers specifications, and the residents comprehensive plan of care. Review of Resident #14's care plan, initiated 3/19/24, showed no antipsychotic medication monitoring. Review of the resident's Physician Order Summary (POS), dated 6/12/24, showed: -Lithium Carbonate (A psychotropic medication) Extended Release (ER) tablet 300 mg. Give three tablets by mouth at bedtime related to schizoaffective disorder (A rare mental illness that combines symptoms of schizophrenia and a mood disorder). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lithium level labs were to be drawn every three months, ordered on 3/18/24. Review of the resident's annual MDS dated [DATE], showed: -The resident was moderately cognitively impaired. -The resident was taking an antipsychotic medication. Review of the resident's pharmacy note dated 9/16/24 at 2:59 P.M., showed the pharmacist recommended to add current labs (past due) to the results section in the resident's medical record for therapy monitoring. Review of the resident's electronic medical record on 10/18/24 at 1:00 P.M., showed: -The resident had one lithium level in his/her medical record for the past 12 months, on 5/29/24. -The resident's medical record did not have documentation nor indication of missing lithium levels or follow up on any resident refusals. -NOTE: The resident should have had 4 documented lithium levels in a 12-month period. During an interview on 10/21/24 at 3:03 P.M., the Director of Nursing (DON) said after his/her review, the resident's lithium level order was not placed in the lab database and that was why the labs were not getting drawn every 3 months as ordered by the physician. During an interview on 10/23/24 at 11:38 A.M., Licensed Practical Nurse (LPN) B said: -The nurses did not have online access to the lab company's database to see resident's orders. -A resident's lab orders should have been placed in the lab database and in the resident's, physician orders in the medical record. -It was the responsibility of the nurses to ensure that resident's labs were drawn, and the physician was notified. -If a resident refused an ordered lab, it should have been documented in the resident's nursing notes section of his/her electronic medical record. -He/she was unaware how often the resident was supposed to have his/her lithium level drawn. During an interview on 10/23/24 at 12:34 P.M., the DON said: -He/she was responsible for putting a resident's lab orders in the lab company database. -He/she was unaware of how the lithium lab order was missed. -When a resident refused a lab draw the refusal should have been charted in the resident's medical record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a resident refused a lab draw, the draw should have been attempted again and the physician notified. -The resident was missing his/her lithium level lab draw from August 2024. -He/she would have expected a lithium level to be drawn and documented every three months as ordered. 22727 3. Review of Resident #51's pharmacy review note dated 8/17/24 showed: -Instructions to assess the medical risk versus benefit for elderly resident with dementia (a progressive mental disorder characterized by memory problems, impaired reasoning, and personality changes) with agitation and if the resident would benefit from a gradual dosage reduction (GDR) of one or more therapy agents; or document that a change in the current therapy regimen was clinically contraindicated for: --Fluoxetine (an antidepressant) 20 milligrams (mg) every morning. --Trazodone (an antidepressant) 50 mg at bedtime. --Valproic acid (an anticonvulsant) 250 mg every six hours. Review of the resident's electronic health record showed no response to the pharmacy review dated 8/17/24. Review of the pharmacy review note dated 9/16/24 showed instructions to follow-up on the August 2024 recommendations. Review of the resident's annual MDS dated [DATE] showed the following staff assessment of the resident: -The mood section was not completed. -The resident had no behaviors. -Some of the resident's diagnoses included dementia, depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life), psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions), and insomnia (difficulty falling asleep or staying asleep). -The resident received antipsychotic medications on a routine basis with no gradual dose reduction and no documentation of clinical contraindication. -The resident received antidepressant medication. Review of the resident's care plan updated 9/18/24 showed: (continued on next page)

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Parkway Health Care Center	2323 Swope Parkway Kansas City, MO 64130

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had mental illness with behaviors included yelling, combativeness, spitting at staff and refusal of cares. -Instructions for a pharmacy consultant to review medications monthly and as needed. Review of the pharmacy review notes dated 10/19/24 showed instructions to follow-up on the August 2024 recommendations. Review of the resident's electronic health record showed no response to the pharmacy review dated 8/17/24. Review of the resident's Physician's Order Sheet dated October 2024 showed the following physician's orders: -Fluoxetine 20 mg, give one capsule in the morning related to major depressive disorder. -Trazodone 50 mg, give one tablet at bedtime related to related to major depressive disorder and insomnia. -Valproic acid 250 mg every six hours related to psychosis. -Quetiapine 50 mg, give 1.5 tablet at bedtime related to psychosis. The responses to the pharmacist's GDR recommendations were requested from the facility on 10/22/24 and none were provided. During an interview on 10/21/24 at 10:11 A.M., Certified Medication Technician (CMT) A said: -The pharmacist reviewed residents' medications monthly. -The DON gave the reviews to the physician to sign off on. -It should be in the resident's record. During an interview on 10/23/24 at 9:03 A.M., the MDS Coordinator said: -The pharmacist reviewed residents' medication regimens monthly. -The DON received the pharmacist's recommendations. -Physicians received a pile to look over and sign off. -The nurse would make a note in the chart that the physician wrote on the recommendation. -Resident labs were usually done after the physician signed off on it. -Pharmacist recommended labs should be done before the end of the month or before the next pharmacy review. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 10:01 A.M.,LPN B said the pharmacy recommendations and responses went to the DON. During an interview on 10/23/24 at 12:30 P.M., the DON said: -The pharmacist documents monthly medication review notes in the medical records. -The follow-up should be in a progress note in the medical records. -If there were no progress notes regarding follow-up on the pharmacist's recommendations, then the physician most likely did not respond. -GDRs were recommended quarterly. -The physician should agree or disagree with the recommendation of a GDR or should document a reason if he/she disagreed. -The documentation should be in the physician's progress note or practitioner's note.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on observation, interview, and record review, the facility failed to ensure medication carts were locked when nursing staff was not in direct observation of the medication cart, failed to ensure there were no extra objects in with the residents prescribed medications, and failed to ensure there were no loose pills in the drawers of the medication cart, The facility census was 50 residents. Review of the facility's policy, Medication Storage Policy, dated 5/18/24 showed: -All drugs and biologicals would have been stored in locked compartments. -During a medication pass, medications must have been under the direct observation of the person administering medications or locked in the medication storage area/cart. -Disinfectants were to have been stored separately from internal medications. 