

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265696	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on Based on observations, interviews and record review, the facility failed to treat each resident with respect and dignity and failed to provide care for each resident in a manner and in an environment that promoted enhancement in their quality of life when staff failed to knock on resident doors prior to entering their room and failed to announce themselves to (Resident #2 and #8), Staff left the bedroom door to the hallway open while providing peri-care to one resident (Resident #35). Additionally, staff failed to answer one resident's call light in timely manner resulting in that resident being incontinent of urine (Resident #21). This affected four residents out of the 17 sampled residents. The facility census was 66.</p> <p>Review of facility policy, Resident Rights, dated 1/30/24, showed:</p> <ul style="list-style-type: none"> -The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident's individuality. -Resident has the right to exercise his/her rights as a resident of the facility and as a citizen or resident of the United States. -Resident has the right to reasonable access to stationary, postage, writing implements (at the resident's expense) as well as the ability to send and receive unopened mail. -When providing resident care, always provide privacy by knocking and announcing self, pulling a curtain around the bed, pulling the drapes to windows, closing the door, and draping the resident's body appropriately; <p>44395</p> <p>1. Review of Resident #35's Quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status of 4, indicated significant cognitive deficit. -Partial to moderate assistance on staff for Activities of Daily Living (ADL's: tasks performed to care for oneself in a day). <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Dependent on staff for standing, maximum assistance for transfers</p> <p>-Occasional incontinence of urine</p> <p>-Continent of bowel</p> <p>-Diagnoses of Alzheimer's Dementia (progressive memory loss that interferes with daily life), and disorientation (a state of mental confusion).</p> <p>Review of the resident's comprehensive Care Plan dated 3/1/24 showed:</p> <p>-He/she takes the assist of 2 staff for toileting</p> <p>-He/She experienced bladder and bowel incontinence; use incontinent pads or briefs to protect his/her dignity.</p> <p>-He/She can be confused at times; break tasks into manageable segments, explain all procedures, allow him/her to make simple decisions.</p> <p>During an observation on 5/08/24 at 5:05 A.M. the resident was in his/her bed, Nurse Aide A entered the resident's room leaving the room door open. The privacy curtain was pulled half way, leaving the lower half of the bed and resident visible from the hallway. NA A pulled the resident's blanket and sheet toward the foot of the bed, exposing the resident's incontinent brief and legs to the hallway. The NA then opened the tabs of the resident's incontinent brief, pulled the front of the brief down; exposing the resident's genital folds to the hallway. NA A told the resident he/she was slightly soiled and they would get a clean brief. He/She then pulled the brief back up between the resident's legs, refastened the tabs, covered the resident with a blanket and left the room.</p> <p>Observation on 5/08/24 at 5:15 A.M. showed NA A and NA B entered Resident #35's room. NA B shut the resident's room door, and provided incontinent care to the resident.</p> <p>During an interview on 5/08/24 at 5:27 A.M. NA A said the resident's door should be shut for any care to provide policy. He/she did not realize he/she left the door open. It would be embarrassing to be exposed to a stranger.</p> <p>During an interview on 5/9/24 at 3:12 P.M. the Director of Nursing (DON) said:</p> <p>-The room door should never be left open during incontinent care.</p> <p>During an interview on 5/9/24 at 3:12 P.M. the Administrator said:</p> <p>-Room doors should not be left open during incontinent care.</p> <p>-She expects staff to close the curtain and the door completely.</p> <p>2. Review of Resident #21's Annual MDS dated [DATE] showed:</p> <p>-BIMS of 14, indicating no cognitive deficits</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Partial assistance from staff for ADL's.</p> <p>-Partial to moderate assistance for standing and transfers.</p> <p>-Touch assist for ambulation (walking)</p> <p>-Occasional incontinence of urine and bowel.</p> <p>-Diagnoses of Transient Ischemic Cerebral Attack (a brief blockage of blood flow to the brain), difficulty in walking, dizziness, low back pain, chronic fatigue syndrome, atrial fibrillation, arthritis.</p> <p>-Review of the resident's comprehensive Care Plan dated 3/21/24 showed:</p> <p>-The resident is incontinent of bowel and bladder occasionally. Provide assistance with toileting every two hours and as needed. Check incontinence pads frequently and change as needed.</p> <p>During an observation on 5/07/24 at 3:28 PM resident call light was on. At 3:47 P.M. CNA B entered the resident's room asking what he/she needed. The resident said he/she needed to use the bathroom. CNA B assisted the resident into the restroom, removed the resident's adult brief. The brief was saturated/wet. CNA B assisted the resident in putting on a new brief, pulled up pants and returned to his/her recliner in his/her room.</p> <p>During an interview on 5/07/24 at 3:52 P.M. the resident said:</p> <p>-His/Her light was on since 3:02 P.M.</p> <p>-He/She knows the time because he/she looked at the digital clock on his/her wall.</p> <p>-His/Her call light is rarely answered quickly enough for him/her to make it to the bathroom in time.</p> <p>-He/she is embarrassed when he/she does not make it to the bathroom in time.</p> <p>During an interview on 5/07/24 at 4:00 P.M. CNA B said:</p> <p>-He/she tried to answer the call light in time.</p> <p>-He/she answered as quickly as he/she could, but he/she was busy with another resident.</p> <p>-There is not enough help to answer the call lights immediately.</p> <p>During an interview on 5/9/24 at 3:12 P.M. the Administrator said:</p> <p>-She expects staff to answer lights as soon as possible.</p> <p>-There is not enough staff to meet all the resident's needs, staff do the best they can.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>31102</p> <p>3. Review of Resident #2's Quarterly MDS, dated [DATE] showed:- Cognitive skills intact;</p> <ul style="list-style-type: none"> - Independent with toilet use, dressing, personal hygiene and transfers; - Occasional incontinence of urine; - Always continent of bowel; - Diagnoses included seizure disorder and depression. <p>Observation and interview on 5/6/24 at 11:05 A.M., showed:</p> <ul style="list-style-type: none"> - The resident's door was closed and the surveyor was interviewing the resident; - The receptionist did not knock or announce him/herself and opened the resident's door, walked in then said, knock, knock and delivered mail to the resident; - The resident said he/she always entered without knocking; - The resident would prefer he/she knocked before he/she entered but around here you just learned to live without any of your rights and privileges. <p>Observation and interview on 5/6/24 at 11:16 A.M., showed:</p> <ul style="list-style-type: none"> - The resident's door was closed and the surveyor was interviewing the resident; - Registered Nurse (RN) A did not knock or announce him/herself and opened the door to the resident's room and gave the resident his/her medication; - The resident said-the staff always enter without knocking. <p>4. Review of Resident #8's Quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> - Cognitive skills intact; - Lower extremity impaired on one side; - Dependent on staff assistance for toilet use, transfers and dressing the lower extremities; - Independent on personal hygiene; - Always continent of bowel and bladder; - Diagnoses included anxiety and depression. <p>Observation and interview on 5/6/24 at 11:16 A.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observations, interview, and record review, the facility failed to create an environment respectful of the rights of a resident to make choices about aspects of his/her life that are significant to them, when the facility failed to allow two out of seventeen sampled residents to go outside unsupervised (Resident #45 and #212). The facility census was 66.</p> <p>Review of the facility's Resident Rights policy, dated 1/30/24., showed:</p> <ul style="list-style-type: none"> -Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident's individuality. -Resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his/her rights and to be supported by the facility and the exercise of those rights. -To receive services with reasonable accommodation of needs and preferences except when to do so would endanger the health and safety of the resident or other residents. -The resident has the right and this facility promotes and supports the right to make choices about aspects of his/her life in the facility that are significant to the resident including: <ul style="list-style-type: none"> -Choose activities and schedules including sleeping and waking times. -Interact with people from community and participate in community activities both inside and outside the facility. -The resident has the right to, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment. <p>1. Review of Resident #45's admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 4/12/24, showed the resident:</p> <ul style="list-style-type: none"> - is cognitively intact; - able to make self-understood, and understand others; -activity preferences- very important to the resident to go outside to get fresh air when the weather allows; -impairment on one side of his/her body; <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-dependent on walker and wheelchair for mobility;</p> <p>-Diagnoses including anxiety disorder.</p> <p>Review of Resident's medical record showed the resident admitted to the facility on [DATE]. The resident did not have a care plan.</p> <p>During an interview on 5/06/24 at 12:57 P.M. resident said he/she loved to go outside. The facility had a smokers area, but he/she was not a smoker and staff did not do anything to help him/her outside. The resident had to be escorted outside if he/she was offered the opportunity.</p> <p>2. Review of Resident #212's admission MDS, dated [DATE], showed the resident:</p> <p>-cognitively intact;</p> <p>- has clear speech, able to make self-understood, and clear comprehension of others;</p> <p>-activity preferences- it was very important to go outside to get fresh air when weather allowed;</p> <p>-limited range of motion to both sides of lower extremities.</p> <p>-dependent on walker and cane for mobility;</p> <p>-Diagnoses : , heart failure, high blood pressure, renal failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), and diabetes.</p> <p>Review of resident's medical record showed the resident admitted to facility on 4/22/24 and primarily responsible for self. The resident did not have a care plan.</p> <p>During an interview on 5/07/24 at 9:35 A.M., Resident said:</p> <p>-He/She could not go outside alone, and that someone had to supervise him/her all the time.</p> <p>-He/She liked to wake up early and has watched the sun come up his/her whole life;</p> <p>-He/She could only smoke one cigarette at one time during scheduled smoke breaks.</p> <p>-He/She was own person (makes his/her own decisions).</p> <p>3. During a group meeting on 5/7/24 at 1:32 P.M., three of the thirteen residents said:</p> <p>-They were not allowed to go outside unless someone was available to go with them;</p> <p>-Residents who smoke had certain times to go outside. If not a smoker, residents cannot go outside unless they have family available to take them out.</p> <p>-They would like to be able to have the opportunity to go outside.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During an interview on 5/9/24 at 10:05 A.M., the Housekeeping Supervisor said:</p> <ul style="list-style-type: none"> -Residents are allowed to go outside, but have to go out with a staff member present; -Residents are not allowed to be left unattended while outside. <p>During an interview on 5/9/24 at 10:32 A.M., Nurse Aide (NA) C said:</p> <ul style="list-style-type: none"> -Residents must have a staff member with them when they go outside; -Residents sit outside on the front porch or at one of the ends of the hall with staff. <p>During an interview on 5/9/24 at 3:12 P.M., the Director of Nursing said:</p> <ul style="list-style-type: none"> -Facility had designated smoke times for residents to go outside; -It was the resident's right to go outside, if they are their own person but the facility was still liable for them. <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -Residents going outside is dependent on staff availability, resident's have to be supervised while outside; -An assessment should be done on whether residents need supervision or could go outside unsupervised; -Facility did not have a courtyard currently available for residents; -He/She had concerns with residents being outside and in front of the building unsupervised; -He/She was concerned with current sloping landscape and providing a safe environment for residents to be outside. -It is the residents rights to go outside, if the resident was safe and did not take off and leave. -If a staff member is available someone will go out with residents; -It is a resident's right to outside, but it has to be done to ensure safety. 		

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<p>F 0570</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure the security of all personal funds of residents deposited with the facility.</p> <p>25681</p> <p>Based on record review and interview, the facility failed to maintain a surety bond sufficient to ensure the protection of resident funds. The facility census was .</p> <p>Review of the facility maintained Resident Trust Bank Statements for the period 05/2023 through 05/2024, showed an average monthly balance of \$27,000.00.</p> <p>Review on 05/07/24, of the Department of Health and Senior Services approved bond list showed the facility had a \$1,000.00 approved bond, making the bond insufficient by \$22,000.00.</p> <p>During an interview on 05/07/24 at 10:42 A.M., the Business Office Manager said the facility had changed ownership recently and was unaware the bond had not been reassessed since the new company had taken control.</p> <p>During an interview on 05/07/24 at 3:44 P.M., the Business Office Manager said she would expect the bond to be sufficient to cover the resident funds.</p>

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>47195</p> <p>Based on observation and interview, the facility failed to protect the resident rights when the facility did not provide accessible information regarding the State Long Term Care Ombudsman program and the State Survey Agency in a location that was readily available and could be read by residents in the facility without assistance. The facility census was 66.</p> <p>Review of facility policy, resident rights, undated, showed:</p> <p>-The resident has the right to receive a list of the names, addresses (mail and email) and telephone numbers of all pertinent state regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care ombudsman program, the protection and advocacy agency, adult protective services, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit. The resident must also receive a statement that he/she may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with advance directives requirements and requests for information regarding returning to the community.</p> <p>Observation on 5/7/24 at 1:45 P.M. showed ombudsman poster hanging on wall in day room of facility, the poster was not visible to someone sitting in a wheelchair.</p> <p>During a group interview on 5/7/24 at 1:32 P.M., the residents said:</p> <p>-All residents interviewed did not know what an ombudsman was or where information was posted in facility or how to reach the ombudsman.</p> <p>-Twelve residents did not know how to formally file a complaint to state survey agency.</p> <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator said:</p> <p>-Ombudsman contact information was posted in the facility day room;</p> <p>-He/She did not know how residents had been educated on reaching the ombudsman representative or state survey agency.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102</p> <p>Based on interviews and record review, the facility failed to clarify the code status (whether the resident wished to have cardio-pulmonary resuscitation- CPR) of two of the 17 sampled residents, (Resident #45 and #214), and failed to ensure Resident #16's Durable Power of Attorney (DPOA) for Health Care Decisions was invoked (activated by verifying incapacity of the resident to make decisions) by two physicians. The facility census was 66.</p> <p>Review of the facility's policy for living will/advance directives/life-sustaining treatment orders, dated [DATE], showed, in part:</p> <ul style="list-style-type: none"> - The purpose is to ensure resident rights are protected when Advance Directives have been executed: - Residents will be given the option of completing a Living Will (a type of advance directive that states the specific types of medical care that a person wishes to receive if that person is no longer able to make medical decisions because of a terminal illness or being permanently unconscious) or Advance Directive if they have not already done so. This option will be presented to a resident on admission to the facility. Advance Directives allows the resident to ask for no lifesaving measures without the need for a terminal diagnosis. The Living Will or Advance Directives will then be noted on the resident's medical record; - A resident who chooses to sign a Living Will or Advance Directive must be of sound mind and competent to make life-directing decisions. <p>1. Review of Resident #16's Durable Power of Attorney (DPOA) for Health Care Decisions, dated and notarized on [DATE] showed:</p> <ul style="list-style-type: none"> - Required two physicians to activate the document; - Designated DPOA as his/her agent to make healthcare decisions. <p>Review of the residents capacity verification, dated [DATE] showed:</p> <ul style="list-style-type: none"> - Only one physician had declared the resident incapacitated. <p>Review of the resident's Outside the Hospital Do Not Resuscitate (OHDNR) order showed;</p> <ul style="list-style-type: none"> - [DATE]- signed by the resident's DPOA; - [DATE]-signed by the physician. <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE] showed:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Cognitive skills moderately impaired; - Upper and lower extremities impaired on both sides; - Dependent on staff for toilet use, showers, dressing, personal hygiene and transfers; - Diagnoses included coronary artery disease (CAD, damage or disease in the heart's major blood vessels causing coronary arteries to narrow, limiting blood flow to the heart), stroke, high blood pressure and diabetes mellitus. <p>Review of the resident's physician order sheet (POS) dated [DATE] showed:</p> <ul style="list-style-type: none"> - Start date - [DATE] - Do Not Resuscitate (DNR). <p>Review of the resident's face sheet showed:</p> <ul style="list-style-type: none"> - admitted ,d+[DATE]; - Current admitted [DATE]; - Code status - DNR. <p>During an interview on [DATE] at 12:14 P.M., the Social Services Designee said:</p> <ul style="list-style-type: none"> - He/she reviewed the resident's medical record and the resident was a DNR; - The resident had only been declared incapacitated by one physician but it should have been two physicians. <p>During an interview on [DATE] at 3:12 P.M., the Administrator said:</p> <ul style="list-style-type: none"> - If the DPOA does not specify if it should be one or two physicians to declare the resident incapacitated, then it should be two physicians. <p>47195</p> <p>2. Review of Resident #45's Admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Resident was cognitively intact; -He/She had clear speech, was able to make self-understood, and understand others; -Diagnoses included aftercare after joint replacement surgery, and high blood pressure. <p>Review of the electronic medical record on [DATE] at 8:34 A.M. showed the resident had a signed do not resuscitate sheet dated [DATE];</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of physician's orders, on [DATE] at 8:35 A.M., showed the resident's code status was full code</p> <p>Review of care plan, dated [DATE], showed the residents code status was do not resuscitate.</p> <p>2. Review of Resident #214's Face Sheet, dated [DATE], showed the resident admitted to facility on [DATE], with diagnoses including rheumatoid arthritis, and generalized muscle weakness.</p> <p>Review of electronic medical record on [DATE], showed the resident had a signed do not resuscitate sheet dated [DATE].</p> <p>Review of physician's orders, [DATE] at 8:50 A.M., showed the resident's code status as full code.</p> <p>Review of care plan, dated [DATE], showed care staff directed to not resuscitate.</p> <p>3.) During an interview on [DATE] at 8:57 A.M., Certified Medication Technician (CMT) A said he/she looks for code status in the resident's care plan. If the code status was not in resident's care plan he/she would go to a nurse and ask them.</p> <p>During an interview on [DATE] at 9:19 A.M., Certified Nurse Aide (CNA) C said:</p> <ul style="list-style-type: none"> -Today was his/her first day working in facility; -He/She believed the sticker on the room doors identified resident's code status; -If there was no sticker on the door he/she would look in resident's electronic medical record. <p>During an interview on [DATE] at 9:39 A.M., Certified Medication Technician (CMT) B said:</p> <ul style="list-style-type: none"> -He/She knew resident's code status by dot on the resident's door; -If the sticker was not on the resident's door would notify charge nurse and look on the electronic medical record. <p>During an interview on [DATE] at 9:40 A.M., Licensed Practical Nurse (LPN) F said:</p> <ul style="list-style-type: none"> -Resident's code status was available on the resident's door and in the electronic medical record; -The physician's order and advance directive should match, if they don't then the orders should be clarified. <p>During an interview on [DATE] at 9:54 A.M., Social Service Designee said:</p> <ul style="list-style-type: none"> -Physician's orders and advance directives should match; -Hard copies of advance directives were kept in his/her office; -He/She wrote code status in care plans. <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 3:12 P.M., Director of Nursing said:</p> <ul style="list-style-type: none"> -The code status in physician's orders should match the advance directives. <p>During an interview on [DATE] at 3:12 P.M., Administrator said:</p> <ul style="list-style-type: none"> -Code status should be the same in physician's orders and the resident's advance directives; -When resident admits to the building they are considered full code until the facility has received the resident's advance directive paperwork; -The social service designee is responsible for scanning in the advance directive paperwork.