1. Observation on 10/16/24 from 9:42 A.M. to 9:48 A.M., showed: -A Certified Medication Technician (CMT) medication cart on [NAME] Hall unlocked for five minutes. -The CMT was in a resident's room out of sight of the unlocked cart. -He/She was not within direct observation of the unlocked medication cart. -He/She had left the medication cart facing outwards to the hall unlocked. -At 9:42 A.M., a resident in a wheelchair rolled past the unlocked cart. -At 9:44 A.M., two residents ambulated behind the unlocked cart. -At 9:47 A.M., two residents were observed standing less than a foot from the unlocked cart. During an interview on 10/18/24 at 7:49 A.M., CMT A said medication carts should not be left unlocked when staff are not at them. 39469 2. Observation on 10/21/24 at 9:50 A.M. with CMT C showed: -The CMT medication cart was unlocked on Cherry Lane. -He/She was passing medications in the dining room, and was not within direct observation of the unlocked medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The unlocked CMT medication cart was stationed in the hallway out of his/her sight for two minutes while he/she was administering medications to the residents three different times. -Two residents went to the nurses' station and walked by the unlocked medication cart within one foot two different times. -There was an opened cup of apple sauce from a previous shift and hand sanitizer in a drawer with the resident's prescribed medications. -There were two loose pills (one red round pill) and (one orange oblong pill) in the bottom of a drawer of the medication cart. -The was a container of bleach wipes in a drawer with the resident's prescribed medications. During an interview on 10/21/24 at 9:50 A.M. CMT C said: -The person who used the cart was responsible for ensuring it was clean. -There should not have been any loose pills in the cart. -At all times the medication cart should have been locked if it was not within sight. -There should not have been bleach wipes, opened applesauce, or hand sanitizer in the same compartment as the resident's prescribed medications. 3. During an interview on 10/21/24 at 10:30 A.M. Licensed Practical Nurse (LPN) A said: -There should not have been any loose pills, opened apple sauce, bleach wipes, or hand sanitizer in with the resident's prescribed medications. -The person who used the medication cart was responsible for keeping it clean and without other objects in with the resident's prescribed medications. -At all times, the medication carts should have been locked if staff were not in front of it using it. -The residents on this floor would get into everything so staff needed to be careful. During an interview on 10/23/24 at 12:30 P.M. the Director of Nursing said: -The medication carts should have been locked if the nursing staff was not within direct observation of it. -The staff member who used the cart was responsible for ensuring there were no other objects in the cart. -There should not have been loose pills in the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There should not have been bleach wipes or hand sanitizer in the medication cart in the same drawer as the resident's medications. -He/She was ultimately responsible for ensuring the medication carts were kept clean and locked when not in direct observation by the nursing staff.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on observation, interview, and record review, the facility failed to ensure routine and emergency dental services to meet the needs of residents were offered for two sampled residents, (Resident #9 and #17) out of 13 sampled residents. The facility census was 50 residents. Review of the facility policy titled Dental Services, updated on 6/26/24, showed: -It is the policy of the facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. -Emergency dental services include services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that requires immediate attention by a dentist. -The dental needs of each resident are identified through the physical assessment and Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) assessment processes and are addressed in each resident's plan of care. -Referrals to dental providers shall be made as appropriate. -All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record. 1. Review of Resident #9's admission Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 6/5/24 showed the resident: -Was admitted to the facility on [DATE]. -Was cognitively intact. -Had no natural teeth or tooth fragments. -NOTE: The resident had his/her natural teeth and had a broken natural tooth upon admission. Review of the resident's concerns questionnaire dated 5/31/24 showed: -Dental services were needed. -The resident had a broken tooth. -The resident requested to see a dentist and to have his/her broken tooth pulled. Review of the resident's history and physical transfer note dated 6/5/24, showed: -The resident had a broken tooth. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident needed to see a dentist. Review of the resident's progress note dated 7/22/24, showed a dental referral was ordered on admission to the facility and was never completed. Observation on 10/16/24 at 10:30 A.M., showed the resident had a broken tooth. During an interview on 10/22/24 at 1:00 P.M., the resident said: -He/she had a broken tooth upon admission to the facility. -He/she informed the facility staff of the broken tooth upon admission to the facility. -He/she had informed the facility Social Services Director several times since admission that he/she needed to see a dentist. -He/she had not been offered to see a dentist since being admitted to the facility. -He/she had not been seen by a dentist since being admitted to the facility. -He/she believed that the same broken tooth also had a cavity in it now. -He/she has pain in the tooth when he/she ate or drank. -He/she was worried about the tooth getting infected. During an interview on 10/23/24 at 9:06 A.M., the MDS Coordinator said: -He/she was currently the one responsible for creating a resident's MDS assessment and care plan. -He/she was temporarily covering as the MDS Coordinator at this facility as they did not have a full time MDS coordinator. -A MDS assessment should have been completed upon a resident's admission to the facility and should have included a dental assessment. -He/she would expect a broken tooth to be reflected on a resident's MDS and care plan. -Social services would be responsible for getting a resident who had a broken tooth on admission the dental services that the resident needed at the facility. -A resident who had a broken tooth upon admission to the facility should have been set up to see a dentist promptly. During an interview on 10/23/24 at 9:25 A.M., Certified Nurse Assistant (CNA) D said: -He/she was not familiar with the resident. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she always worked on the locked unit and had never worked with the resident. -He/she would report a broken tooth to the charge nurse, if made aware of one. During an interview on 10/23/24 at 9:30 A.M., Certified Medication Technician (CMT) D said: -He/she was not aware that the resident had a broken tooth. -He/she was not aware how often the dentist came to the facility to see residents. -He/she was not aware of the process the facility takes to ensure that the residents get the dental care that they need. -He/she would report resident dental issues to the charge nurse. During an interview on 10/23/24 at 9:40 A.M., the Social Services Director said: -He/she worked as the social services director at this facility part time. -He/she worked on average 2-3 days per week at the facility. -He/she was not aware of the resident's broken tooth. -The Director of Nursing (DON) had been the one making appointments for residents who needed to see a dentist. -He/she wanted to change ways that appointments with Physicians were being made because many residents were being missed. -The admission nurse and the MDS Coordinator should have told the previous social worker about the resident having a broken tooth upon admission to the facility. -He/she was unsure how often the dentists saw residents at the facility. -He/she had not seen or scheduled any visits with a dentist since he/she took his/her position. -He/she would have expected a resident who had a broken tooth upon admission to the facility be able to see a dentist within a couple weeks. During an interview on 10/23/24 at 11:38 A.M., Licensed Practical Nurse (LPN) B said: -He/she did not know a lot about the resident. -He she was not aware the resident had any dental problems. -He/she would notify the Director of Nursing (DON) or the Social Services Director if he/she was made aware a resident had a broken tooth. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 12:34 P.M., the DON said: -A resident who had a broken tooth on their initial assessment should have been addressed on the MDS and care plan. -A resident with a broken tooth on their initial assessment should have been communicated to the Social Services Director. -He/she would have expected a resident who had a broken tooth on their initial assessment to be set up to see the dentist. -He/she was not aware of the resident having a broken tooth. -He/she was not aware of the documentation that reflected the resident having a broken tooth. -He/she was not sure why the information was not relayed to the Social Services Director or why an appointment with a dentist had not been made. 37576 2. Review of Resident #17's Admission Record showed a diagnosis of Dysphagia (inability or difficulty swallowing) on 3/1/2024. Review of the resident's dental record dated 5/16/24, no time noted showed: -Resident was last seen on 3/21/24. -Resident presented for his/her six-month exam and was edentulous (having no teeth). -Resident had dentures. -Resident didn't like the lower denture but had no ridge. -Adjusted fit. Review of the resident's Care Plan dated 6/14/24 showed: -The resident had a swallowing problem and was an aspiration risk (the likelihood of inhaling food, liquids, or vomit into the lungs). -He/She was on a mechanical soft diet (a diet that restricts foods that are difficult to chew or swallow, foods can be finely chopped, blended, or ground to make them smaller, softer and easier to chew). -The resident did have partial dentures (removable dental device that replaces one or more missing teeth and have a clasp that hooks around the remaining teeth). (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Quarterly MDS dated [DATE] showed no loose fitting full or partial dentures. Review of the resident's Physicians Order Sheet (POS) dated October 2024 showed a dental consult was ordered on 4/22/24 regarding a nodule under the right side of the tongue due to dentures. Review of the resident's electronic medical record showed he/she had not been seen by the dentist after the 4/22/24 order. During an interview on 10/15/24 at 11:22 A.M., the resident said: -He/She had full dentures and the bottom one did not match up with the top denture. -Saw a dentist that came to the facility a long time ago who was supposed to fix the bottom denture. -The dentist had not fixed them yet. -Wore the bottom denture when eating but it was uncomfortable to wear. -Was put on ground up food to be able to chew easier. -Kept the bottom denture in a denture cup in his/her room when not eating. Observation on 10/15/24 at 12:30 P.M., during the lunch meal showed: -The resident took his/her lower denture from a denture cup and put it in his/her mouth to eat. -The resident finished eating and he/she removed the denture and placed it back in the denture cup -The resident took the denture cup to his/her room. Review of the resident's Health Status Note dated 10/18/24 at 1:22 P.M. showed: -The resident reported that his/her dentures needed to be shaved down, so they fit better. -The resident showed the nurse his/her dentures and he/she felt like they don't fit well because they were too thick. -The nurse offered adhesive to cushion and he/she declined. -The resident asked nurse for a file. -Notified the Social Service Director (SSD) for dental appointment. During an interview on 10/23/24 at 8:55 A.M., the SSD said: -Had been at the facility for six weeks. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had been collecting all the ancillary visits including dental visits to keep track of what residents may need. -The SSD was supposed to be responsible for making appointments for the residents. -The DON had been the one making appointments for residents who needed to see a dentist. -He/she had not scheduled any visits with a dentist since he/she took his/her position. During an interview on 10/23/24 at 9:24 A.M., the MDS Coordinator said: -If a resident had dentures it should be reflected in the MDS and in the care plan. -He/She was the temporary MDS coordinator at this time. -MDS's were updated quarterly. -He/She updated the care plan when he/she did the MDS. During an interview on 10/23/24 at 12:32 P.M., the DON said: -The SSD was the person who should be making appointments for residents. -He/She had been making appointments when he/she knew that a resident needed an appointment. -The SSD was fairly new. -He/She would find out what appointments a resident may need from a resident self-report, or the resident told a staff member, or indication of eating problems or pain.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 38452 Based on observation and interview, the facility failed to hire an adequate number of dietary staff to safely carry out all of the functions of the food and nutrition services, in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service and safety. This deficient practice potentially affected all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 50 residents with a licensed capacity for 97 residents at the time of the survey. 1. Observation on 10/15/24 between 2:04 P.M. and 2:52 P.M. showed the Dietary Manager (DM) was the only staff in the kitchen at that time. During an interview on 10/15/24 between 2:04 P.M. and 2:52 P.M. the DM said the following: -The dietary staff consisted of 1 morning cook and aide and 1 afternoon cook and aide. -There was not enough staff because of their low resident census. -He/She filled in the gaps in staffing as needed. Observation on 10/18/24 between 12:03 P.M. and 12:11 P.M. showed the DM was accompanied by two other staff members in the kitchen at that time. During an interview on 10/18/24 at 12:11 P.M. the DM said they had started to use Styrofoam plates and cups and plastic utensils because though he/she normally had a cook and two aides, one of which was a dishwasher, because of the low census his/her staff was cut down and they were without a dishwasher now.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation, interview, and record review, the facility failed to follow pre-prepared menus to ensure they met the nutritional adequacy needs of residents; failed to have basic food items in stock that were called for in their main menus; and failed to have a comparable always available or alternate foods menu posted that was nutritionally equal to the main dishes, in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service. This deficient practice potentially affected all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 50 residents with a licensed capacity for 97 residents at the time of the survey. Review of the 7-page Dietary Resident Rights Policy, last reviewed 11/6/23 and provided by the Administrator, showed under Section XIII. Accommodation of Needs, that Substitutes of like calorie value will be offered to the resident if the planned menu is refused. 1. Review of the pre-prepared 4-week rotation of menus for the current month provided by the Dietary Manager (DM) showed the meal items that were listed were taken from a website called DiningRD.com. During an interview on 10/15/24 at 2:04 P.M. the DM said the following: -Their menus did not come from their food vendor who was U.S. Foods. -If a resident did not like the pork being served, they had soup on hand. Observation on 10/18/24 between 9:33 A.M. and 11:07 A.M. showed there were no alternate foods or always available foods menus posted in either of the dining rooms currently in use. Review of the pre-prepared 4-week rotation of menus for the current month provided by the DM showed the meal items that were listed for lunch on 10/23/24 were roast beef, mashed potatoes and gravy, mixed vegetables, and cake with a beverage. Observation on 10/23/24 at 12:19 P.M. showed a test plate delivered from the kitchen consisted of a Sloppy [NAME] on a hamburger bun and tater tots. During an interview on 10/23/24 between 12:11 P.M. and 12:44 P.M. the DM said the following: -He/She did not order their foodstuffs, their Regional Dietary Manager (RDM) did. -Sometimes the RDM did not check the menus for what was actually needed. -One time they received hot dogs instead of the scheduled pulled pork so they had to make a substitution. -That day they apparently did not order the roast beef for lunch so he/she had to substitute Sloppy [NAME]'s instead. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-If a resident did not like what was scheduled for a particular meal he/she would try to give them something in similar calories and nutritional value.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation and interview, the facility failed to keep the kitchen and Dry Storage (DS) room floors clean; failed to retain operable thermometers in all refrigerators and/or freezers to confirm adequate temperature ranges; failed to maintain plastic and/or rubber cutting boards and utensils in good condition to avoid food safety hazards (cross-contamination); failed to separate damaged foodstuffs; and failed to store foodstuffs within recommended temperature parameters, in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 50 residents with a licensed capacity for 97 residents at the time of the survey. 1. Observation on 10/15/24 between 2:04 P.M. and 2:52 P.M. during the initial kitchen inspection with the Dietary Manager (DM) showed the following: -There was a 6 pound (lb.) 10 ounce (oz.) can of fruit cocktail on a dispenser rack that was heavily dented at its bottom side and two 7 lb. 5 oz. cans of jellied cranberry sauce with rusted top rims on the top shelf of a bakers rack next to the dispenser rack in the DS room. -Blood was puddling in the bottom of Unit #4 reach-in refrigerator labeled Meat Freezer and a temperature log on the outside with only [DATE] & 2 marked at 0 degrees Fahrenheit (F.), but an inside thermometer read 20 F. -An open 1 gallon (gal.) jug of teriyaki sauce approximately (app.) 1/7 full on a rack next to the can dispenser read Refrigerate After Opening on its label. -There was cardboard, an artificial sweetener packet, an onion peel, a 32 oz. bag of powdered sugar, and puddling water under the food racks in the DS. -An open 1 gal. jug of soy sauce on a rack behind the door to the DS read Refrigerate After Opening for Quality on its label. -There was paper residue on a manual can opener in the kitchen. -2 white spatulas with chipped edged blades were in a utensil drawer of a food preparation table. -A green cutting board by the dishwashing machine was excessively scored to the point of plastic bits flaking off. Observation on 10/18/24 between 12:03 PM and 12:11 P. M showed the following: -There was a 6 lb. 10 oz. can of fruit cocktail on a dispenser rack that was heavily dented at its bottom side and two 7 lb. 5 oz. cans of jellied cranberry sauce with rusted top rims on the top shelf of a bakers rack next to the dispenser rack in the DS room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Blood was puddling in the bottom of Unit #4 reach-in refrigerator labeled Meat Freezer and no temperature log on the outside, but an inside thermometer read 22 F. -An open 1 gal. jug of teriyaki sauce approximately 1/7 full on a rack next to the can dispenser read Refrigerate After Opening on its label. -There was a small packet of iodized salt, an artificial sweetener packet, an onion peel, a 32 oz. bag of powdered sugar, and puddling water under the food racks in the DS. -An open 1 gal. jug of soy sauce on a rack behind the door to the DS read Refrigerate After Opening for Quality on its label. -There was paper residue on a manual can opener in the kitchen. -2 white spatulas with chipped edged blades were in a utensil drawer of a food preparation table. -A green cutting board by the dishwashing machine was excessively scored to the point of plastic bits flaking off. During an interview on 10/23/24 at 1:44 P.M. the new DM said the following: -All dietary staff were responsible for cleaning the kitchen and DS floors twice weekly. -He/She would expect if a foodstuff read store at a certain temperature on its label that it would be. -Damaged foodstuff cans were set aside, their Regional Dietary Manager (RDM) notified, and they would contact the food vendor for a credit. -Damaged food preparation items were reported to the RDM, tossed and replaced. -He/She would expect food to be free of foreign substances.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 38452 Based on observation, interview, and record review, the facility failed to maintain a well-known, on-site policy regarding the acceptance, usage, and storage of foods brought into the facility for residents by food delivery services, family, and/or other visitors, to ensure the food's safe and sanitary handling, storage, and consumption. This deficient practice had the potential to affect all residents who ate food brought in by visitors. The facility census was 50 residents with a licensed capacity of 97 residents. 1. Observation on 10/15/24 between 2:04 P.M. and 2:52 P.M. during the initial kitchen inspection with the Dietary Manager (DM) showed there was a reach-in refrigerator in a hallway outside the kitchen and a reach-in freezer in the Dry Storage room. Review of the Dietary Resident Rights Policy, last reviewed 11/6/23 and provided by the Administrator, under Section XIII. Accommodation of Needs, read, Food purchased from vending machines, brought in by family or friends of the patient, or ordered by the resident will be considered personal property of the patient. Staff will assist resident in storage of food in a safe, sanitary manner. During an interview on 10/23/24 at 12:44 P.M., in the kitchen the DM said the following: -He/She did not know if the facility had any policy about outside food brought in for residents. -He/She did know they would need to eat it in the lobby and not take it back to their room.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive, facility-specific infection prevention and control program designed to help prevent the development and transmission of Legionella (A [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease), in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) standards and guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. Additionally the facility failed to ensure an Infection Control Surveillance program was completed for the previous 12 months to include all infections in the facility, including those not treated with an antibiotic, failed to ensure residents were tested upon admission and annually with a two step tuberculosis (TB - a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) skin test for five sampled residents (Resident #5, #43, #46, #41, and #33) out of 13 sampled residents and for four sampled employees (Employee A, B, C, and G) out of seven sampled employees, failed to ensure staff wore gloves when cleaning up a bodily fluid spill, failed to ensure supplies were available for staff and residents to perform hand hygiene (soap and towels), failed to ensure Enhanced Barrier Precautions were utilized while staff provided wound care, and failed to ensure EBP signage and an isolation cart with Personal Protective Equipment (PPE) supplies were readily available outside of the resident rooms for one sampled resident (Resident #43), and failed to ensure soap, towels, and toilet paper were readily available for staff and residents to perform hand hygiene on the locked unit. The facility census was 50 residents with a licensed capacity for 91 residents at the time of the survey. 