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>31102</p> <p>Based on observation, record review and interviews, the facility failed to ensure they maintained a safe, clean, comfortable homelike environment for the residents when staff did not keep all areas of the facility clean and safe; and failed to maintain comfortable temperatures in the common areas of the building between 71 and 81 degrees Fahrenheit (F). Additionally, the facility failed to ensure they provided a sufficient amount of bed linens, towels and wash cloths. The facility census was 66.</p> <p>Review of the facility policy Cleaning Resident Rooms dated 1/30/24 showed:</p> <ul style="list-style-type: none"> -Ensure rooms are clean and sanitary. <p>The facility did not provide a policy on cleaning hallways, general areas or common areas of the facility.</p> <p>The facility did not provide a policy on Homelike Environment.</p> <p>The facility did not provide a policy for the amount of linens the facility should have on hand.</p> <p>1. Observations beginning on 5/06/24 at 10:03 A.M., showed:</p> <ul style="list-style-type: none"> -the ceiling vent, at room C111, had cobwebs and thick coating of dust on the grates; -C hall handrails had chips in the paint and exposed wood; -Ceiling vent, at room C109, had dust and dirt debris on the grates and inside the vent; -the floor behind the C hall fire doors was coated with dust, dirt and debris; -D hall handrails had chips in the paint and exposed wood; and -D hall sheetrock had multiple gouges and scuffs along the lower 1/3 of the wall. <p>Observations on 05/06/24 at 11:38 A.M, showed:</p> <ul style="list-style-type: none"> -a dining room window had a thick coating of dust, dirt and glitter; -vinyl coating of multiple dining room chairs was cracked, exposing the soft surface underneath; -a large cobweb with dead bugs at the corner of the courtyard exit door; -the baseboard at the exit door was loose and peeling away from the wall; and -the vinyl surface of the love seat was peeling, exposing the soft surface underneath. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 05/06/24 at 2:45 P.M., showed:</p> <ul style="list-style-type: none"> - a cubby area by the salon, had broken, misfit floor tiles. The wall was patched with appeared to be cardboard; - a ceiling vent by the soiled linen room had dust, debris and fuzz hanging from it; -the exit door had blue painters tape painted down to the door frame; -cobwebs showed in the exit door corners; -a 12 feet (ft) by 3 ft area of white tile that were cracked with a pitted, rough surface; -ceiling fan at D108 had dirt and debris hanging down; -light fixture outside D108 had no protective cover; -light fixture outside D104 had broken, misshapen metal stay in middle; -cobwebs at corner of fire doors; and -dark brown/black debris, dirt and dust behind fire doors. <p>Observations on 5/06/24 at 4:41 P.M., showed:</p> <ul style="list-style-type: none"> -B hall temperature of 81.9 degrees F and -E hall temperature of 82.4 degrees F. <p>Observation on 05/07/24 at 7:58 A.M., showed:</p> <ul style="list-style-type: none"> -dining room temperature of 65.8 degrees F; -dining/activity room temperature of 66.4 degrees F; -E hall temperature of 84.0 degrees F; -TV/sitting area/nurse's station temperature of 84.7 degrees F; -F hall temperature of 81.1 degrees F; -Multiple residents covered in blankets, one resident wearing a stocking cap. -Resident #35 stated he/she was cold and requested a blanket from staff. <p>During an interview on 5/08/24 at 9:21 A.M., the Maintenance Supervisor said:</p> <ul style="list-style-type: none"> -the air conditioning was not working prior to him/her taking this position; (when was he hired?) <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-he/she is unsure when it started not working correctly;</p> <p>-it is cold in the dining room;</p> <p>-Heating, Ventilation, Air Conditioning (HVAC) company was scheduled to be in the facility the week of 5/13 for repairs;</p> <p>-maintenance is responsible for the vents and light cleaning; and</p> <p>-vents and lights are to be cleaned monthly.</p> <p>During an interview on 5/8/24 2:25 P.M., Certified Medication Technician B said:</p> <p>-he/she was told by maintenance only two of the air conditioning units worked;</p> <p>-he/she thought it is too hot in the building;</p> <p>-every morning residents complain about the dining room being too cold;</p> <p>- it is usually about 65 degrees in the dining room, and he/she needed a jacket when he/she was in there.</p> <p>During an interview on 5/09/24 at 11:37 A.M., Housekeeping Aide C said:</p> <p>-he/she sweeps the hall as she goes from room to room;</p> <p>-the vents and dusting are housekeeping staff responsibility;</p> <p>-he/she is unsure if housekeeping is responsible for the light fixtures;</p> <p>-staff are assigned to clean the halls and general areas of the facility;</p> <p>-the Supervisor has a deep cleaning list and tells staff daily what is to be deep cleaned for that day; and</p> <p>-windows and sills are cleaned weekly</p> <p>During an interview on 5/09/24 at 1:31 P.M., the Housekeeping Supervisor said:</p> <p>-he/she took over as supervisor about two months ago;</p> <p>-housekeepers are responsible for all dusting;</p> <p>-maintenance is responsible for vent and light cleaning;</p> <p>-deep cleans are done weekly; and</p> <p>-windows and sills are to be cleaned monthly.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/9/24 at 3:12 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -housekeeping is responsible for all cleaning and dusting of rooms and halls; -maintenance is responsible for the vents and lights; -there is not a cleaning list for daily, weekly or deep cleaning; -the floor is on a list of updates to be completed; -the dining room was cold last summer as well; - they are waiting on someone to fix the main air conditioning unit; and -she is working with staff on ensuring the building is maintained and clean. <p>2. Review of Resident #8's Quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff, dated 2/3/24 showed:</p> <ul style="list-style-type: none"> - Cognitive skills intact; - Lower extremity impaired on one side; - Dependent on staff assistance for toilet use, transfers and dressing the lower extremities; - Always continent of bowel and bladder; and - Diagnoses including anxiety and depression. <p>Observation and interview on 5/6/24 at 1:03 P.M., showed:</p> <ul style="list-style-type: none"> - The resident was covered up with a fitted sheet; - The resident said he/she had asked for a clean top sheet and the staff brought him/her a fitted sheet because they did not have any clean top sheets; - The staff never switch the fitted sheet out for a clean top sheet when they become available. <p>During an interview on 5/7/24 at 1:58 P.M., the Dietary Manager said:</p> <ul style="list-style-type: none"> - he/she is also the head of laundry; - if they have a machine go down, then it might take longer to get the laundry completed; - they have enough linens, top sheets, fitted sheets, towels, wash cloths and hand towels; - they have one laundry person who may come in either in the morning or in the evening; and <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- linens were coming up missing, so now they have codes on the doors. The Charge Nurses (CNs) have the door codes.</p> <p>During an interview on 5/8/24 at 5:05 A.M., Nurse Aide (NA) B said they have run out of linens before.</p> <p>During an interview on 5/8/24 at 2:06 P.M., Certified Medication Technician (CMT) B said:</p> <ul style="list-style-type: none"> - the facility does not have enough linens; - he/she went through all the rooms and pulled any extra linens to give the staff more access to the linens; - they do not have enough top sheets, wash cloths or towels; and - they have enough hand towels because the residents do not use them. <p>During an interview on 5/8/24 at 2:38 P.M., Certified Nurse Aide (CNA) A said:</p> <ul style="list-style-type: none"> - there are not enough linens in the facility, it's slim pickings; - he/she thought there was supposed to be someone working in laundry in the morning and in the evening; and - the aides are not supposed to know what the codes are to get the supplies and it makes it hard to do your job when you don't have access to what you need. You spend a lot of time going from room to room or hall to hall hunting for supplies when they could be providing care to the residents. <p>During an interview on 5/9/24 at 9:55 A.M., Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> - we do not have enough lines; - there are codes on all the doors; and - he/she did not think the towels were getting washed as quickly as they should. <p>During an interview on 5/9/24 at 10:29 A.M., CNA D said:</p> <ul style="list-style-type: none"> - laundry comes in around 11:00 A.M., and starts washing the laundry; - he/she has started showers at 5:00 A.M., and has run out of towels by 10:00 A.M., and has to wait until 1:00 P.M. before there are more towels ready for him/her to use; and - if the beds are stripped on the resident's shower days, there's not enough linens to make the beds. <p>Observation and interview with the Dietary and Laundry Manager on 5/9/24 at 11:54 A.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - he/she had taken over laundry and housekeeping two months ago; - he/she checked the room the laundry is stored in after being washed and dried. They had 20 wash clothe, 28 hand towels, 30 towels, four top sheets, 13 fitted sheets and two pillow cases; - the shower room on D hall did not have any linens in it; - the linen cart on C hallway had four fitted sheets; - the shower room on B hallway had approximately 20 wash cloths and six towels; - the linen cart on A hallway had one fitted sheet; - the linen cart on F hallway had nine fitted sheets and six top sheets; and - E hallway did not have a linen cart. <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator and the DON said they do not have enough linens, as they keep disappearing.</p> <p>44395</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>47195</p> <p>Based on interviews and observation, the facility failed to ensure residents knew how to file a grievance. This deficient practice had the potential to affect any resident wanting to file a grievance. The facility census was 66.</p> <p>Review of facility policy, resident rights, undated, showed a resident has the right to voice grievances to this facility or other agency concerning treatment, care, behavior of staff and/or other residents as well as other concerns about his/her stay without discrimination or reprisal. The resident has the right to information on how to file a grievance or complaint as well as to the prompt resolution of grievances.</p> <p>1. During a group meeting on 5/7/24 at 1:32 P.M., thirteen of thirteen residents said that they did not know how to file a formal grievance or who the grievance officer in the facility was.</p> <p>Observation on 5/9/24 at 10:51 A.M., showed a red folder hanging on the wall at four feet, which is inaccessible to residents in wheelchair position. This folder contained blank grievance forms with no area or information identified of where grievance forms were to be submitted.</p> <p>During an interview on 5/9/24 at 10:05 A.M., the housekeeping supervisor said he/she:</p> <ul style="list-style-type: none"> -did not know facility grievance process; -did not know where grievance forms are located; and -he/she believed the Dietary Manager had some in his/her office; <p>During an interview on 5/9/24 at 10:17 A.M., Dietary Manager said:</p> <ul style="list-style-type: none"> -facility grievance forms are available by administrator's door, where a form is available to be filled out; -grievance forms are filled out by the social worker; and -the social worker distributes the grievance to appropriate departments heads and they go back to the administrator. <p>During an interview on 5/9/24 at 10:32 A.M., Nurse Aide (NA) C said:</p> <ul style="list-style-type: none"> -he/She did not know what the grievance process was for the facility; -he/She had been told to tell residents the Social Service Designee (SSD) would take care of complaints; and -the Social Service Designee would take complaints to managers. <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/9/24 at 10:48 A.M., Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> -he/She did not know what facility grievance process was; -he/She though the SSD would just talk with residents; and -he/She did not know if residents had access to forms to fill out for a formal complaint. <p>During an interview on 5/9/24 at 10:50 A.M., Certified Nurse Aide (CNA) A said a folder of blank grievance forms was hung inside the red folder on the wall near the nurses station.</p> <p>During an interview on 5/9/24 at 3:12 P.M., Administrator said:</p> <ul style="list-style-type: none"> -the grievance process now included a red folder hanging outside the copier room towards the front of facility, that was available to residents and families; -families are encouraged to fill out grievance form; -grievance forms given to the SSD who reviewed them and decided what department the grievance needed to go to for the department to investigate and remedy the problem; -the grievance should then came back to his/her desk for review; -the grievance folder was not accessible to someone seated in wheelchair; -he/she did not know if there was a way for residents or families to make anonymous complaints; -he/she was aware the facility had a corporate compliance line- but did not know if that information was provided to residents in the facility admission packet; and -he/she did not know how resident's were educated about the grievance process but expected the SSD to educate during the 48 hour care plan meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265696	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>47195</p> <p>Based on record review and interview, the facility staff failed to check the Certified Nurse Assistant (CNA) Registry for all staff to ensure they did not have a Federal Indicator (a marker given by the federal government to individuals who have committed abuse/neglect). This affected three of ten sampled staff (Certified Medication Technician A, Dietary Aide C, and Licensed Practical Nurse C). The facility census was 66.</p> <p>Review of facility Policy, Abuse and Neglect, dated 1/30/24, showed:</p> <p>-Employee background checks and employment history collection will be done before hire. The facility will not knowingly employ any individual who had been found guilty of abusing, neglecting, exploiting, misappropriating, or mistreating individuals.</p> <p>-The abuse prevention program provides polices and procedures that govern, as a minimum:</p> <p>-Conducting employee background checks.</p> <p>1. Review of Certified Medication Technician (CMT) A's employee file., showed:</p> <p>- Employee hired on 12/26/23;</p> <p>-No Family Care Registry check had been completed;</p> <p>-No Employee Disqualification List (EDL) check had been completed.</p> <p>2. Review of Dietary Aide C employee file., showed:</p> <p>- Employee hired on 11/2/23;</p> <p>-Family Care Registry checked 5/7/24, six months after date of hire;</p> <p>-No EDL check had been completed;</p> <p>-No Nurse Aide Registry had been checked.</p> <p>3. Review of Licensed Practical Nurse (LPN) C employee file., showed:</p> <p>-Employee hired on 12/16/23;</p> <p>-No EDL check had been completed.</p> <p>-No Nurse Aide Registry Check had been completed.</p> <p>During an interview on 5/7/24 at 3:49 P.M., the Business Office Manager said:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She started in the Business Office Manager position, on 3/15/24;</p> <p>-Family care registry should be done on employees before they are hired;</p> <p>-Nurse Aide Registry checks are completed on all employees;</p> <p>-Background checks were completed upon hire;</p> <p>-Facility did not do periodic background checks of employees.</p> <p>During an interview on 5/9/24 at 3:12 P.M., the Director of Nursing said:</p> <p>-Background checks should be done on employees prior to start of employment;</p> <p>-Nurse aide registry checks should be completed on all employees.</p> <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator said:</p> <p>-Background checks should be completed prior to hire and as soon as employee has interviewed;</p> <p>-Nurse aide registry checks should be completed before the employee is hired.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102</p> <p>Based on interview and record review, the facility failed to ensure staff provided a written notice of transfer or discharge to residents or their responsible parties that included the reason for the transfer, in writing and in a language they understood. The notice should have included the effective date of discharge or transfer, the location to which the resident would be transferred or discharged, and information regarding the resident's appeal rights, including how to file an appeal or obtain assistance in completing and submitting it. The facility also failed to notify the State Long-Term Care Ombudsman of the transfers and discharges. This affected two of 17 sampled residents, (Resident #14 and #27). The facility census was 66.