1. Observation on 10/15/24 between 2:04 P.M. and 2:52 P.M. during the initial facility Life Safety Code (LSC) kitchen inspection with the Dietary Manager (DM) showed there was a three-sink area, an ice machine, a chemical dish-washing machine, a hand-washing sink, and an ice machine out in the hallway. Review of the facility's policy, dated 2017 and provided by the Administrator, showed a 2-page (pg.) document entitled Emergency Water Protocol, that consisted of guidelines and procedures on how much drinkable water they should have on-hand in an emergency or disaster, and included nothing about water-borne pathogen prevention. During an interview on 10/21/24 at 2:07 P.M. the Administrator said that 2-pg. document was their Legionella paperwork. Observation on 10/23/24 between 12:56 P.M. and 1:45 P.M. during the facility LSC walk-through inspection showed the following: -The building was equipped with a full fire sprinkler system and had its incoming water supplied by the local water company. -There were two commercial clothes washers in the laundry area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On the 100 Unit there was a steam table and a sink in the dining room along with a Utility closet with a mop hopper and six multi-bed resident rooms with restrooms. -On the East 200-300 Unit there was a Bathhouse along with 14 single and multi-bed resident rooms with restrooms. -There was a steam table and a sink in the Main Dining Room that led to the 400 Unit. -On the [NAME] 400 Unit that was being renovated behind plastic curtains there was a Bathhouse along with 12 unoccupied single and multi-bed resident rooms with restrooms. -On the Lower Level 30 Unit that was also being renovated there was a sink in the dining room, a Bathhouse, and 11 unoccupied resident rooms with restrooms. Review on 10/23/24 of the facility's undated binder entitled Legionella Water Management, provided by the Maintenance Supervisor (MS), showed the following: -There were eight sections of various information, guidelines, policies and procedures, most of which were educational. -The pages with the Building Water Flow Diagram also had a written explanation of the water flow throughout the facility, but nowhere indicated specific areas of risk, like dead ends or unused plumbing/pipes, with their rated potential of likelihood and risk level for each. -The last section was a 36-pg. CDC toolkit with the assessment questions left blank. -There was no facility-specific risk management plan assessment that considered all elements of the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188. -There was no documentation of any site logbook being maintained with any cleanings, sanitizings, descalings, and/or inspections mentioned. During an interview on 10/23/24 at 2:03 P.M. the Administrator said the following: -He/She read their Legionella policies in order to apply things to this facility. -His/Her Regional Plant Operations person also showed them how to find certain things. During an interview on 10/23/24 at 2:11 P.M. the MS said the following: -He/She went by the binder to implement the program's basic requirements. -They had started the program after a resident was admitted with Legionella a few years ago. -He/She was educated on the requirements by the previous Administrator. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The two units being renovated was due to a resident having pulled down a fire sprinkler pipe which burst and flooded the [NAME] 400 Unit and the Lower Level 30 Unit below it. 32720 2. Review of the facility's Infection Prevention and Control Program policy dated 6/26/24 showed: -A system of surveillance was utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. -The Infection Preventionist (IP) served as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility. Review of the facility's Infection Control Surveillance log book for the previous 12 months showed: -No documentation of infection tracking for October 2023, November 2023. -December 2023 showed one resident had a Urinary Tract Infection (UTI - an infection of one or more structures in the urinary system). -January 2024 and February 2024 showed no documentation of any infections. -March 2024 showed three residents with a UTI and one resident with an unknown infection. -April 2024 showed one resident with an unknown infection. -May 2024 showed one resident with an unknown infection and one resident with a UTI. -June 2024 showed one resident with an unknown infection. -July 2024 showed one resident with an unknown infection and three residents with a UTI. --A map included in the tracking folder showed two residents with UTI, five residents with a skin infection, and one resident with COVID (a new disease caused by a novel (new) coronavirus). -August 2024 showed one resident with a UTI. -September 2024 showed no documentation of any infections. During an interview on 10/21/24 at 2:07 P.M., the Director of Nursing (DON) said: -The Infection Control Surveillance log book should have included all infections in the building. -He/She had a system in the electronic medical records he/she could use to help track infections in the building. It did not match the infections listed in the log book. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-It appeared the book only contained infections that were treated with antibiotics. -The July 2024 map included all infections, not just those that were treated with antibiotics. -The log book was incomplete. 3. Review of the facility's Tuberculosis Testing policy dated 6/29/23 showed: -The purpose was to ensure each resident and employee of the facility was tested for TB after entering the facility to prevent the spread of infection. -Upon hire, a new employee would receive a two step TB skin test. -Upon admission and readmission each resident would receive a two step TB skin test. -Each resident would also have an annual one step TB skin test. Review of the facility's Infection Prevention and Control Program policy dated 6/26/24 showed direct care staff should be tested for TB upon hire. 3a. Review of Employee A's employment file showed: -His/Her hire date was 7/30/24. -He/She had a TB skin test completed on 8/1/24. A second step TB skin test was not completed. 3b. Review of Employee B's employment file showed: -His/Her hire date was 9/24/24. -No documentation a TB skin test was completed. 3c. Review of Employee C's employment file showed: -His/Her hire date was 4/23/24. -No documentation a TB skin test was completed. 3d. Review of Employee G's employment file showed: -His/Her hire date was 6/11/24. -No documentation a TB skin test was completed. 4a. Review of Resident #5's face sheet showed he/she was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's annual TB skin test showed a TB skin test was documented as administered on 1/11/24 with a result of 0 millimeters (mm) induration. The result did not include the date the TB test was read. 4b. Review of Resident #43's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's admission TB skin test showed: -He/She had a TB skin test from a previous facility. The test was documented as completed on 4/23/24 with a result of 0 mm induration. The result did not include the date the TB test was read. -No documentation a second TB skin test was completed upon admission to the facility. 4c. Review of Resident #46's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's annual TB skin test showed no documentation of a TB skin test since 6/29/22. 4d. Review of Resident #41's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's annual TB skin test showed he/she had a TB skin test on 1/11/24 with a result of 0 mm induration. The result did not include the date the TB skin test was read. 4e. Review of Resident #33's face sheet showed he/she was admitted to the facility on [DATE], Review of the resident's annual TB skin test showed: -He/She had a TB skin test on 1/11/24 with a result of 0 mm induration. The result did not include the date the TB skin test was read. -He/She had a TB skin test on 1/23/24 with a result of 0 mm induration. The result did not include the date the TB skin test was read. During an interview on 10/21/24 at 2:07 P.M., the DON said: -All residents should have a two step TB skin test upon admission to the facility. -If the resident had a recent TB skin test from another facility, they would use that as the first step, but the resident would still need a second step TB skin test upon admission. -All staff should have a two step TB test. The first step upon hire, the second step a couple weeks later. -TB skin tests should have a read date within 48-72 hours from the test being administered. -It appeared as though the resident TB skin tests were not entered in the electronic medical records correctly which was why it did not give staff the option of entering the TB skin test read dates. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Any staff nurse could administer and read the TB skin tests. -Normally the Human Resource person would track staff TB to ensure they were completed and completed timely. 39469 5. Review of the CDC Implementation of PPE Use in Nursing Homes to Prevent Spread of Multi Drug-Resistant Organisms (MDROs), dated 4/2/2024, showed the following: -Enhanced Barrier Precautions (EBP) may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO. -When implementing enhanced barrier precautions, it was critical to ensure that staff had awareness of the facility's expectations about hand hygiene and gown/glove use. -Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE. -For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. -Make PPE, including gowns and gloves, available immediately outside of the resident room. Review of the facility Enhanced Barrier Precautions policy dated 5/18/24 showed: -EBP expanded the use of PPE beyond situations which exposure to blood and body fluids was anticipated. -EBP used gown and gloves during high contact resident care activities. -EBP (gown and gloves) must be used for high contact resident care activities for residents with wounds and/or indwelling medical devices. -High contact resident care activities included but were not limited to: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, indwelling device care or use, or wound care. 6. Observation on 10/15/24 at 10:23 A.M. showed Licensed Practical Nurse (LPN) B was wiping up a resident's saliva (spit) with paper towels and ungloved bare hands. He/She did not wash his/her hands after cleaning up the saliva. Observation on 10/15/24 at 11:25 A.M. showed: -No paper towels were readily available for staff or residents to dry their hands at the sink in the dining room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An unidentified resident washed his/her hands in the dining room sink and wiped his/her hands dry on his/her dirty pants due to not having paper towels available. Observation on 10/15/24 at 1:15 P.M. showed: -The outside door leading to the smoking area had a red colored stain on it. -The warming table in the resident's dining room had not been cleaned off after lunch service. Observation on 10/16/24 at 9:00 A.M. showed: -The warming table in the resident's dining room had not been cleaned off after breakfast service. -One resident was eating crumbs off of the warming table. -The outside door leading to the smoking area had a red colored stain on it. Observation on 10/16/24 at 1:00 P.M. of resident room [ROOM NUMBER] showed: -The bathroom did not have any soap or paper towels for hand hygiene and did not have any toilet paper for the residents. -The bathroom was shared by four residents who resided in room [ROOM NUMBER]. Observation on 10/18/24 at 9:00 A.M. of resident rooms [ROOM NUMBER] showed: -room [ROOM NUMBER] was shared by four residents. The bathroom did not have any soap or paper towels for hand hygiene and did not have any toilet paper for the residents. -room [ROOM NUMBER] was shared by four residents. The bathroom did not have any soap or paper towels for hand hygiene and did not have any toilet paper for the residents. -room [ROOM NUMBER] was shared by four residents. The bathroom did not have any soap or paper towels for hand hygiene and did not have any toilet paper for the residents. During an interview on 10/18/24 at 9:28 A.M., LPN B said he/she did not know how the residents would have cleansed their hands after they used the restroom without soap or paper towels. During an interview on 10/18/24 at 10:10 A.M., Certified Medication Technician (CMT) B said: -He/She knew they did not put paper towels or soap in the residents' bathrooms because the residents would eat the soap or flush the paper towels down the toilet. -There should be toilet paper in the rooms. During an interview on 10/21/24 at 9:50 A.M. , CMT C said: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 8/23/24 showed he/she was moderately cognitively impaired. Observation on 10/16/24 at 9:30 A.M. of the resident showed no isolation cart or signage on his/her bedroom door indicating the resident was on Enhanced Barrier Precautions. During an interview on 10/16/24 at 9:30 A.M., Agency LPN A said: -He/She did the resident's wound care daily. -The resident did not require any precautions when providing care. During an interview on 10/16/24 at 9:30 A.M., the resident said: -The nurse usually did his/her cares. -The staff did not wear a gown when providing cares, but they did wear gloves. During an interview on 10/18/24 at 6:15 A.M., Registered Nurse (RN) A said: -The locked unit had one resident who required Enhanced Barrier Precautions. -There was one isolation cart for the unit that was kept near the nurse's station. -The nurse's station was on the far side of the locked unit and not near the resident's room who was on EBP. -The DON had provided an inservice last week on EBP. The education included staff were to wear a gown and gloves when providing catheter care or wound care for a resident. -Resident #43 had a diabetic foot wound and another (unsampled) resident had a scalp laceration (cut) which required a bandage dressing. -Staff should wear gown and gloves when treating those two wounds. -He/She thought there should have been a sign on the residents' doors showing they were on EBP, but they did not have any of the signs on the residents' doors on the locked unit. Observation on 10/18/24 at 6:30 A.M. showed: -The isolation cart was stored at the nurse's station which was not near the hall the resident resided on. -RN A went into multiple rooms to help the residents get dressed wearing the same gown. -He/She did not change gowns between resident rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of Resident #43's wound care and interview with LPN B on 10/18/24 at 9:28 A.M. showed: -No EBP signage outside the resident's room. -No isolation cart outside the resident's room or near the resident's room. -LPN B provided wound care to the resident's left foot diabetic ulcer. He/She wore gloves but did not wear a gown. During an interview on 10/18/24 at 9:28 A.M. LPN B said: -He/She had education last week from the DON regarding EBP. -He/She should have worn a gown and gloves since the resident had an open wound. During an interview on 10/18/24 at 10:10 A.M., Certified Medication Technician (CMT) B said: -He/She did not know when he/she should wear gown and gloves. -He/She was not sure if he/she had any education on using PPE with EBP. During an interview on 10/21/24 at 9:50 A.M. , CMT C said he/she did not know anything about EBP. During an interview on 10/23/24 at 12:30 P.M. the DON said: -They had just started to use EBP at the facility maybe two weeks ago. -The DON and Administrator were in charge of educating the staff about EBP. -He/She had educated the staff about EBP on 10/3/24. -The education included when EBP should have been used and what PPE staff was expected to wear. -If a resident had a tube such as a catheter, central line, or any wound which required more than a band aide staff was to have used EBP. -There should have been an EBP sign on the resident's door. -There should have been an isolation cart nearby the resident's door. -The residents who should have had EBP should have been passed on in report. -EBP should have been in the resident's care plan. -He/She would have expected the residents to have hand soap, paper towels, and toilet paper in their rooms. Staff should have over seen hand hygiene after the residents used the restroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The rooms including bathrooms should have been in good repair or maintenance should have been notified. -Maintenance should have been notified about the stain on the door. -Housekeeping or a CNA should have cleaned the warming table after each use.