</p> <p>The facility did not provide a policy for transfer/discharge of a resident.</p> <p>1. Review of Resident #27's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/8/24 showed:</p> <ul style="list-style-type: none"> - cognitive skills moderately impaired; - upper and lower extremities impaired on one side; - dependent on staff for toilet use and transfers; and - diagnoses including stroke, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and the ability to carry out the simplest tasks), dementia (the inability to think), anxiety, depression, and hemiplegia (paralysis affecting one side of the body). <p>Review of the resident's medical record dated 3/23/24 at 10:45 P.M., showed the nurse called to the resident's room. The resident was lying face down on the floor under the room mate's bed. The nurse assessed the resident as able to move extremities on the right side of his/her body. Left side unable to move, same as baseline. Resident noted to have large hematoma (localized swelling that is filled with blood outside of a blood vessel) to forehead. Alert and oriented times two as his/her usual baseline. Resident complained of a headache and neck pain. Vital signs obtained. Administration, physician notified. Called Emergency Medical Services (EMS).</p> <p>Review of the resident's medical record on 3/24/24 at 4:27 A.M., showed the resident returned from the hospital via EMS. The residents lab work and scans were negative. The resident had a broken nose.</p> <p>The medical record did not have a copy of a transfer or discharge letter issued to the resident or responsible party.</p> <p>During an interview on 5/9/24 at 9:55 A.M., Licensed Practical Nurse (LPN) B said:</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- when a resident is sent out to the hospital, he/she sent a transfer sheet (which contained the resident's name, date of birth, and where they were being transferred), the face sheet, physician order sheet, and advance directives; and</p> <p>- he/she did not know about any form with email or mailing address, appeal rights or notifying the State Long-Term Care Ombudsman.</p> <p>47195</p> <p>2. Review of Resident #14's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/15/24, showed the resident assessed as:</p> <p>-cognitively intact;</p> <p>-has clear speech, able to make self-understood, and has clear comprehension of others;</p> <p>-dependent on wheelchair for mobility;</p> <p>-impairment to both sides of upper and lower extremity range of motion;</p> <p>-dependent on staff for eating, oral care, toileting, bathing, lower body dressing, personal hygiene, rolling left and right, lying to sitting, sitting to stand, chair to bed transfers, and shower transfers;</p> <p>-diagnoses including neurogenic bladder (a condition in people who lack bladder control due to a brain, spinal cord, or nerve problem), pneumonia, septicemia (a blood poisoning by bacteria), urinary tract infection, wound infection, paraplegia (paralysis of the legs and lower body), quadriplegia (symptoms of paralysis that affects all a person's limbs and body from the neck down), anxiety disorder, depression, post traumatic stress disorder, asthma, chronic pain due to trauma, neurogenic bowel (loss of normal bowel function), and pressure ulcers.</p> <p>During an interview on 5/6/24 at 11:18 A.M , the resident said he/she was hospitalized in February for over a week for being septic and had pneumonia.</p> <p>Review of the resident's medical record, dated 2/3/24, showed:</p> <p>-On 2/3/24 at 2:27 P.M., LPN A called the physician at 1:38 P.M. and gave report of decreased oxygen and temperature and obtained orders to send resident to the emergency room . Resident was in agreement. Call made to 911 to transport patient. They arrived at 1:45 P.M.</p> <p>-On 2/3/24 at 2:59 P.M., LPN D gave report to emergency room nurse.</p> <p>-On 2/3/24 at 7:39 P.M., LPN E received call from resident's family who stated resident was in intensive care unit with pneumonia, urinary tract infection, and was septic.</p> <p>-On 2/12/24 at 5:00 P.M., LPN E wrote resident returned via emergency medical support and was on isolation until further notice.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The medical record did not have a copy of a transfer or discharge letter issued to the resident or responsible party.</p> <p>Review of census records showed the resident discharged on [DATE] and he/she returned to facility 2/12/24.</p> <p>During an interview on 5/9/24 at 11:07 A.M., Administrator said he/she started as administrator in March. The previous Administrator would notify the Ombudsman, however, he/she did not know to do so and so he/she had not done so. The Social Service Designee also did not know he/she was supposed to contact the Ombudsman when a resident was discharged .</p> <p>During an interview on 5/9/24 at 3:12 P.M., Director of Nursing said he/she was new to his/her position as Director of Nursing and did not know about about notice of transfer and discharge.</p> <p>During an interview on 5/9/24 at 3:12 P.M., Administrator said he/she could not find a notice of transfer packet for the facility. He/she would ensure the Ombudsman was notified monthly.</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102</p> <p>Based on interviews and record review, the facility failed to ensure staff informed the residents and their family/legal representatives of the bed hold policy at the time of the transfer/discharge to the hospital for two of 17 sampled residents, (Resident #14 and #27). The facility census was 66.</p> <p>The facility did not provide a bed hold policy.</p> <p>1. Review of Resident #27's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/8/24 showed:</p> <ul style="list-style-type: none"> - cognitive skills moderately impaired; - upper and lower extremities impaired on one side; - dependent on staff for toilet use and transfers; - frequently incontinent of urine; - always incontinent of bowel; <p>- diagnoses including stroke, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and the ability to carry out the simplest tasks), dementia (the inability to think), anxiety, depression, and hemiplegia (paralysis affecting one side of the body).</p> <p>Review of the resident's medical record dated 3/23/24 at 10:45 P.M., showed the nurse was called to the resident's room. The resident was lying face down on the floor under the room mate's bed. Nurse assessed the resident, able to move extremities on the right side of his/her body. Left side unable to move, same as baseline. Resident noted to have large hematoma (localized swelling that is filled with blood outside of a blood vessel) to forehead. Alert and oriented times two as his/her usual baseline. Resident complained of a headache and neck pain. Vital signs obtained. Administration, physician notified. Called Emergency Medical Services (EMS).</p> <p>Review of the resident's medical record showed t:he resident was sent to the hospital on 3/23/24 after a fall. There was no documentation in the medical record that the resident or the responsible party was provided provide written information explaining the facility's bed-hold policy. The record did not have have a copy of any bed hold notice/letter that would have been issued to the resident.</p> <p>During an interview on 5/9/24 at 9:55 A.M., Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> - when a resident is sent out to the hospital, he/she sent a transfer sheet (which contained the resident's name, date of birth, and where they were being transferred), the face sheet, physician order sheet and advance directives; - he/she was not aware of any bed hold letter/notice that needed to be sent with the resident. <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47195</p> <p>2. Review of Resident #14's quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/15/24, showed the resident:</p> <ul style="list-style-type: none"> -cognitively intact; -had clear speech, was able to make self-understood and had clear comprehension of others; -dependent on wheelchair for mobility; -with an impairment to both sides of upper and lower extremities; -dependent on staff for all activities of daily living. <p>-Diagnoses including neurogenic bladder (a condition in people who lack bladder control due to a brain, spinal cord, or nerve problem), pneumonia, septicemia (a blood poisoning by bacteria), urinary tract infection, quadriplegia (symptoms of paralysis that affects all a person's limbs and body from the neck down), anxiety disorder, depression, post traumatic stress disorder, chronic pain due to trauma, neurogenic bowel (loss of normal bowel function), and pressure ulcers.</p> <p>During an interview on 5/6/24 at 11:18 A.M., Resident #14 said:</p> <ul style="list-style-type: none"> -he/she was hospitalized in February for over a week; -he/she was septic and had pneumonia; -he/she did not recall a bed hold notice at time of hospitalization . <p>Review of the resident's medical record, dated 2/3/24, showed:</p> <ul style="list-style-type: none"> -On 2/3/24 at 2:27 P.M., LPN A called the physician at 1:38 P.M. and gave report of decreased oxygen and temperature and obtained orders to send resident to the emergency room . Resident was in agreement. Call made to 911 to transport patient, whom arrived at 1:45 P.M., and report called to hospital. Resident's family also contacted. -On 2/3/24 at 2:59 P.M., LPN D gave report to emergency room nurse. -On 2/3/24 at 7:39 P.M., LPN E received call from resident's family who stated resident was in intensive care unit with pneumonia, urinary tract infection, and was septic. <p>Review of census records showed the resident discharged [DATE]. The resident returned to the facility 2/12/24.</p> <p>During an interview on 5/9/24 at 3:12 P.M., Director of Nursing said he/she did not know about a bed-hold policy.</p> <p>(continued on next page)</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/9/24 at 3:12 P.M., Administrator said he/she could not find a discharge packet that included a bed-hold notice. The Social Services Designee also did not know about bed-hold notices.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observation, interview's and record review, the facility failed to complete a Minimum Data Set (MDS) a federally mandated assessment completed by the facility staff within the required time frames, upon the resident's admission for 3 of 17 sampled resident's (Resident #214, #216, and #212). The facility census was 66.</p> <p>The facility did not provide a policy regarding comprehensive assessments.</p> <p>Review of facility policy, Medically Related Social Services, dated 1/30/24, showed:</p> <p>-Facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>-Social services services may include identifying and seeking ways to support resident's individual needs through the assessment and care planning process.</p> <p>1. Review of Resident #214's Face Sheet, dated 5/7/24, showed:</p> <p>-He/She admitted to facility on 4/19/24;</p> <p>-Diagnoses included rheumatoid arthritis and generalized muscle weakness.</p> <p>Review of MDS showed resident did not have MDS completed.</p> <p>Review of care plan, dated 5/6/24, showed:</p> <p>-He/She had one goal regarding do not resuscitate orders.</p> <p>Review of baseline care plan, dated 4/19/24, showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She wore glasses;</p> <p>-He/She had verbal communication;</p> <p>-He/She required an assist of one staff for bed mobility, grooming, hygiene, bathing, and locomotion;</p> <p>-He/She required an assist of two staff for transfers and toileting;</p> <p>-He/She needed interventions for skin issues;</p> <p>-He/She needed monitoring for safety and assist while eating and drinking;</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She had history of falls and was a fall risk;</p> <p>-He/She was dependent on a wheelchair for mobility;</p> <p>-He/She had psychosocial needs and took as needed medications;</p> <p>-He/She was incontinent of bowel and bladder;</p> <p>During an interview on 5/6/24 at 3:16 P.M., resident said:</p> <p>-He/She had a fall prior to arriving to facility;</p> <p>-He/She experienced pain and took pain pills;</p> <p>Review of fall assessment, dated 4/19/24, showed:</p> <p>-He/She was low risk for falls.</p> <p>During an interview on 5/14/24 at 10:34 A.M., State RAI Coordinator said:</p> <p>-Resident's MDS was submitted late and accepted on 5/9/24.</p> <p>2. Review of Resident #216's face sheet, dated 5/7/24, showed:</p> <p>-Resident admitted to facility on 4/22/24</p> <p>-Diagnoses included: neurocognitive disorder with lewy bodies (a type of progressive dementia that leads to decline in thinking, reasoning, and independent function), generalized osteoarthritis (a condition in which three or more joint groups are affected when cartilage that cushions end of bones deteriorates), chronic pain syndrome.</p> <p>Review of MDS showed resident did not have MDS completed.</p> <p>Review of care plan, dated 5/8/24, showed:</p> <p>-Resident had one goal regarding full code status.</p> <p>Review of baseline care plan, dated 4/22/24, showed:</p> <p>-He/She had confused cognition status;</p> <p>-He/She required assist of two staff for bed mobility, transfers, bathing, locomotion, and toileting;</p> <p>-He/She had safety concerns regarding balance and gait, muscle weakness, and fatigue;</p> <p>-He/She required assist of one staff with eating;</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She used a mechanical lift for transfers;</p> <p>-His/Her bed should be in lowest position;</p> <p>-He/She displayed aggression, agitation, and crying;</p> <p>-He/She had as needed medications for psychosocial interventions;</p> <p>-He/She was always incontinent of bowel and bladder.</p> <p>During an interview on 5/14/24 at 10:34 A.M., State RAI Coordinator said:</p> <p>-Resident's MDS was submitted and accepted on 5/9/24;</p> <p>-Facility received an error for the MDS being completed late;</p> <p>-Assessment should have been completed by 5/5/24.</p> <p>3. Review of Resident #212's face sheet, dated 5/7/24, showed:</p> <p>-He/She admitted to facility on 4/22/24;</p> <p>-Diagnoses included dependence on renal dialysis (a treatment that removed extra fluid and waste products from the blood when kidneys are not able to), diabetes (a condition resulting in too much sugar in the blood, neuropathy (weakness, numbness, or pain from nerve damage), and kidney disease.</p> <p>Review of MDS showed resident did not have MDS completed.</p> <p>Review of care plan showed facility did not provide base line care plan or care plan.</p> <p>During an interview on 5/14/24 at 10:34 A.M., State RAI Coordinator said:</p> <p>-Resident's MDS was submitted and accepted on 5/9/24;</p> <p>-Facility received an error for the MDS being completed late;</p> <p>-Admission assessment should have been completed by 5/5/24.</p> <p>4. During an interview on 5/7/24 at 3:41 P.M., Social Service Designee said:</p> <p>-He/She did some sections of the MDS including sections A, E, and Q;</p> <p>-He/She went to training in August with the regional team;</p> <p>-The MDS process was interdisciplinary within the facility;</p> <p>-The staff member who completed MDS at the facility was fired in February;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The regional staff member who was helping with getting MDS in order was fired last week.</p> <p>During an interview on 5/9/24 at 3:12 P.M., Administrator said:</p> <p>-MDS assessments should be completed on time;</p> <p>-He/She was aware MDS assessments had not been completed;</p> <p>-He/She knew that the previous Regional MDS coordinator had moved a bunch of dates around on the MDS due to him/her going to [NAME] and being out of facility, the facility will have to go back and review time frames to ensure compliance;</p> <p>-Many MDS were not 92 days a part because of the Regional MDS Coordinator changing dates.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</p> <p>Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific needs of the residents, for three of 16 sampled residents (Residents #162, #45, #216, and #214). The census was 66.</p> <p>Review of the facility provided policy, Comprehensive Care Plan, dated 1/30/24 showed:</p> <ul style="list-style-type: none"> -Each resident will have a person centered comprehensive care plan developed and implemented to meet his/her preferences and goals and address the resident's nursing medical, physical, mental and psychosocial needs identified in the comprehensive assessment. -The comprehensive care plan will be developed within seven days after the completion of the comprehensive assessment. -The comprehensive care plan will be reviewed and revised, based on changing goals, preferences and needs of the resident, and in response to current interventions. <p>1. Review of Resident # 162 Annual Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 4/12/24 showed:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) of 10, indicated cognitive loss. -Dependent on staff for completion of Activities of Daily Living (ADL's: tasks completed to care for oneself in a day) -Indwelling urinary catheter (tube inserted into the bladder to drain urine) -Frequently incontinent of bowel -Hospice services -Use of oxygen (O2) <p>Review of the Physician order sheet for May 2024 showed:</p> <ul style="list-style-type: none"> -No order for use of side rails/half rails/assist rails <p>Review of the resident's electronic medical record showed:</p> <ul style="list-style-type: none"> -A neurological assessment completed 4/30/24 with note of unwitnessed fall. -No progress note about a fall. -No indication side rails were in use or placed after the fall. <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Review of the comprehensive care plan 5/6/24 showed:</p> <p>-No care plan for need for assistance with ADL's, use of side rails, Hospice services, use of catheter or use of O2.</p> <p>During observation and interview on 5/06/24 at 2:31 P.M. showed half side rails on bed, in the up position. The resident said the rails were up because he/she had rolled out of bed before.</p> <p>During observation on 05/08/24 at 9:10 A.M. showed half rails on bed, in the up position.</p> <p>During an interview on 05/08/24 at 2:33 P.M. Certified Medication Technician (CMT) B said: -Hospice brought the bed in to the resident.</p> <p>-He/She did not know why the resident had them.</p> <p>47195</p> <p>2. Review of Resident #45's Admission minimum data set (MDS), dated [DATE], showed:</p> <p>-He/She was cognitively intact;</p> <p>-He/She had clear speech, was able to make self-understood, and understand others;</p> <p>-He/She had impairment on one side;</p> <p>-He/She was dependent on walker and wheelchair for mobility;</p> <p>-He/She required setup or clean-up assistance eating</p> <p>-He/She required substantial/maximal assistance for showers, lower body dressing, sitting to standing, sit to lying, chair to bed transfer, toilet transfer,</p> <p>-He/She required partial/moderate assistance with personal hygiene and rolling left and right.</p> <p>-Diagnoses included aftercare after joint replacement surgery, anemia, high blood pressure, gastroesophageal reflux disease, wound infection, arthritis, anxiety disorder, asthma.</p> <p>Review of physician's orders dated 4/8/24 to 5/8/24 showed:</p> <p>-Order started 4/18/24, Bed rail to assist with getting out of bed and turning unassisted.</p> <p>Review of care plan, dated 5/1/24, showed:</p> <p>-Side rails not care planned;</p> <p>-Shower preferences not care planned;</p> <p>-Activity preferences not care planned;</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Pressure ulcer not care planned.</p> <p>-He/She able to move self some in bed but required staff assistance with transfers and bed mobility. Staff to assist him/her with repositioning in bed. He/She had pressure reducing mattress on his/her bed.</p> <p>-He/She was at risk from injury from falls;</p> <p>-Make sure bed was in lowest position with wheels locked;</p> <p>-He/She had fall with a hip fracture prior to admitting to facility, and was on therapy services;</p> <p>-He/She had a lot of anxiety related to fall and impacted ability to transfer his/her self.</p> <p>-Resident is alert and able to communicate his/her needs. Encourage him/her to call for assistance with his/her ADL care.</p> <p>-Resident required assistance of staff with his/her bathing needs.</p> <p>During an interview on 5/6/24 at 1:00 P.M., the resident said:</p> <p>-He/She had a side rail put on to help him/her turn in bed;</p> <p>-He/She slept in recliner now because of swelling in his/her legs and had not used bed rail since it was put on.</p> <p>-He/She last had a shower over a week ago on 4/30/24;</p> <p>-He/She preferred to have showers twice a week on scheduled shower days of Tuesdays and Fridays;</p> <p>-There was not enough activities that he/she enjoyed;</p> <p>-He/She loved to be outside but outside of smoking facility did not do activities for resident's outside;</p> <p>-He/She had cellulitis of his/her legs.</p> <p>Review of electronic medical record, dated 4/18/24 at 12:06 P.M. showed new order was received from physician for bed rail to assist with getting out of bed and turning unassisted.</p> <p>Review of facility matrix showed resident had a pressure ulcer.</p> <p>Review of physician's orders, dated 4/8/24 to 5/8/24, showed:</p> <p>-Order start date 4/12/24, ultra sound to left lower extremity to rule out deep vein thrombosis (DVT)</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Order start date 4/12/24, venous ultra sound of left lower extremity to rule out DVT redness and pain in lower left extremity</p> <p>-Order start date 4/15/24 - check skin tear to left lower leg. Keep clean, dry, and covered until healed;</p> <p>-Order start date 4/19/24 - Check and change dry dressing to lower left leg skin tear daily until healed.</p> <p>-Order start date 5/1/24 - Lasix (Furosemide) tablet 20 mg; amt: 1: oral for diagnosis cellulitis of left lower limb once a day in AM;</p> <p>-Order start date 5/1/24, potassium chloride capsule, extended release; 10 mEq; amount: 1 capsule; oral for diagnosis cellulitis of left lower limb, once a day in morning;</p> <p>-Order start date 5/3/24 - nystatin powder; 100,00 unit/gram; amt: apply this layer; topical, special instructions: apply under her breast folds and her abdominal folds twice daily a thin layer.</p> <p>-Order start date 5/3/24 to 5/5/24 - Xeroform petrolatum dressing (bismuth tribrom-petrolatum, wh) bandage; 4x4; amt: 4x4; topical Special instructions: left lower extremity; cleanse area with N/S, apply xeroform dressing and wrap with kerlix daily for diagnosis of Cellulitis of left lower limb once a day; AM;</p> <p>-Order start date 5/5/24, may have wound care plus diagnosis of cellulitis of left lower limb,</p> <p>-Order start date 5/5/24 to 5/15/24, cephalixin capsule; 500 mg; amt: 500 mg; oral Special instructions: times 10 days for diagnosis cellulitis of left lower limb, three times daily; AM 7:00 AM, 12:00 P.M., 7:00 P.M.</p> <p>-Order start 5/5/24, open ended; Xeroform Petrolatum Dressing (bismuth tribrom-petrolatum, wh) bandage; 4x4' amt: 4x4; topical. Special instructions: lower extremity; cleanse area with N/S, Apply xeroform dressing and wrap with kerlix daily (DX: cellulitis of left lower limb) once a day: am</p> <p>Observation on 5/6/24 at 1:00 P.M. showed resident had side rails on left side of bed only.</p> <p>Review of Side Rail Assessment, dated 4/18/24, showed:</p> <p>-Implemented for bed mobility</p> <p>-Resident had expressed desire to have side rails</p> <p>-Quarter rail will be used to assist in positioning and transfers - Side not indicated.</p> <p>-Use - day and night</p> <p>-Additional interventions: provide frequent staff monitoring at night, visual and verbal reminders to use call light.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Entrapment zones not filled out on the assessment.</p> <p>Review of shower logs from 4/8/24 to 5/8/24 showed:</p> <p>-He/She had 2 of 9 scheduled showers on 4/30/24 and 5/7/24.</p> <p>During an interview on 5/8/24 at 9:54 A.M., Social Service Designee said:</p> <p>-He/She expected side rails to be included in a care plan.</p> <p>3. Review of Resident #216's face sheet showed:</p> <p>-Resident admitted to facility on 4/22/24</p> <p>-Diagnoses included: neurocognitive disorder with lewy bodies (a type of progressive dementia that leads to decline in thinking, reasoning, and independent function), generalized osteoarthritis (a condition in which three or more joint groups are affected when cartilage that cushions end of bones deteriorates), chronic pain syndrome.</p> <p>Review of MDS showed resident did not have MDS completed.</p> <p>Review of physician's orders, dated 4/8/24 to 5/8/24, showed:</p> <p>-He/She was taking antipsychotic medications</p> <p>-Order started 5/1/24 rexulti tablet, .5 mg 1 oral tablet for seven days then increase to 1.0 mg;</p> <p>Review of care plan showed resident did not have care plan completed.</p> <p>Review of baseline care plan, dated 4/22/24, showed:</p> <p>-He/She had impaired cognition;</p> <p>-He/She was assist of two staff for bed mobility, transfers, toileting, grooming, hygiene, bathing, and locomotion;</p> <p>-He/She was assist of one for eating;</p> <p>-He/She had safety concerns of balance and gait, muscle weakness, and fatigue/endurance concerns;</p> <p>-He/She had psychosocial concerns of sad and crying, agitation, aggression;</p> <p>-He/She was always incontinent of bowel and bladder.</p> <p>During an interview on 5/7/24 at 10:44 A.M., Resident's representative said:</p> <p>-He/She had not participated in any care plan meeting with the facility;</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The facility had provided no team collaboration or phone call regarding resident's care.</p> <p>During an interview on 5/8/24 at 9:54 A.M., Social Service Designee (SSD) said:</p> <p>-He/She did baseline care plan meeting with resident's sister;</p> <p>-Resident did not yet have a regular care plan completed yet.</p> <p>During an interview on 5/8/24 at 12:06 P.M., Resident's sister said:</p> <p>-Resident could not feed themselves.</p> <p>3. Review of Resident #214's face sheet, dated 5/7/24, showed:</p> <p>-He/She admitted to facility on 4/19/24;</p> <p>-Diagnoses included rheumatoid arthritis and generalized muscle weakness.</p> <p>Review of MDS showed resident did not have MDS completed.</p> <p>Review of physician's orders, dated 4/7/24 to 5/7/24, showed:</p> <p>-He/She was on mechanical soft diet;</p> <p>-He/She had medications for chronic pain;</p> <p>-He/She had as needed medication for generalized anxiety disorder;</p> <p>-He/She had skin prep to right second toe.</p> <p>Review of care plan, dated 5/6/24, showed:</p> <p>-He/She had only do not resuscitate orders care planned.</p> <p>Review of baseline care plan, dated 4/19/24, showed:</p> <p>-He/She was alert and cognitively intact;</p> <p>-He/She used verbal communication;</p> <p>-He/She wore glasses;</p> <p>-He/She was assist of one staff for bed mobility, grooming, bathing, locomotion;</p> <p>-He/She was assist of two for transfers, toileting;</p> <p>-He/She was independent with eating;</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She was dependent on a manual wheelchair;</p> <p>-He/She had psychosocial concerns of nervousness;</p> <p>-He/She was sometimes incontinent of bowel and bladder.</p> <p>4. During an interview on 5/8/24 at 9:54 A.M., SSD said:</p> <p>-Care plans should be written 14 days after admission;</p> <p>-He/She led and scheduled care plan meetings;</p> <p>-The writing of care plans was more interdisciplinary;</p> <p>-Care plans are scheduled off the minimum data set (MDS) schedule;</p> <p>-He/She kept a list of upcoming care plans on his/her calendar;</p> <p>-Nursing staff completed the baseline care plans when resident admitted to facility;</p> <p>-He/She did not have families, residents, or care plan participants sign anything when they participated in care plan meetings;</p> <p>-He/She called resident families or representatives for care plan meetings and will make a note in resident's electronic medical record when he/she notified individuals of care plan meetings.</p> <p>-The former MDS Coordinator wrote most of the care plans;</p> <p>-He/She did not know who was responsible for updating the care plans;</p> <p>-He/She usually only completes the code status and trauma section of care plans but had not been trained on doing other areas of the care plans.</p> <p>During an interview on 5/9/24 at 3:12 P.M. the Administrator said:</p> <p>-There was not a MDS coordinator and that position was responsible for checking and updating the care plans.</p> <p>-Nobody has had formal training on completion of the care plan and the MDS process.</p> <p>-A new MDS/Care plan coordinator started Monday.</p> <p>-Each department should update their part of the care plan with any changes.</p> <p>-The MDS coordinator should oversee the quality of the care plan.</p> <p>-Anyone can update a care plan.</p>

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>44395</p> <p>Based on interview and closed record review, the facility staff failed to complete a comprehensive discharge summary for one resident (Resident #61) out of three discharged residents. The facility census was 66.</p> <p>The facility did not provide a policy regarding the discharge process.</p> <p>Review of Resident #61 Electronic Medical Record showed:</p> <p>-The resident was admitted to the facility 09/30/2023.</p> <p>- Diagnoses included: Diverticulosis of intestine (small bulging pouches in the digestive tract), Type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), Mild neurocognitive disorder with behavioral disturbance (a decline in function, memory, learning and attention), dementia with psychotic disturbance (a decline in thinking and problem solving skills as well as seeing/hearing things that are not there or belief that something is real when it is not), Alcohol dependence, Acute metabolic acidosis (a condition in which acids build up in your body.), Hallucinations (seeing or hearing something that isn't there).</p> <p>-The Comprehensive Care Plan showed: the resident was to discharge from the facility. The facility was to provide written instructions for care and resources to use in case of emergency; plan for specific resident needs/continuing care needs after discharge; assist the resident and/or support person in locating and coordinating post-discharge services; and ensure access to services.</p> <p>-Progress Notes showed:</p> <p>-2/07/2024 at 3:29 P.M. the resident discharged home with a Home Health agency for nursing, Physical Therapy, and Occupational Therapy. A follow up appointment with the primary care provider was set up and the information was emailed to the resident's family. The resident was discharged home.</p> <p>There was no discharge summary completed.</p> <p>During an interview on 5/9/24 at 3:12 P.M. the Administrator said:</p> <p>-No one is doing discharge summaries.</p> <p>-She is unsure who took over the responsibility when the last Minimum Data Set (MDS) Coordinator left.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102</p> <p>Based on observations, interviews and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADL's) received the necessary services to maintain good personal hygiene when staff did not provide complete perineal care which affected three of the 17 sampled residents, (Residents #9, # 35 and #57), as well as failed to ensure showers were completed for four Residents #2, #45, #50 and #162, and additionally the staff failed to reposition Resident #57 who was dependent upon staff for assistance with repositioning. The facility census was 66.</p> <p>Review of the facility's undated policy for shower/tub bath, showed, in part:</p> <ul style="list-style-type: none"> - The purpose is to promote cleanliness and comfort, relax the resident, stimulate circulation, and facilitate observation of the resident's skin condition. . Review of the facility's policy for perineal care, dated [DATE], showed, in part: <ul style="list-style-type: none"> - The purpose was to cleanse the perineum (the thin layer of skin between the genitals and anus, and the bottom region of the pelvic cavity) and to prevent infection and odor; - Knock and pause before entering the resident's room; - Introduce yourself; - For the female resident - Use one gloved hand to stabilize and separate the perineal folds, with the other hand wash from front to back; - For the males - follow the above instructions for the female perineal care except wash the skin folds. Pull back the uncircumcised skin fold, wash, dry and replace the skin fold; - Use and new wash cloth and wash around the rectal area. <p>1. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE] showed:</p> <ul style="list-style-type: none"> - Cognitive skills intact; - Set up and clean up with showers; - Independent with dressing, personal hygiene and oral hygiene; - Occasionally incontinent of urine; - Diagnoses included seizure disorder and coronary artery disease (CAD, damage or disease in the heart's major blood vessels). <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's shower sheets for February 2024, showed:</p> <ul style="list-style-type: none"> - [DATE] - the resident had a shower; - [DATE] - the resident had a shower; - [DATE] - the resident had a shower; - [DATE] - the resident had a shower. <p>Review of the resident's care plan, dated [DATE], showed:</p> <ul style="list-style-type: none"> - The resident was at risk for skin breakdown related to lymphedema (a condition caused by a blockage in the lymphatic system and generally occurs in an arm or leg), in both lower extremities. Showers or baths at least twice weekly or as desired. <p>Review of the resident's shower sheets for [DATE], showed:</p> <ul style="list-style-type: none"> - [DATE] - the resident had a shower; - [DATE] - the resident had a shower; - [DATE] - the resident refused his/her shower; - [DATE] - the resident refused his/her shower due to not feeling well; - [DATE] - the resident had a shower; - [DATE] - the resident had a shower. <p>Review of the resident's skin attention forms for [DATE], showed:</p> <ul style="list-style-type: none"> - [DATE]- the resident had a shower; - [DATE] - the resident refused his/her shower; - [DATE] - the resident had a shower; - [DATE] - the resident had a shower. <p>Requested shower sheets for May, 2024 and none were provided.