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720 Based on interview and record review, the facility failed to establish a facility-wide infection prevention and control program that included an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic usage. Five sampled residents included in the antibiotic stewardship review out of 13 sampled residents. The facility census was 50 residents. Review of the facility Antibiotic Stewardship Program policy dated 6/29/23 showed: -The facility will track and monitor antibiotic prescribing practices and resistance patterns among its residents. -At the end of each month, the Facility Antibiotic Steward will print the Monthly Infection Log and place the report in the Antibiotic Stewardship Program binder. -All antibiotics will be entered into the Physician Orders in the electronic medical record. -The electronic medical record will be used to generate a list of all residents receiving antibiotic prescriptions and the date the antibiotic was started. -Hospital records and/or pre-admission medical records will be used to obtain list of residents who started antibiotic outside of the facility. -The Antibiotic Utilization Report will be used to collect and track antibiotic usage. 1. Review of the facility Infection Prevention Monitoring log for the previous 12 months showed: -No documentation of infection tracking and/or antibiotic usage for October 2023 and November 2023. -December 2023 showed one resident had a Urinary Tract Infection (UTI - an infection of one or more structures in the urinary system). No documentation of any lab results, signs or symptoms, or if an antibiotic was administered. -January 2024 and February 2024 showed no documentation of any infections and/or antibiotic usage. -March 2024 showed three residents with a UTI and one resident with an unknown infection. No documentation of any lab results, signs or symptoms, or if an antibiotic was administered. -April 2024 showed one resident with an unknown infection. No documentation of any lab results, signs or symptoms, or if an antibiotic was administered. -May 2024 showed one resident with an unknown infection and one resident with a UTI. No documentation of any lab results, signs or symptoms, or if an antibiotic was administered. -June 2024 showed one resident with an unknown infection. No documentation of any lab results, signs or symptoms, or if an antibiotic was administered. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-July 2024 showed one resident with an unknown infection and three residents with a UTI. No documentation of any lab results, signs or symptoms, or if an antibiotic was administered. A map included in the tracking folder showed two residents with UTI, five residents with a skin infection, and one resident with COVID (a new disease caused by a novel (new) coronavirus). No documentation of any lab results, signs or symptoms, or if an antibiotic was administered. -August 2024 showed one resident with a UTI. No documentation of any lab results, signs or symptoms, or if an antibiotic was administered. -September 2024 showed no documentation of any infections and/or antibiotic usage. 2. Review of Resident #43's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's physician orders showed: -Doxycycline (an antibiotic) 100 milligram (mg) by mouth twice daily for wound infection for seven days dated 5/11/24. -Doxycycline 100 mg by mouth every 12 hours for left foot wound infection for 14 days dated 8/12/24. --NOTE: These antibiotics were not included in the Antibiotic Stewardship program. 3. Review of Resident #46's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's physician orders showed: -Doxycycline 100 mg twice daily for laceration to his/her right foot for seven days, first dose given in emergency roiagnom on [DATE] dated 9/18/24. -Doxycycline 100 mg twice daily for cellulitis (an infection of deep skin tissue) for 10 days dated 9/30/24. -Doxycycline 100 mg twice daily for cellulitis until 10/16/24 dated 10/6/24. --NOTE: These antibiotics were not included in the Antibiotic Stewardship program. 4. Review of Resident #41's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's physician orders showed: -Cephalexin (an antibiotic) 500 mg four times daily for five days for a laceration dated 5/30/24. --NOTE: This antibiotic was not included in the Antibiotic Stewardship program. 5. Review of Resident #33's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's physician orders showed: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sulfamethoxazole/Trimethoprim (a combination antibiotic) one tablet twice daily for five days, start five days prior to procedure on 8/1/24 dated 7/3/24 to start on 7/26/24. -Fluconazole (an antifungal) 150 mg one tablet for one time dose for UTI dated 7/25/24. -Cephalexin (an antibiotic) 500 mg twice daily for seven days for UTI dated 4/20/24. -Cephalexin 500 mg twice daily for five days for surgery prophylaxis dated 4/20/24 to start on 5/22/24. -Cephalexin 500 mg twice daily for seven days for UTI dated 9/14/24. --NOTE: These antibiotics were not included in the Antibiotic Stewardship program. 6. During an interview on 10/21/24 at 2:07 P.M., the Director of Nursing (DON) said: -The previous DON started the Infection Control book, which should include tracking the use of antibiotics. -He/She could not see where the previous DON was tracking antibiotic usage, so he/she started infection/antibiotic monitoring in the facility electronic medical record. -Antibiotic stewardship should include any signs or symptoms of infection, any lab results, radiology results, or other diagnostic results to show why an antibiotic was determined appropriate.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 32720 Based on interview and record review, the facility failed to designate one or more individuals, qualified by completing specialized training in infection prevention and control, as the Infection Preventionist (IP) responsible for the facility's Infection Prevention and Control Program. The facility had a census of 50 residents. A policy for Infection Preventionist was requested but not received at the time of exit. 1. Review of the facility Infection Control Surveillance log book showed the Director of Nursing (DON) completed the infection control training modules 1 - 15 on 10/19/24. The final test showed he/she did not pass the IP test. During an interview on 10/21/24 at 2:07 P.M., the DON said: -He/She was the IP for the facility. -He/She was not IP certified. -He/She had been in classes for the IP program since 10/1/24 and finished the last module on 10/17/24. -The previous DON was the previous IP. -He/She did not spend a minimum of 20 hours per week on the Infection Control Program due to also performing DON duties.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720 Based on interview and record review, the facility failed to ensure residents were provided education to accept or decline the influenza and/or pneumococcal vaccine for four sampled residents (Residents #43, #46, #41, and #33) out of 13 sampled residents. The facility census was 50 residents. Review of the facility Influenza and Pneumococcal Immunization policy dated 5/14/24 showed: -This policy is to ensure that all residents residing in the facility are offered influenza and pneumococcal immunizations to prevent infection and the spread of communicable diseases. -As part of the admission process, the resident and/or the resident's legal representative will be provided education on the benefits and potential side effects of both the influenza and pneumococcal immunization. -The resident or their legal representative will be informed that the influenza immunizations are provided yearly (between October 1 and March 31) unless medically contraindicated. -The resident or their legal representative will be informed that the pneumococcal immunization will be offered upon admission per Centers for Disease Control and Prevention (CDC) guidelines. 1. Review of Resident #43's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's medical record showed no documentation of education, administration, and/or declination of the pneumococcal vaccine since admission to the facility. 2. Review of Resident #46's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's medical record showed no documentation of education, administration, and/or declination of the influenza vaccine since admission to the facility. 3. Review of Resident #41's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's medical record showed no documentation of education, administration, and/or declination of the influenza vaccine since admission to the facility. 4. Review of Resident #33's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's medical record showed: -No documentation of education, administration, and/or declination of the influenza vaccine since admission to the facility. -No documentation of education, administration, and/or declination of the pneumococcal vaccine since admission to the facility. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 10/21/24 at 2:07 P.M., the Director of Nursing (DON) said: -Staff talk to the residents about immunization education during resident council. -Pharmacy would also provide immunization education when they were [NAME] the vaccine clinics. -Residents should be provided education and either sign the declination form or have the influenza and pneumococcal vaccines administered upon admission to the facility. -Influenza vaccines were also offered yearly. There should be education and either a declination or consent form at that time as well. -Staff should document the refusal or administration in the resident's medical records.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720 Based on interview and record review, the facility failed ensure provision and documentation of education regarding the benefits, risks and potential side effects associated with the COVID-19 (a new disease caused by a novel (new) coronavirus) vaccine for residents upon admission to the facility for one sampled resident (Resident #33) out of 13 sampled residents and for two out of seven sampled staff (Employees C and E). The facility census was 50 residents. A policy for COVID vaccination for residents and staff was requested and not received at the time of exit. 1. Review of Resident #33's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's medical record showed no documentation of education, administration, and/or declination of the COVID vaccine since admission to the facility. 2. Review of Employee C's employment record showed: -He/She was hired on 4/23/24. -An undated COVID declination form in his/her employee file. 3. Review of Employee E's employment record showed: -He/She was hired on 10/1/24. -No documentation of education, administration, and/or declination of the COVID vaccine since his/her employment with the facility. During an interview on 10/21/24 at 2:07 P.M., the Director of Nursing (DON) said: -For residents, COVID vaccine education should be documented in the resident's progress notes. -If the resident or staff did not have documentation of a previous COVID vaccine, he/she could get the information from the internet. -Resident COVID vaccines should be in the resident's medical records. -For employees, COVID vaccine status and/or education/declination should be obtained upon hire and included in the employee file.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 38452 Based on observation and interview, the facility failed to maintain essential kitchen cooking, cleaning, and/or storage equipment in a proper and safe operating condition to ensure the ability to meet the residents' nutritional needs in an uncontaminated and timely manner. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility census was 50 residents with a licensed capacity for 97 residents at the time of the survey. 1. Observation on 10/15/24 between 2:04 P.M. and 2:52 P.M. during the initial kitchen inspection with the Dietary Manager (DM) showed various kitchen appliances and equipment including, but not limited to, a chemical dishwasher, a stove with a flat-top grilling surface, and a convection oven. During an interview on 10/15/24 between 2:04 P.M. and 2:52 P.M. the DM said the following: -The stove did not work very well because they had to turn it on around 5:00 A.M. so it would be warm enough for lunch time use. -The chemical dishwasher's thermometer was broken so he/she could never tell if it got hot enough to clean items well; no steam issued out when opened after its use. -The convection oven hardly operated any better than the stove. During an interview on 10/23/24 at 2:03 P.M. the Administrator said the following: -They had always had trouble with the dishwashing machine in the kitchen. -The kitchen needed to be gutted and completely redone to work well.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on interview and record review, the facility failed to provide the required annual 12 hours of in-service training for Certified Nursing Assistants (CNA). The facility census was 50 residents. Policies were requested for staffing and 12-hour education/in-service and were not received at the time of exit. 1. Review of the Facility assessment dated [DATE] showed: -Facility assessment would be used to ensure there were a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care. -The facility was licensed for 97 beds. -The average number of occupied beds during the previous quarter was 48. -Staffing as described (in the assessment) was adequate as evidenced by: --License. --In-Services. --Performance evaluations. -Staffing was adequate for caring for residents with: --Dementia, mental health conditions, or history of trauma as evidenced by: ---In-Service training. Review of the Employee List showed the following five CNA's were employed for the last 12 months or longer: -CNA D hired on 9/6/22. -CNA E hired on 2/11/19. -CNA F hired on 10/2/18. -CNA G hired on 5/24/22. -CNA H hired on 7/18/23. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility In-Services signature sheets for the last 12 months dated October 2023 to October 2024 showed: -Only 11 in person in-services/staff meetings were held. --NOTE: There were three different dates and topics held in April 2024. ---One did not have the signature page of who attended. -No in-services were held in February 2024, March 2024, May 2024, June 2024, and September 2024. -The in-services/education sign-in sheets provided did not include the following training's during the previous 12 months: --Behavior. --Resident rights. Review of the facility's Relias online self-paced training program and the In-service signature sheets showed the following three of the five CNA's did not receive a total of 12 hours of trainings for the previous year: -CNA D received 1.25 hours of Relias behavioral training for a total of 5.25 hours online and in person in-service/education. -CNA E received 1.25 hours of Relias behavioral training for a total of 7.25 hours online and in person in-service/education. -CNA H received 1.25 hours of Relias behavioral training for a total of 4.25 hours online and in person in-service/education. Review of the employee competencies for the previous 12 months showed: -CNA D had no competency reviews. -CNA E had no competency reviews. -CNA F had no competency reviews. -CNA G had no competency reviews. -CNA H had no competency reviews. During an interview on 10/23/24 at 11:55 A.M., CNA D said: -The last behavioral training he/she had was about two weeks ago. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two people came in and talked about working with behaviors and residents with Alzheimer's and was given handouts on this. -He/She did the online Relias trainings when he/she had time. During an interview on 10/23/24 at 11:58 A.M., Licensed Practical Nurse (LPN) B said: -Last time he/she did behavioral training was probably in June 2024. -The Director of Nursing (DON) came in and did in-services a lot as needed. -There were other in-services monthly on different things. -He/She had done the online Relias on Alzheimer's and dementia care of residents. During an interview on 10/23/24 at 12:32 P.M., the DON said: -In-services were held monthly in person and more often if there was a need or an issue that needed to be addressed. -The facility also used the online Relias program for trainings. -He/She did not track in-service hours for each nursing staff but, probably should.