</p> <p>Observation and interview on [DATE] at 11:15 A.M., showed:</p> <ul style="list-style-type: none"> - The resident was in his/her room; - The resident's hair appeared dull and greasy; <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265696	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- The resident stated he/she has gone two weeks without a shower. It made him/her feel like a filthy pig, nasty and just awful and bad all the way around. He/she was able to give him/herself a shower with staff just helping to set things up. The resident did not understand why he/she didn't get showered twice weekly.</p> <p>During an interview on [DATE] at 2:06 P.M., Certified Medication Technician (CMT) B said:- Showers do not always get done because they do not have enough staff;</p> <p>- The facility had a designated shower aide but he/she worked last night so none of the residents would be getting a shower today.</p> <p>During an interview on [DATE] at 9:55 A.M., Licensed Practical Nurse (LPN) B said:</p> <p>- When they are short staffed, it is difficult to get the resident's showers completed.</p> <p>During an interview on [DATE] at 10:29 A.M., Certified Nurse Aide (CNA) D said:</p> <p>- He/she was the designated shower aide;</p> <p>- He/she gets pulled to work the floor and when that happens, the showers do not get completed;</p> <p>- The other issue with the showers is they do not have enough lines. He/she started showers at 5:00 A.M., and by 10:00 A.M., he/she is out of towels and wash cloths. If Laundry did not come in until 11:00 A. M., then he/she would have to wait until after 1:00 P.M. before he/she could start showers again.</p> <p>2. Review of Resident #9's Quarterly MDS, dated [DATE] showed;</p> <p>- Cognitive skills severely impaired;</p> <p>- Required substantial to maximal assistance with showers, personal hygiene, toilet use and transfers;</p> <p>- Always incontinent of bowel and bladder;</p> <p>- Diagnoses included non traumatic brain dysfunction (causes damage to the brain by internal factors, such as a lack of oxygen, exposure to toxins, or pressure from a tumor), congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body), anxiety, depression, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and the ability to carry out the simplest tasks), and psychotic disorder (a mental disorder characterized by a disconnection from reality).</p> <p>Review of the resident's care plan, dated [DATE] showed:</p> <p>- The resident required assistance with activities of daily living (ADL's) due to weakness, decreased cognition related to Alzheimer's disease. Assist the resident with cares. Provide extensive assistance for bed mobility, transfers, locomotion on the unit and off the unit, dressing, toileting, and personal hygiene. The resident is not able to walk.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on [DATE] at 9:41 A.M., showed:</p> <ul style="list-style-type: none"> - The resident sat in his/her Broda chair (reclining geri chair) in the assist dining room and was leaning over on the left side of the chair with his/her eyes closed. There was a puddle of urine under the resident's Broda chair; - CNA A took the resident back to his/her room; - CNA A and CNA D did not wash their hands and applied gloves; - CNA A and CNA D used the gait belt (a safety device and mobility aid used to provide assistance during transfers, ambulation or repositioning) and transferred the resident from the Broda chair to his/her bed; - There was a puddle of urine under the resident's Broda chair; - CNA A and CNA D removed the resident's wet pants and the saturated and soiled incontinent brief; - CNA A and CNA D turned the resident on his/her side; - CNA D wiped from front to back one time; - CNA D used a new wipe and wiped the rectal area with fecal material noted. CNA D used three different wipes and wiped the rectal area; - The clean incontinent brief fell on to the floor and CNA D picked it up and placed it on the resident and fastened it; - CNA D walked through the urine on the resident's floor and CNA A placed the fall mat over the urine on the floor beside the resident's bed. CNA A and CNA D did not clean the seat of the resident's Broda chair; - CNA D did not provide any peri care to the front perineal folds, did not separate and clean all the perineal folds and did not clean all areas of the skin where urine or fecal material had touched. <p>During an interview on [DATE] at 2:38 P.M., CNA A said:</p> <ul style="list-style-type: none"> - Should separate all the skin folds and clean all areas of the skin where urine or feces had touched; - Should have cleaned the front perineal folds; - Should not have used the brief after it had fallen on the floor; - He/she should have clean the seat of the resident's Broda chair and cleaned the urine from the floor before placing the fall mat on the floor. <p>During an interview on [DATE] at 10:29 A.M., CNA D said:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - He/she should have separated and cleaned all the perineal folds, especially where the urine had touched; - He/she should have cleaned the front perineal folds; - We should not have used the clean incontinent brief after it had fallen on the floor; - Should have cleaned the urine from the floor and the seat of the resident's Broda chair. <p>44395</p> <p>3. Review of Resident #35's Quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) of 4, indicated significant cognitive deficit; -Partial to moderate assistance on staff for Activities of Daily Living (ADL's: tasks performed to care for oneself in a day); -Dependent on staff for standing, maximum assistance for transfers; -Occasional incontinence of urine; -Continent of bowel; -Diagnoses of Alzheimer's Dementia (progressive memory loss that interferes with daily life), disorientation (a state of mental confusion), chronic pain, atrial fibrillation (A-Fib: a type of abnormal heartbeat). <p>Review of the resident's comprehensive Care Plan dated [DATE] showed:</p> <ul style="list-style-type: none"> -He/she takes the assist of 2 staff for toileting; -He/She experienced bladder and bowel incontinence; use incontinent pads or briefs to protect his/her dignity; -He/She can be confused at times; break tasks into manageable segments, explain all procedures, allow him/her to make simple decisions. <p>Observation on [DATE] at 5:05 A.M. showed:</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Nurse Aide (NA) A and NA B entered the resident's room; NA B closed the resident's bedroom door, removed wipes and removed cream from the resident bedside dresser. NA B uncovered the resident, unfastened the resident's brief and removed the brief from the front of the resident. NA A used one cleansing wipe to wipe the outer skin folds at the thigh and down the middle. The resident said his/her skin was very sore and felt better when cream was applied. The resident was then turned to his/her side. NA A removed another cleansing wipe and with a back and forth motion cleansed the resident's buttocks. NA A then picked up a tube of A&D ointment and applied it to the resident's skin folds. A new incontinent brief was applied and the resident was covered with a blanket. NA A and NA B removed the gloves and left the resident's room.</p> <p>During an interview on [DATE] at 5:31 A.M., NA A said:</p> <p>-He/She had been working in facility a couple of months;</p> <p>-He/She would be starting certified nurse aide (CNA) classes soon, but was still waiting to find out;</p> <p>-His/Her training involved staff showing him/her every resident, showing him/her supplies, and what to fill out to help residents, and telling me what he/she can and cannot do.</p> <p>4. Review of Resident #57 Quarterly MDS dated [DATE] showed:</p> <p>-BIMS of 99, indicated significant cognitive deficit;</p> <p>-Dependent on staff for ADL's;</p> <p>-Always incontinent of bowel and bladder;</p> <p>-Diagnoses of Intracerebral hemorrhage (bleeding into the brain), Aphasia (loss of ability to understand or express speech), hemiplegia (loss of the ability to move one side of the body). Diabetes Mellitus (a health condition that affects how your body turns food into energy), seizures (a condition where you have a temporary, unstoppable surge of electrical activity in your brain) Hypertension (high blood pressure).</p> <p>Review of Resident #57 comprehensive Care Plan, dated [DATE] showed:</p> <p>-He/She needed assist of ,d+[DATE] staff with ADL's;</p> <p>-Keep his/her call light within reach and answer in a timely manner;</p> <p>-Provide him/her adequate rest periods between activities;</p> <p>-During two hour checks and as needed (PRN: per resident need) please ask the resident if he/she needs any of his/her belongings moved closer so they are within reach;</p> <p>-Frequent checks at night, every one to two hours and pm;</p> <p>-He/she was at risk for pressure ulcers because of incontinent episodes of bowel/bladder;</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She needs assist with bed mobility;</p> <p>-Keep him/her clean and dry as possible;</p> <p>-Minimize his/her skin exposure to moisture;</p> <p>-Turn and reposition him/her every two hours and PRN;</p> <p>-Encourage toileting before and after meals, before assisting to bed and prn.</p> <p>Continuous observation beginning on [DATE] at 5:39 A.M. showed:</p> <p>-The resident was taken to the dining /Activity room by staff. He/she was placed in front of the TV with cartoons on and lights off;</p> <p>- 7:26 A.M. the resident was taken to the dining table for breakfast and assisted with meal;</p> <p>- 9:03 AM he/she remained in the dining/ activity room; he/she was yelling out. MDS Coordinator entered the room and asked the resident if he/she was missing his/her friend. The MDS coordinator assured the resident his/her friend was missing him/her too and walked away. The resident was not offered or taken to the restroom, repositioned or offered food or drinks;</p> <p>- 9:08 AM staff entered the dining/activity room, laid the back of her Broda chair (a tilting, reclining, and wheeled chair) down. The resident was not offered or taken to the restroom, repositioned or offered food or drinks;</p> <p>-9:18 AM the resident was yelling out. LPN A asked the resident why he/she was yelling. The resident said he/she was tired. LPN A asked the resident if he/she wanted to lay down. Resident #57 replied yes. LPN A told the resident he/she would notify CNA staff. The resident began to cry. LPN A asked the resident why he/she was crying. The resident said staff would not come. LPN A asked the resident if he/she was crying because staff had not come to help; the resident responded yes. LPN A then walked away. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>- 9:22 A.M. Nurse Aide C took the resident from the dining/activity room to his/her room. NA C pulled covers back then left room to obtain assistance. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>-9:24 AM NA C returned the resident to the dining/activity room.</p> <p>-9:36 AM the resident remained in the Broda chair in the dining/activity room. NA C had the ice cart, stopped at the resident's chair and covered the resident with a blanket, and left. The resident closed his/her eyes and began snoring. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>- 9:42 AM the resident was dozing off and on, snoring lightly then opening his/her eyes.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-10:01 AM the Activity Director (AD) approached the resident, observed the resident with eyes closed, and walked away. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>-10:10 AM Exercise group began in the activity/dining room. The resident remained in his/her Broda chair, reclined, with eyes closed.</p> <p>-10:54 AM staff moved the resident to a dining table. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>During an interview on [DATE] at 10:33 A.M. NA C said residents should be moved, toileted, or cleaned up every two hours or as needed. There is not enough help to get everything done that needs to be done. He/she was not aware it had been over two hours that Resident #57 was changed or repositioned.</p> <p>5. Review of Resident # 162's Annual MDS dated [DATE] showed:</p> <p>-He/she admitted on [DATE];</p> <p>-BIMS of 10, indicated cognitive loss;</p> <p>-Dependent on staff for completion of ADL's;</p> <p>-Indwelling urinary catheter (tube inserted into the bladder to drain urine);</p> <p>-Frequently incontinent of bowel;</p> <p>-Hospice services;</p> <p>-Use of oxygen (O2).</p> <p>-Review of the comprehensive care plan [DATE] showed:</p> <p>-The resident was a do not resuscitate (DNR: a directive to withhold Cardiopulmonary Resuscitation (CPR) if the resident is found deceased);</p> <p>-No care plan for need for assistance with ADL's, use of side rails, Hospice services, use of catheter or use of O 2.</p> <p>Review of the facility provided shower sheets for April and [DATE] showed no shower sheets for Resident #162.</p> <p>Review of the electronic medical record showed no documented oral care, morning care or bathing.</p> <p>Observation and interview on [DATE] at 2:31 PM showed:</p> <p>-The resident had white, stringy, sticky material on his/her teeth and lips;</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she said his/her teeth had not been brushed and he/she had not had a bath or shower since he/she admitted to the facility;</p> <p>-His /her hair was disheveled and matted at the back of his/her head.</p> <p>Observation and interview on [DATE] at 9:10 A.M. showed:</p> <p>-The resident had white, stringy, sticky material on his/her lips, tongue and teeth;</p> <p>-His/her eyes have crusted debris at the corners;</p> <p>-His/her hair is disheveled and matted;</p> <p>-He/she said staff had not brushed his/her teeth, washed his/her face or given him/her a bath since he/she had admitted to the facility.</p> <p>-During an interview on [DATE] at 12:06 P.M. CMT B said:</p> <p>-He/she had come in and done 24 showers on his/her day off because none of the residents had one for over a week;</p> <p>-The facility is short staffed;</p> <p>-There is not enough help to get everything done, and things get missed;</p> <p>-They do the best they can to meet the resident's needs.</p> <p>During an interview on [DATE] at 3:10 PM CNA A said:</p> <p>-Residents should be repositioned every two hours;</p> <p>-Oral care should be done at least a couple times a shift, more if on 02 because of drying out the mouth;</p> <p>-They do not have enough staff and complete cares when they can.</p> <p>During an interview on [DATE] at 9:56 A.M. LPN B said:</p> <p>-Turning, repositioning, incontinent care should be completed every two hours;</p> <p>-Oral care should be completed as needed.</p> <p>47195</p> <p>6. Review of Resident #45's admission MDS, dated [DATE], showed:</p> <p>-He/She was cognitively intact;</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She had clear speech, was able to make self-understood, and understand others;</p> <p>-He/She had impairment on one side;</p> <p>-He/She was dependent on walker and wheelchair for mobility;</p> <p>-He/She required substantial/maximal assistance for showers;</p> <p>-Diagnoses included aftercare after joint replacement surgery and arthritis.</p> <p>Review of care plan, dated [DATE], showed</p> <p>-Resident was alert and able to communicate his/her needs.</p> <p>-Encourage him/her to call for assistance with his/her ADL care;</p> <p>-Resident required assistance of staff with his/her bathing needs;</p> <p>-Resident admitted with a hip fracture and was on therapy services. He/She required assistance with mobility of ambulation with a walker and does use a wheelchair for longer distances;</p> <p>-Care plan did not specify resident's shower preferences.</p> <p>Review of baseline care plan, dated [DATE], showed:</p> <p>-He/She required assistance of one staff for bathing;</p> <p>-Assist with ADL care as needed to promote health, hygiene, and safety;</p> <p>-He/She was sometimes incontinent of bowel;</p> <p>-He/She was always incontinent of bladder.</p> <p>During an interview on [DATE] at 12:49 P.M. Resident said:</p> <p>-He/she had his/her last shower over a week ago on [DATE];</p> <p>-He/She preferred to have a shower twice a week;</p> <p>-His/Her shower days were supposed to be on Tuesday and Fridays.</p> <p>Review of shower logs from [DATE] to [DATE] showed:</p> <p>-He/She had two documented showers on [DATE] and [DATE].</p> <p>During an interview on [DATE] at 2:38 P.M., CNA A said:</p> <p>-Shower aide is often pulled to help cover the floor, and did not do showers;</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 2:25 P.M., CMT B said:</p> <ul style="list-style-type: none"> -Showers did not get done due to shower aide working last night; -There was not enough wash clothes, towels in order to provide showers to every resident; <p>During an interview on [DATE] at 2:38 P.M., CNA A said:</p> <ul style="list-style-type: none"> -There is limited supply on towels, hand towels, and wash clothes; <p>During an interview on [DATE] at 3:12 P.M., the Administrator and the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> - The resident's showers should be completed per the resident's choice. - Staff should separate and clean all areas of the skin where urine or feces had touched; - Staff should have cleaned the urine from the floor or had housekeeping clean it before they placed the fall mat on the floor; - Staff should have cleaned the seat of the Broda chair; - Staff should not have used the clean incontinent brief once it had fallen on the floor.

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</p> <p>Based on observations, interviews and record review, the facility staff failed to assure staff used proper techniques to reduce the possibility of accidents and injuries during the use of a gait belt transfer (a safety device and mobility aid used to provide assistance during transfers, ambulation or repositioning) for one of 17 sampled residents, (Resident #9) and properly transfer two residents (Residents #21 and #4) in a manner to prevent accidents. The facility census was 66.</p> <p>Review of the facility provided policy, Accidents, dated 1/30/24 showed:</p> <ul style="list-style-type: none"> -The facility must ensure that each resident receives adequate supervision and use of assistance devices to prevent accidents. -All staff will commit to and promote safety. <p>Review of the facility policy, Safe Resident Handling/Transfers, dated 2021 showed:</p> <ul style="list-style-type: none"> -It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote safe, secure and comfortable experience for the resident while keeping the employees safe accordance with current standards and guidelines. -All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. -Mechanical lifting equipment or other approved transferring aides will be used based on the resident's needs to prevent manual lifting except in medical emergencies. -Handling aids may include gait belt, transfer boards, and other devices. -Resident lifting and transferring will be performed according to the resident's individual care plan. -Two staff members must be utilized when transferring residents with a mechanical lift. <p>1. Review of Resident #21's Annual MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> - No cognitive deficits -Partial assistance from staff for ADL's. -Partial to moderate assistance for standing and transfers. -Touch assist for ambulation (walking) -Occasional incontinence of urine and bowel. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses of Transient Ischemic Cerebral Attack (a brief blockage of blood flow to the brain), difficulty in walking, dizziness, low back pain, chronic fatigue syndrome, atrial fibrillation, arthritis.</p> <p>-Review of the resident's comprehensive Care Plan dated 3/21/24 showed:</p> <p>-The resident was extensive assistance of one staff with bed mobility, transfers, locomotion on unit, dressing and toileting.</p> <p>-The resident was incontinent of bowel and bladder occasionally.</p> <p>-Provide assistance with toileting every two hours and as needed.</p> <p>-Check incontinence pads frequently and change as needed.</p> <p>-The resident was at risk for falls</p> <p>-Provide individualized toileting interventions based on needs/patterns.</p> <p>Observation and Interview on 5/07/24 at 3:47 P.M. showed:</p> <p>-Resident #21's call light was on, Certified Nurse Aide (CNA) E entered the room, and resident reported he/she needed to use the restroom.</p> <p>-CNA E raised the resident's mechanical lift chair to a partially standing position.</p> <p>-CNA E placed his/her forearms under the resident's armpit, lifting and pulling the resident into a standing position. CNA E then pivoted the resident around and assisted him/her to sit into a wheelchair.</p> <p>-CNA E took the resident into the bathroom, and again placed his/her forearms underneath the resident's armpits, applying pressure and lifting the resident to a standing position then onto the toilet.</p> <p>-The resident used the toilet and requested assistance to go back to his/her recliner.</p> <p>-CNA E placed his/her forearms underneath the resident's armpits, applying pressure and lifting the resident to a standing position then into the wheelchair.</p> <p>-CNA A assisted the resident to the side of the mechanical lift chair. He/she then placed his/her forearms under the resident's armpits lifting and pulling on the resident, standing the resident up and pivoting the resident into the mechanical chair.</p> <p>-The resident then lowered the mechanical chair into a reclined position, CNA E said he/she would get the resident for the evening meal and left the room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #21 said the transfer did not hurt his/her arms or chest today. There are times when staff do not use a gaitbelt and it pulls his/her pacemaker and that hurts a lot. Sometimes staff twist his/her skin when they do not use a gaitbelt and that hurts.</p> <p>2. Review of Resident #4's Annual MDS dated [DATE] showed:</p> <p>-Significant cognitive deficits.</p> <p>-Impaired movement on one side of the body, right side.</p> <p>-Substantial to maximum assistance of staff for ADL's.</p> <p>-Frequently incontinent of bowel and bladder.</p> <p>-Diagnoses of spastic quadriplegic cerebral palsy (a disorder of posture and movement that effects the entire body), need for assistance with personal care, major depressive disorder (a persistently low or depressed mood), contractures (a fixed tightening of muscle, tendons, ligaments, or skin that prevents normal movement), pain.</p> <p>Review of the resident's comprehensive Care Plan dated 2/15/24 showed:</p> <p>-Limited range of motion, contractures.</p> <p>-At risk for falls.</p> <p>-1 assist with transfers.</p> <p>-Wears a gait belt to assist with transfers/ambulation.</p> <p>-He/she tends to lean to one side, use a gait belt to help distribute weight.</p> <p>Observation on 5/06/24 at 12:12 P.M. showed:</p> <p>-The resident was sitting at the dining room table, eating the noon meal, leaning to his/her left side, with left forearm/elbow on the arm of the chair.</p> <p>-CNA E was standing at the resident's left side.</p> <p>-CNA E placed his/her left forearm under the resident's left armpit, pulled up and to the left, dragging the resident to the left side of the chair and pushing his/her upper body to the right, sitting the resident upright.</p> <p>-The resident grunted loudly.</p> <p>-CNA E then went to the right side of the resident, sat in a chair, and assisted the resident with his/her meal.</p> <p>During an interview on 5/14/24 at 4:55 P.M. CNA E said:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Gait belts or mechanical lifts should be used to move residents, depending on the resident's needs.</p> <p>-For resident #21 and #4 he/she would use a gait belt.</p> <p>-Gait belts are sometimes available on the linen cart, but not always available.</p> <p>-Some staff have their own gait belt, he/she does not.</p> <p>-He/She should not pull on a resident's arms or pants to adjust position.</p> <p>-He/She tried to hurry to get things done and didn't take the time to put a gait belt on.</p> <p>31102</p> <p>3. Review of Resident #9's Quarterly MDS, dated [DATE], showed:</p> <p>- Cognitive skills severely impaired;</p> <p>- Required substantial to maximal assistance with showers, transfers, and toilet use;</p> <p>- Always incontinent of bowel and bladder;</p> <p>- Diagnoses included non traumatic brain dysfunction (causes damage to the brain by internal factors, such as a lack of oxygen, exposure to toxins, or pressure from a tumor), congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body), anxiety, depression, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and the ability to carry out the simplest tasks), and psychotic disorder (a mental disorder characterized by a disconnection from reality).</p> <p>Review of the resident's care plan, dated 3/13/24 showed:</p> <p>- The resident required assistance with activities of daily living (ADL's) due to weakness, decreased cognition related to Alzheimer's disease;</p> <p>- Transfers: mechanical lift with two person assistance, manual wheelchair for mobility;</p> <p>- Provide extensive assistance for bed mobility, transfers, locomotion on the unit and off the unit, dressing, toileting, and personal hygiene. The resident is not able to walk;</p> <p>- The resident does not walk and can propel self in wheel chair for short distances. He/she is assist of one staff for transfers and toilet use and assist of two staff at times.</p> <p>Observation on 5/7/24 at 9:41 A.M., showed:</p> <p>- The resident was in the assist dining room in his/her Broda chair (a type of reclining geri chair) leaning to the left side with a puddle of urine under his/her Broda chair;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - CNA A took the resident to his/her room; - CNA A and CNA D did not wash their hands and applied gloves; - CNA A placed the gait belt around the resident's breasts; - CNA A and CNA D reached under the side of the resident's arms and grabbed the side of the gait belt with one hand and used their other hand and held onto the resident's arm; - When CNA A and CNA D lifted the resident up, the gait belt slid up in the back between the resident's shoulder blades and they transferred him/her to the side of the bed and removed the gait belt and provided incontinent care. <p>During an interview on 5/8/24 at 2:38 P.M., CNA A said:</p> <ul style="list-style-type: none"> - He/she placed the gait belt under the resident's breasts; - He/she should have placed one hand on the front of the gait belt and the other hand on the back of the gait belt; - The gait belt should not have slid up in the back. <p>During an interview on 5/9/24 at 10:29 A.M., CNA D said:- The gait belt should be placed around the resident's waist under their breasts;</p> <ul style="list-style-type: none"> - The gait belt should not slide up in the back; - She normally reaches under the resident's arm and grabs the side of the gait belt and uses his/her other hand to grab the back of the gait belt. <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator and the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> - The DON thought the gait belt should be place under the resident's arm pit. The Administrator said it should be place below the resident's waist; - Staff should not grab a hold of the resident's arms during the transfer; - The gait belt should not slide up in the back. -Gait belt should be used to reposition residents. -Staff should never pull on a resident's arms/shoulders. -He/she is working with Therapy Director to provide education to staff. 		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102</p> <p>Based on observations, interviews and record review, the facility failed to ensure staff maintained the hydration status for three of the 17 sampled residents, (Resident #2, #8 and #56), and all residents who attended the group meeting, when staff did not pass fresh ice water to the residents. The facility census was 66.</p> <p>Review of the facility's policy for assisted nutrition and hydration, dated 1/30/24 showed, in part:</p> <ul style="list-style-type: none"> - The purpose is to ensure each resident maintains, to the extent possible, acceptable parameters of nutritional and hydration status and the facility provides nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment; - Based on a resident's comprehensive assessment, the facility must ensure that each resident is offered sufficient fluid intake to maintain proper hydration and health. <p>1. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/3/24 showed:</p> <ul style="list-style-type: none"> - Cognitive skills intact; - Required set up and clean up with eating; - Independent with oral care; - Diagnoses included seizure disorder, depression, and coronary artery disease, (CAD, damage or disease in the heart's major blood vessels). <p>Review of the resident's care plan, dated 3/4/24 showed;</p> <ul style="list-style-type: none"> - The resident attended activities that he/she enjoyed with encouragement from the staff. Encourage the resident to drink fluids and have a snack during activities; - The resident is at risk for skin breakdown related to lymphedema (caused by a blockage in the lymphatic system causing swelling that generally occurs in an arm or leg) to both lower extremities. Encourage fluids every shift and at meal time; - The resident was at risk for constipation related to psychotropic and Opioid medication use. Encourage fluids every shift and at meal time. <p>Review of the resident's physician order sheet (POS), dated May, 2024 showed:</p> <ul style="list-style-type: none"> - Start date: 1/9/2024 - regular diet. <p>Observation and interview on 5/6/24 at 11:14 A.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - The resident said the staff rarely pass fresh ice water each shift; - He/she did not think they had enough staff to pass fresh ice water every shift; - He/she would like to have fresh ice water each shift; - The resident's water pitcher was less than half full and did not have any ice in it; - The resident said it was from yesterday. <p>2. Review of Resident #8's care plan, revised 12/19/23 showed:</p> <ul style="list-style-type: none"> - The resident was at risk for constipation related to psychotropic and Opioid medication use. Encourage fluids and high fiber food unless contraindicated; - The resident was at risk for pressure ulcers related to bedfast status and incontinent episodes. Encourage adequate fluid intake daily. <p>Review of the resident's Quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> - Cognitive skills intact; - Lower extremity impaired on one side; - Set up and clean up with eating and oral hygiene; <p>- Diagnoses included anxiety, depression and anemia (a condition in which the blood doesn't have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues).</p> <p>Review of the resident's POS, dated May, 2024 showed:</p> <ul style="list-style-type: none"> - Start date: 1/9/2024 - regular diet. <p>Observation and interview on 5/6/24 at 1:02 P.M., showed:</p> <ul style="list-style-type: none"> - The resident said the staff do not pass fresh ice water every shift; - The resident's water pitcher did not have any ice in it and he/she did not know how long it had been there. <p>3. Review of Resident #56's Quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> - Cognitive skills intact; - Required set up and clean up with eating; - Independent with oral hygiene; <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Diagnoses included cancer, anxiety, depression, pneumonia (an infection that affects one or both lungs), anxiety, respiratory failure (a serious condition that makes it difficult to breathe on your own) and chronic obstructive pulmonary disease (COPD. obstruction of air flow that interferes with normal breathing).</p> <p>Review of the resident's care plan, revised 2/27/24 showed:</p> <p>- The resident attended activities that he/she enjoyed with encouragement from the staff. Encourage the resident to drink fluids and have a snack during activities.</p> <p>Review of the resident's POS, dated May, 2024 showed:</p> <p>- Start date: 1/9/24 - regular diet.</p> <p>Observation and interview on 5/6/24 at 10:42 A.M., showed:</p> <p>- The resident said the staff do not pass fresh ice water every shift;</p> <p>- He/she currently had a water pitcher without a lid on it and said it had been sitting there since yesterday;</p> <p>- The water pitcher was less than half full and did not have any ice in it.</p> <p>4. During a group interview on 5/7/24 at 1:32 P.M., the residents said:</p> <p>- Two residents said he/she had to ask for fresh ice water;</p> <p>- One resident said facility staff did not pass water at all.</p> <p>During an interview on 5/8/24 at 2:06 P.M., Certified Medication Technician (CMT) B said:</p> <p>- Ice water does not get passed every day because there's not enough staff;</p> <p>- Usually only pass fresh ice water if a resident asks for it.</p> <p>During an interview on 5/8/24 at 2:38 P.M., Certified Nurse Aide (CNA) A said:</p> <p>- Fresh ice water does not get passed every shift.</p> <p>During an interview on 5/9/23 at 3:12 P.M., the Administrator and the Director of Nursing (DON) said:</p> <p>- Staff should be passing fresh ice water every shift and sometimes twice a shift.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102</p> <p>Based on observations, interviews and record review, the facility failed to assure staff provided proper respiratory care for residents, when staff failed to ensure the oxygen concentrator had humidified sterile water which affected two of 17 sampled residents, (Resident #7 and #56), failed to properly clean the oxygen concentrator filter for Resident #56, and additionally failed to date oxygen/ nebulizer tubing for Resident #7 and #56. The facility census was 66.</p> <p>The facility did not provide a policy for respiratory care.</p> <p>1. Review of Resident #7's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/1/24 showed:</p> <ul style="list-style-type: none"> - Cognitive skills moderately impaired; - Upper extremities impaired on both sides; - Dependent on staff for personal hygiene, - Diagnoses included traumatic brain injury (TBI, happens when a sudden, external, physical assault damages the brain), chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing). <p>Review of the resident's care plan, dated 3/13/24 showed:</p> <ul style="list-style-type: none"> - The resident is at risk for decrease oxygen related to diagnosis of COPD; - Administer medications and oxygen as ordered and monitor for any changes; - Check oxygen saturation (amount of oxygen in the blood) as ordered and as needed; - Oxygen at two liters per nasal cannula (2L/NC) as needed for shortness of breath to keep saturation above 92%. <p>Review of the physician's order sheet (POS) dated May, 2024 showed:</p> <ul style="list-style-type: none"> - Start date: 10/6/23 - oxygen at 3L/NC as needed for shortness of breath. <p>Observation on 5/6/24 at 10:32 A.M., showed:</p> <ul style="list-style-type: none"> - The resident had oxygen on at 2L/NC; - The oxygen tubing was not dated; - The humidified water bottle was empty. <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of Resident #56's Quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> - Cognitive skills intact; - Independent with toilet use, showers, dressing, personal hygiene, and transfers; - Diagnoses included cancer, pneumonia (an infection that affects one or both lungs), anxiety, depression, respiratory failure (a serious condition that makes it difficult to breathe on your own) and COPD. <p>Review of the resident's care plan, dated 2/27/24 showed:</p> <ul style="list-style-type: none"> - Resident has a diagnosis of COPD and acute or chronic respiratory failure, emphysema (a disorder that affects the tiny air sacs of the lungs) and shortness of breath and is at risk for decreased oxygen; - Administer oxygen and medication as ordered and monitor for any changes; - Nebulizer treatments and inhalers for wheezing as per orders. <p>Review of the resident's POS dated May, 2024 showed:</p> <ul style="list-style-type: none"> - Order date: 2/29/24 - Change nebulizer tubing monthly on the first of the month; - Order date: 2/29/24 - Change oxygen tubing monthly on the first of the month; - Order date: 2/29/24 - Oxygen 2L/NC as needed for shortness of breath. <p>Observation and interview on 5/6/24 at 10:49 A.M., showed:</p> <ul style="list-style-type: none"> - The resident stated he/she had pneumonia twice; - The humidified water bottle was empty; - The oxygen tubing was not dated and was laying on the floor; - The filter was covered in gray lint; - The nebulizer tubing and mask was dated 4/4/24. <p>During an interview on 5/8/24 at 2:38 P.M., Certified Nurse Aide (CNA) A said:</p> <ul style="list-style-type: none"> - He/she knew the oxygen tubing and nebulizer tubing should be changed but did not know when or how often; - He/she knew the tubing should be dated and placed in a zip lock bag and should not be on the floor. <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/9/24 at 9:55 A.M., Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> - He/she thought the oxygen and nebulizer tubing was changed weekly but it might be monthly; - The tubing should be dated when changed; - The filters on the oxygen concentrators should be cleaned but he/she did not know how or when; - There should be distilled water in the humidified water bottle; - The oxygen tubing should not be on the floor and if it was on the floor it should not be used. <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator and the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> - The oxygen and nebulizer tubing should be changed weekly unless it needed to be changed earlier; - The oxygen and nebulizer tubing should be dated and initialed when changed; - The filters on the oxygen concentrator should be cleaned; - The oxygen and nebulizer tubing should not be on the floor, they should be placed in a bag; - There should be distilled water in the humidified water bottles.

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observation, interview, and record review, the facility staff failed to assess residents for risk of entrapment from bed rails prior to installation and failed to ensure the bed's dimensions were appropriate for the residents size and weight, failed to complete side rail assessments, and failed to obtain a physician's order prior to installation for five of seventeen sampled residents (Resident #45, #216, #14, #1, and #162). The facility census was 66.</p> <p>Facility did not provide a policy on side rails.</p> <p>Review of facility policy, Bed and Bed Rail Maintenance to Reduce/Prevent Entrapment, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Ensure that facility beds meet FDA guidance to reduce/prevent resident entrapment. The facility will only utilize beds and bed rails that meet this guidance. -Facility will assess the bed and bed rails for each resident and document such assessment prior to the use of bed rails for every resident. If resident uses a different bed or when bed rails are added, the assessment and subsequent documentation must be repeated. -There are seven areas in a bed system where there is potential for entrapment: <ul style="list-style-type: none"> -Zone 1: Within the Rail; -Zone 2: Under the Rail, between the rail supports or next to a single rail support -Zone 3: Between the rail and the mattress -Zone 4: Under the Rail, at the ends of the rail -Zone 5: Between split bed rails; -Zone 6: Between the end of the rail and the side edge of the head or foot board; -Zone 7: Between the head or foot board and the mattress end. <p>Review of facility's Accident policy, dated [DATE], showed:</p> <ul style="list-style-type: none"> -The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. -Evaluating and analyzing hazards and risks. -Implementing interventions to reduce hazards and risks <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	
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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Monitoring for effectiveness and modifying interventions when necessary.</p> <p>-Individualized, person-centered interventions will be implemented, including adequate supervision and assistive devices, to reduce risks related to hazards in the environment.</p> <p>-Monitoring for effectiveness and modification of interventions, when necessary, will be implemented.</p> <p>1. Review of Resident #45's Admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated [DATE], showed:</p> <p>-Resident was cognitively intact;</p> <p>-He/She had clear speech, was able to make self-understood, and understand others;</p> <p>-He/She had impairment on one side;</p> <p>-He/She was dependent on walker and wheelchair for mobility;</p> <p>-He/She required setup or clean-up assistance eating</p> <p>-He/She required substantial/maximal assistance for showers, lower body dressing, sitting to standing, sit to lying, chair to bed transfer, toilet transfer,</p> <p>-He/She required partial/moderate assistance with personal hygiene and rolling left and right.</p> <p>-Diagnoses included aftercare after joint replacement surgery, arthritis, and anxiety disorder.</p> <p>Review of care plan, dated [DATE], showed:</p> <p>-Resident was able to move self some in bed but required staff assistance with transfers and bed mobility. Staff to assist him/her with repositioning in bed. He/She had a pressure reducing mattress on his/her bed and a cushion in his/her wheelchair.</p> <p>-Care plan did not include use of bed rails</p> <p>Review of physician's orders dated [DATE] to [DATE] showed:</p> <p>-Order started [DATE], Bed rail to assist with getting out of bed and turning unassisted.</p> <p>Review of side rail assessment completed [DATE] at 1:07 P.M. showed:</p> <p>-Implemented for bed mobility;</p> <p>-Resident had expressed desire to have side rails;</p> <p>-Quarter rail will be used to assist in positioning and transfers - Side of rail was not indicated.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Use of side rail during day and night;</p> <p>-Additional interventions: provide frequent staff monitoring at night, visual and verbal reminders to use call light.</p> <p>-Entrapment zones not filled out on the assessment.</p> <p>Review of electronic medical record, dated [DATE], at 12:06 P.M. showed new orders received from the physician for bed rail. To assist resident with getting out of bed and turning unassisted.</p> <p>Observation on [DATE] at 1:00 P.M. showed resident had side rails on left side of bed only.</p> <p>During an interview on [DATE] at 1:00 P.M., The resident said they had the side rail put on to help him/her turn in bed. He/She slept in recliner now because of swelling in his/her legs and had not used bed since railing was put on.</p> <p>During an interview on [DATE] at 2:25 P.M., Certified Medication Technician (CMT) B said:</p> <p>-Resident had a side rail because he/she requested one.</p> <p>During an interview on [DATE] at 2:38 P.M., Certified Nurse Aide (CNA) A said:</p> <p>-Not sure why resident had side rails;</p> <p>-Resident did not sleep in bed, he/she slept in his/her recliner.</p> <p>2. Review of Resident #216's face sheet showed:</p> <p>-Resident admitted to facility on [DATE]</p> <p>-Diagnoses included: neurocognitive disorder with lewy bodies (a type of progressive dementia that leads to decline in thinking, reasoning, and independent function), generalized osteoarthritis (a condition in which three or more joint groups are affected when cartilage that cushions end of bones deteriorates), and chronic pain syndrome.</p> <p>Review of care plan, dated [DATE], showed:</p> <p>-Side rails not care planned.</p> <p>Review of baseline care plan, dated [DATE], showed:</p> <p>-Bed mobility, transfers, toileting, showed assist of two</p> <p>-Safety concerns included balance and gait unsteady, muscle weakness, fatigue/endurance concerns;</p> <p>-He/She used mechanical lift for transfers;</p> <p>-Bed should be in lowest position;</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of physician's orders, dated [DATE] to [DATE], showed:</p> <ul style="list-style-type: none"> -No orders for side rails. <p>Review of electronic medical record for the month of April., showed:</p> <ul style="list-style-type: none"> -No side rail or entrapment assessment completed. <p>Observation on [DATE] at 10:03 A.M. showed resident had side rail on both sides of bed.</p> <p>Observation on [DATE] at 12:06 P.M. showed both resident's side rails were up. resident's bed was not lowered to ground.</p> <p>Observation on [DATE] at 1:29 P.M. showed resident's side rails were up. resident's bed was not lowered to ground.</p> <p>During an interview on [DATE] at 2:25 P.M., CMT B said:</p> <ul style="list-style-type: none"> -Resident had side rails so he/she did not slide around in his/her bed. <p>During an interview on [DATE] at 2:38 P.M., CNA A said:</p> <ul style="list-style-type: none"> -Resident had side rails because he/she leans more to right side and would probably fall if side rails were not in place; -He/She had not had falls since coming to facility that he/she was aware of. <p>3. Review of Resident #14's Quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -He/She had clear speech, was able to make self-understood and had clear comprehension of others; -He/She was dependent on wheelchair; -He/She had impairment to both sides of upper and lower extremity range of motion; -He/She was dependent on staff for eating, oral care, toileting, bathing, lower body dressing, personal hygiene, rolling left and right, lying to sitting, sitting to stand, chair to bed transfers, and shower transfers. -He/She had no falls since admission; -Diagnoses included paraplegia, quadriplegia, post traumatic stress disorder, chronic pain due to trauma. <p>Review of care plan, dated [DATE], showed:</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Provide assistance with bed mobility every ,d+[DATE] hours;</p> <p>-He/She was at risk for falling due to quadriplegic;</p> <p>-Keep bed in lowest position with brakes locked;</p> <p>-Keep personal items and frequently used items within reach</p> <p>-Keep call light in reach at all times;</p> <p>-Side rails not care planned.</p> <p>Review of physician's orders, dated</p> <p>-No order for side rails.</p> <p>Review of electronic medical record showed:</p> <p>-No side rail assessment.</p> <p>During an interview on [DATE] at 11:02 A.M., Resident #14 said:</p> <p>-He/She had side rails to help him/her turn;</p> <p>-He/She had nerve damage from neuropathy (sensation of burning pain or loss of feeling in extremities).</p> <p>During an interview on [DATE] at 2:25 P.M., CMT B said:</p> <p>-Resident requested side rails so he/she could move themselves.</p> <p>During an interview on [DATE] at 2:38 P.M., CNA A said:</p> <p>-Resident requested side rails when he/she first moved into facility.</p> <p>44395</p> <p>Review of Resident #1 Quarterly MDS dated [DATE] showed:</p> <p>- Indicated severe cognitive loss.</p> <p>-Dependent on staff for ADL's and mobility.</p> <p>-Urinary catheter (a tube inserted into the bladder used to drain urine)</p> <p>-Always incontinent of bowel.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Diagnoses of quadriplegia (paralysis of all four limbs) , hypertension (high blood pressure) , seizures (a sudden, uncontrolled burst of electrical activity in the brain, that can cause changes in behavior, movements, feelings and levels of consciousness), intellectual disability (a term used when there are limits to a person's ability to learn at an expected level and function in daily life) , anxiety (a feeling of fear, dread, and uneasiness) contractures (fixed tightening of muscle, tendons, ligaments, or skin. It prevents normal movement) and hydronephrosis (kidney swelling the does not allow the urine to drain).</p> <p>Review of the resident's comprehensive Care Plan dated [DATE] showed:</p> <p>-Side rails up in use with pads in place for safety/seizure precaution.</p> <p>Review of the resident's skilled note assessment, dated [DATE] showed:</p> <p>-He/She was dependent on staff assistance for mobility</p> <p>Review of the resident's Physician Orders for [DATE] showed:</p> <p>-No order for side rails.</p> <p>Review of the resident's electronic medical record showed:</p> <p>-No assessment for use of side rails</p> <p>-No entrapment assessment or measurements completed.</p> <p>Observation on [DATE] at 10:04 AM showed:</p> <p>-He/she was in bed , leaning to the right side.</p> <p>-His/Her air mattress set to firm.</p> <p>-Bed in low position</p> <p>-Full side rail on right side of bed, in the low position, no padding on rail.</p> <p>Observation on [DATE] at 10:38 A.M. showed:</p> <p>-The resident had a full side rail in the raised position, on the right side of the bed, without any padding,</p> <p>-His/Her bed was in low position.</p> <p>-An air mattress was on the bed.</p> <p>-He/She was in bed leaning to the right side</p> <p>During an interview on [DATE] at 2:32 PM CMT B said:</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident has a side rail on one side of the bed.</p> <p>-He/She is not sure why the resident has the rail.</p> <p>Review of Resident # 162 Annual MDS dated [DATE] showed:</p> <p>-He/she admitted on [DATE]</p> <p>-Cognition not intact</p> <p>-Dependent on staff for completion of ADL's</p> <p>-Indwelling urinary catheter (tube inserted into the bladder to drain urine)</p> <p>-Frequently incontinent of bowel</p> <p>-Hospice services</p> <p>-Use of oxygen (O2)</p> <p>-Review of the comprehensive care plan [DATE] showed:</p> <p>-The resident was a do not resuscitate (DNR: a directive to withhold Cardiopulmonary Resuscitation (CPR) if the resident is found deceased)</p> <p>-No care plan to address need for assistance with ADL's, or use of side rails.</p> <p>Review of the resident's electronic medical record showed:</p> <p>-A neurological assessment completed ,d+[DATE] with nursing note of unwitnessed fall.</p> <p>-No progress note about a fall. no indication side rails were in use.</p> <p>-Physician orders showed no order for use of side rails.</p> <p>-No side rail assessment or entrapment risk assessment.</p> <p>Observation and interview on [DATE] at 2:31 PM showed:</p> <p>-Half side rails on both sides of the bed, in the up position.</p> <p>-The resident said he/she had the rails because of a fall from the bed.</p> <p>Observation on [DATE] at 9:10 AM showed:</p> <p>-Half side rails on both sides of the bed, in the up position.</p> <p>During an interview on [DATE] at 2:33 PM CMT B said:</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She thought Hospice brought that bed to the resident.</p> <p>-He/she does not know why the resident has bed rails.</p> <p>During an interview on [DATE] at 9:21 A.M., Maintenance Supervisor said:</p> <p>-He/she did install bedrails;</p> <p>-He/She did not know who authorized bed rails in facility;</p> <p>-He/She did not do any assessments or measurements of side rails;</p> <p>-He/She put side rails on if there was a physician's order on;</p> <p>-He/She made sure side rails were installed good and tight;</p> <p>-He/She would check side rails if he got around to it or was in the area;</p> <p>-He/She did not keep track of side rails or log details of side rails;</p> <p>-He/She did not do any measurements of the bed frames or mattresses;</p> <p>-He/She did not check for entrapment but made sure side rails were on good.</p> <p>During an interview on [DATE] at 3:12 P.M., Administrator said:</p> <p>-He/She felt therapy and nursing should work together to decide when side rails are put on, it was a joint effort;</p> <p>-The nurse does side rail assessment in computer;</p> <p>-Side rail assessments are located in electronic medical record under assessments;</p> <p>-Side rail assessments should be completed upon admission;</p> <p>-There are multiple kinds of side rails used in the building;</p> <p>-Side rail checks are completed by nursing staff;</p> <p>-He/She thinks part of side rail assessment asked for measurements;</p> <p>-Right now there is nobody in facility that is doing bed measurements, measurements of gaps in the mattress or bed frame.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observations, interviews, record review, the facility failed to provide sufficient nursing staff to meet the resident needs for six of the 17 residents. When staff failed to timely answer resident call lights, failed to provide assistance for one resident to use the bathroom (Resident #21), failed to reposition one resident (Resident #57), failed to provide feeding assistance to one resident (Resident #216), failed to have nursing staff available to speak with family (Resident #216), and failed to provide showers twice a week for three residents (Resident #50, #39, #45) of the 17 sampled residents. The facility census was 66.</p> <p>The facility did not provide a policy regarding staffing.</p> <p>Review of facility policy, resident rights, dated 1/3/24, showed:</p> <ul style="list-style-type: none"> -The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and enhancement of his/her quality of life and recognizes each resident's individuality. -Resident has a right to live in facility and receive services with reasonable accommodation of needs and preferences except when to do so would endanger the health and safety of the resident or other residents. <p>1. During a group interview on 5/07/24 at 1:32 PM, The residents said:</p> <ul style="list-style-type: none"> -Showers are sometimes far and in between; -There had been ten days between some showers and longer; -The facility often ran out of towels, which meant showers would not be completed; -The facility was understaffed; -Weekends were often short of staff; -Call lights could be longer, depending on staffing -On weekends there were longer call light wait times; -They had to ask for fresh ice water, or staff did not pass water at all. <p>2. Review of Resident #21's Annual MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -Partial assistance from staff for ADL's; <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Partial to moderate assistance for standing and transfers;</p> <p>-Touch assist for ambulation (walking);</p> <p>-Occasional incontinence of urine and bowel;</p> <p>-Diagnoses of Transient Ischemic Cerebral Attack (a brief blockage of blood flow to the brain), difficulty in walking, dizziness, low back pain, chronic fatigue syndrome, atrial fibrillation, arthritis.</p> <p>Review of care plan, dated 2/5/24, showed:</p> <p>-The resident is incontinent of bowel and bladder occasionally;</p> <p>-Provide assistance with toileting every two hours and as needed;</p> <p>-Check incontinence pads frequently and change as needed.</p> <p>-Resident is at risk for falls due to related to history of falls and unsteady gait.</p> <p>During an interview on 5/6/24 at 2:49 P.M., resident said:</p> <p>-He/She sometimes had to wait an hour or more for his/her call light to be answered;</p> <p>-Weekends are worse with call light response.</p> <p>Observation on 5/7/24 at 3:28 P.M. showed resident's call light was already on, and was answered by Certified Nurse Aide (CNA) E at 3:46 P.M., eighteen minutes after observation started.</p> <p>During an interview on 5/7/24 at 3:47 P.M., Resident said:</p> <p>-Call light was on quite a while, I saw my clock said 3:02 P.M. when I turned it on;</p> <p>-He/She needed to go to the bathroom;</p> <p>-He/She did not make it to the bathroom in time</p> <p>-He/She was embarrassed;</p> <p>-Staff rarely come right away.</p> <p>During an interview on 5/07/24 at 4:00 P.M. CNA E said:</p> <p>-He/she tried to answer the call light quickly.</p> <p>-He/she answered as quickly as he/she could, but he/she was busy with another resident.</p> <p>-There is not enough help to answer the call lights immediately.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>. Review of Resident #45's Admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -He/She had clear speech, was able to make self-understood, and understand others; -He/She had impairment on one side; -He/She was dependent on walker and wheelchair for mobility; -He/She required substantial/maximal assistance for showers; -Diagnoses included aftercare after joint replacement surgery and arthritis. <p>Review of care plan, dated 5/1/24, showed</p> <ul style="list-style-type: none"> -Resident was alert and able to communicate his/her needs. -Encourage him/her to call for assistance with his/her ADL care; -Resident required assistance of staff with his/her bathing needs; -Resident admitted with a hip fracture and was on therapy services. He/She required assistance with mobility of ambulation with a walker and does use a wheelchair for longer distances; -Care plan did not specify resident's shower preferences. <p>Review of baseline care plan, dated 4/8/24, showed:</p> <ul style="list-style-type: none"> -He/She required assistance of one staff for bathing; -Assist with ADL care as needed to promote health, hygiene, and safety; -He/She was sometimes incontinent of bowel; -He/She was always incontinent of bladder. <p>During an interview on 5/6/24 at 12:49 P.M. Resident said:</p> <ul style="list-style-type: none"> -He/she had his/her last shower over a week ago on 4/30/24; -He/She preferred to have a shower twice a week; -His/Her shower days were supposed to be on Tuesday and Fridays. <p>Review of shower logs from April 8, 2024 to May 8, 2024 showed:</p> <ul style="list-style-type: none"> -He/She had two documented showers one on 4/30/24 and on 5/7/24. <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/8/24 at 2:38 P.M., CNA A said:</p> <ul style="list-style-type: none"> -Shower aide is often pulled to help cover the floor, and did not do showers; -The shower aide worked overnight on 5/7/24 so showers were not getting completed on 5/8/24. <p>3. Review of Resident #50's Quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact; -He/She had impairment on one side of body in upper and lower extremities; -He/She was dependent on wheelchair for mobility; -He/She was dependent for bathing assistance, toileting, upper and lower body dressing; -He/She required substantial/maximal assistance for personal hygiene and mobility; <p>-Diagnoses included stroke, weakness, lack of coordination, difficulty in walking, and need for assistance with personal care.</p> <p>Review of care plan, dated 3/13/24, showed:</p> <ul style="list-style-type: none"> -Resident required assistance with most activities of daily living due to hemiplegia affecting left dominant side due to status post cerebral vascular accident. -Provide extensive assistance by two staff with personal hygiene, dressing, toileting, bed mobility, and transfers; -Shower preferences not care planned. <p>During an interview on 5/6/24 at 10:31 A.M. Resident said:</p> <ul style="list-style-type: none"> -He/She had not had a shower in quite awhile because the facility did not have any towels; -His/Her last shower was on a Thursday maybe towards end of March; -He/She would like to have showers two times a week; -Therapy staff gave him/her one of his/her last showers; -He/She had not had any bed baths. <p>Review of shower logs from February 1, 2024 to May 8, 2024 showed:</p> <ul style="list-style-type: none"> -He/She had sixteen of twenty-eight opportunities for showers; <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She had showers provided on 2/3, 2/7, 2/10, 2/15, 2/21, 2/28, 3/2, 3/7, 3/9, 3/13, 3/20, 4/1, 4/3, 4/9, 4/15, and 4/19;</p> <p>-His/Her last documented shower was two and half weeks ago.</p> <p>4. Review of Resident #39's quarterly MDS, dated [DATE], showed:</p> <p>-He/She had mildly impaired cognition;</p> <p>-He/She had clear speech, was usually able to make self-understood and usually understand others;</p> <p>-He/She had impairment to upper and lower extremities on one side causing limited range of motion;</p> <p>-He/She was dependent on a wheelchair for mobility;</p> <p>-He/She required set up or clean up assistance with bathing;</p> <p>-Diagnoses included: stroke, aphasia (disorder that occurs from damage to brain after a stroke that affects ability to communicate), hemiparesis (one sided muscle weakness).</p> <p>Review of care plan, dated 4/24/24, showed:</p> <p>-Resident was limited to transfer self due to right side weakness from stroke;</p> <p>-He/She will transfer with assistance;</p> <p>-He/She was at risk for falls due to weakness on one side related to stroke;</p> <p>-He/She will be free from serious injuries related to falls;</p> <p>-He/She will bathe with assistance;</p> <p>-He/She had impaired vision due to glaucoma;</p> <p>-He/She was at risk for impaired skin integrity and pressure ulcer development due to decreased mobility and incontinent episodes;</p> <p>-Showers and bathes at least twice a week or as requested;</p> <p>-Turn and reposition at least every two hours and PRN when in bed;</p> <p>-Shower preferences not care planned.</p> <p>During an interview on 5/7/24 at 7:45 A.M., Resident #39 said:</p> <p>-He/She did not think facility had enough staff because it took a long time to answer call lights, showers did not get done, and facility did not pass fresh ice water every shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She said it can take up to five days to get laundry back, and that was not often enough;</p> <p>-Second shift was not good about answering call lights;</p> <p>-He/She had to wait over thirty minutes multiple times to get his/her call light answered;</p> <p>-He/She had waited 1-1.5 hours at least three times in a week for his/her call light to get answered;</p> <p>-He/She received a shower only one time every two weeks which made him/her feel dirty.</p> <p>Review of shower logs, February 1, 2024 to May 8, 2024, showed:</p> <p>-Resident was provided 10 opportunities of 27 scheduled shower days;</p> <p>-He/She had received 8 out of 27 scheduled shower dates on 2/5, 2/13, 2/26, 2/29, 3/11, 3/14, 3/25, and 3/28</p> <p>-He/She had refused 2 showers on 3/18 and 3/21</p> <p>5. Review of Resident #216's face sheet showed:</p> <p>-Resident admitted to facility on 4/22/24</p> <p>-Diagnoses included: neurocognitive disorder with lewy bodies (a type of progressive dementia that leads to decline in thinking, reasoning, and independent function), generalized osteoarthritis (a condition in which three or more joint groups are affected when cartilage that cushions end of bones deteriorates), and chronic pain syndrome.</p> <p>Review of MDS showed resident did not have MDS completed.</p> <p>Review of care plan, dated 5/8/24, showed:</p> <p>-Resident had one goal regarding full code status.</p> <p>Review of baseline care plan, dated 4/22/24, showed:</p> <p>-He/She had confused cognition status;</p> <p>-He/She required assist of two staff for bed mobility, transfers, bathing, locomotion, and toileting;</p> <p>-He/She had safety concerns regarding balance and gait, muscle weakness, and fatigue;</p> <p>-He/She required assist of one staff with eating;</p> <p>-He/She displayed aggression, agitation, and crying;</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 5/7/24 at 10:35 A.M. showed food was sitting at beside bed, cover had not been removed, food was cold.</p> <p>Observation on 5/8/24 at 8:39 A.M. showed resident's breakfast was sat on table in front of her, food was covered, resident was not assisted to eat breakfast.</p> <p>Observation on 5/8/24 at 9:32 A.M. showed resident's breakfast was on bedside table in front of her, no staff had assisted him/her to eat breakfast.</p> <p>During an interview on 5/7/24 at 10:56 A.M., The resident's representative said:</p> <ul style="list-style-type: none"> -Facility did not make attempts to feed resident; -Resident's sister had been going to facility to ensure resident had been fed; -Receptionist told him/her on the phone that there was not a nurse available to talk to him/her on the phone because the nurse was busy and facility was short staffed when he/she called to speak to facility nurse regarding his/her mother. <p>During an interview on 5/8/24 at 2:25 P.M., CMT B said:</p> <ul style="list-style-type: none"> -Resident did not feed herself; -Most days sister was at facility to feed resident; -Facility did not have enough staff to get resident assistance to eat. <p>During an interview on 5/8/24 at 2:38 P.M., CNA A said:</p> <ul style="list-style-type: none"> -Resident needed assistance with eating; -Resident's son or sister come in to assist resident with eating. <p>6. During an interview on 5/8/24 at 2:25 P.M., Certified Medication Technician (CMT) B said:</p> <ul style="list-style-type: none"> -Ice water did not get passed every day because of staffing; -There was not enough staff to meet the resident's needs; -Today there is one nurse aide, one Certified Nurse Aide (CNA), and myself working; -Showers did not get done because the shower aide worked last night; -Activity of Daily Living charting rarely gets done due to staffing; -He/She did not get to document residents meal intake at meals due to staffing; -There was not enough staff to assist all residents that choose to eat in their rooms; <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Three residents did not get served their meal trays served last night.</p> <p>During an interview on 5/8/24 at 2:38 P.M., Certified Nurse Aide (CNA) A said:</p> <p>-Facility did not have enough staff;</p> <p>-He/She had not been able to work in his/her official position as staffing coordinator due to staffing so mostly worked the floor;</p> <p>-Showers do not get done due to staffing;</p> <p>-He/She had to pull staffing aide to cover shifts;</p> <p>-When a nurse aide is working he/she had them pass ice water, but ice water is not always passed;</p> <p>-Staff have to wait for laundry staff to get to the building to do the laundry in order to have supplies needed for showers and other cares;</p> <p>-He/She had transferred patients using gait belt and the mechanical lift by him/herself more often than not due to staffing;</p> <p>-It was hard to get residents repositioned due to staffing.</p> <p>During an interview on 5/9/24 at 9:55 A.M., Licensed Practical Nurse (LPN) B said:</p> <p>-When facility was short staffed it was hard to get showers done;</p> <p>-He/She does not feel have enough staff to meet resident needs;</p> <p>-He/She had a hard time completing treatments, getting showers done, passing fresh ice water, turning, repositioning the residents, call lights will take awhile to get answered;</p> <p>-It may take longer to give pain medications when short staffed.</p> <p>During an interview on 5/9/24 at 10:17 A.M., Dietary Manager said:</p> <p>-He/She was made aware that residents were missed for their meal on 5/7/24's meal due to trays being given to the wrong resident or were lost.</p> <p>-There was a lot of turn over off facility staff. New staff were not aware of the new residents. It was more of a training and orientation issue with staff.</p> <p>During an interview on 5/9/24 at 10:29 A.M., CNA D said:</p> <p>-There was not enough staff;</p> <p>-He/She got pulled from working as a shower aide to cover the floor a lot;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-It took longer around lunch time to get call lights answered due to staffing;</p> <p>-Laundry staff come in to work at 11:00 A.M., he/she started showers at 5:00 A.M. and was often out of towels by 10:00 A.M. so he/she cannot continue showers until approximately 1:00 P.M.</p> <p>During an interview on 5/9/24 at 3:12 P.M., Director of Nursing said:</p> <p>-The facility did not even have close to enough staff to meet the resident's needs in the facility.</p> <p>-Timeliness of call lights is a result of being short staffed;</p> <p>-He/She had heard staff are lifting patients by themselves.</p> <p>44395</p> <p>7. Review of Resident #57's Quarterly MDS dated [DATE] showed:</p> <p>-BIMS of 99, indicated significant cognitive deficit</p> <p>-Dependent on staff for ADL's.</p> <p>-Always incontinent of bowel and bladder.</p> <p>-Diagnoses of Intracerebral hemorrhage (bleeding into the brain), Aphasia (loss of ability to understand or express speech), hemiplegia (loss of the ability to move one side of the body). Diabetes Mellitus (a health condition that affects how your body turns food into energy), seizures (a condition where you have a temporary, unstoppable surge of electrical activity in your brain) Hypertension (high blood pressure)</p> <p>Review of Resident #57 Comprehensive Care Plan, dated 1/24/24 showed:</p> <p>-He/She needed assist of 1-2 staff with ADL's</p> <p>-Keep his/her call light within reach and answer in a timely manner.</p> <p>-Provide him/her adequate rest periods between activities.</p> <p>-During two hour checks and as needed (PRN: per resident need) please ask the resident if he/she needs any of his/her belongings moved closer so they are within reach.</p> <p>-Frequent checks at night, every one to two hours and prn.</p> <p>-He/she was at risk for pressure ulcers because of incontinent episodes of bowel/bladder.</p> <p>-He/She needs assist with bed mobility.</p> <p>-Keep him/her clean and dry as possible.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Minimize his/her skin exposure to moisture.</p> <p>-Turn and reposition him/her every two hours and PRN.</p> <p>-Encourage toileting before and after meals, before assisting to bed and prn.</p> <p>Continuous observation beginning on 5/08/24 at 5:39 A.M. showed:</p> <p>-The resident was taken to the dining /Activity room by staff. He/she was placed in front of the TV with cartoons on and lights off.</p> <p>- 7:26 A.M. the resident was taken to the dining table for breakfast and assisted with meal.</p> <p>- 9:03 AM he/she remained in the dining/ activity room; he/she was yelling out. MDS Coordinator entered the room and asked the resident if he/she was missing his/her friend. The MDS coordinator assured the resident his/her friend was missing him/her too and walked away. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>- 9:08 AM staff entered the dining/activity room, laid the back of her Broda chair (a tilting, reclining, and wheeled chair) down. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>-9:18 AM the resident was yelling out. LPN A asked the resident why he/she was yelling. The resident said he/she was tired. LPN A asked the resident if he/she wanted to lay down. Resident #57 replied yes. LPN A told the resident he/she would notify CNA staff. The resident began to cry. LPN A asked the resident why he/she was crying. The resident said staff would not come. LPN A asked the resident if he/she was crying because staff had not come to help; the resident responded yes. LPN A then walked away. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>- 9:22 A.M. Nurse Aide C took the resident from the dining/activity room to his/her room. NA C pulled covers back then left room to obtain assistance. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>-9:24 AM NA C returned the resident to the dining/activity room.</p> <p>-9:36 AM the resident remained in the Broda chair in the dining/activity room. NA C had the ice cart, stopped at the resident's chair and covered the resident with a blanket, and left. The resident closed his/her eyes and began snoring. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>- 9:42 AM the resident was dozing off and on, snoring lightly then opening his/her eyes.</p> <p>-10:01 AM the Activity Director (AD) approached the resident, observed the resident with eyes closed, and walked away. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-10:10 AM Exercise group began in the activity/dining room. The resident remained in his/her Broda chair, reclined, with eyes closed.</p> <p>-10:54 AM staff moved the resident to a dining table. The resident was not offered or taken to the restroom, repositioned or offered food or drinks.</p> <p>During an interview on 05/08/24 at 10:33 A.M. NA C said residents should be moved, toileted, or cleaned up every two hours or as needed. There is not enough help to get everything done that needs to be done. He/she was not aware it had been over two hours that Resident #57 was changed or repositioned.</p> <p>During an interview on 5/9/24 at 3:12 P.M. Administrator said:</p> <p>-He/She did not have enough staff to meet the needs of residents in facility;</p> <p>-Due to staffing shortages there was issues with getting people up and down after meals, repositioning and turning residents, completing bed checks.</p> <p>-Facility had two dedicated shower aides but shower aide gets pulled to the floor to help cover and then showers did not get done;</p> <p>-He/She was aware of five residents who did not receive a meal tray on 5/7/24 due to issues getting people in the kitchen to do their job correctly;</p> <p>-Care plans have not been done because MDS Coordinator had been fired and nobody had been taught how to do them;</p> <p>-No staff currently completing discharge summaries;</p> <p>-He/She had been wearing so many hats he/she had not had time to sit down to train staff</p> <p>-He/She had busted numerous staff completing transfers by themselves or using hoysers by themselves.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>47195</p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident diagnosed with dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) had a personalized plan of care in place to ensure appropriate services to promote the resident's highest level of functioning and psychosocial needs were provided for one resident (Residents #216) out of the seventeen sampled residents. The facility census was 66.</p> <p>The facility did not provide a policy in regards to addressing behaviors or care for residents with dementia.</p> <p>1. Review of Resident #216's face sheet, dated 5/7/24, showed:</p> <ul style="list-style-type: none"> -Resident admitted to facility on 4/22/24 -Diagnoses included: neurocognitive disorder with lewy bodies (a type of progressive dementia that leads to decline in thinking, reasoning, and independent function). <p>Review of Resident's Brief Interview Mental Status (BIMS) Assessment, dated 4/26/24, showed:</p> <ul style="list-style-type: none"> -Resident had severely impaired cognition. <p>Review of Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, showed resident did not have a completed MDS.</p> <p>Review of physician's orders dated 4/8/24 to 5/8/24, showed:</p> <ul style="list-style-type: none"> -Primary admission diagnosis was Neurocognitive disorder with lewy bodies <p>Review of care plan, dated 5/8/24, showed:</p> <ul style="list-style-type: none"> -Did not address specific nursing interventions for dementia care; -Did not address specific interventions for activities for a resident diagnosed with dementia care; -Did not address specific behavioral interventions for dementia care. <p>Review of the resident's baseline care plan, dated 4/22/24, showed:</p> <ul style="list-style-type: none"> -He/She had confused cognition status; -He/She required assist of two staff for bed mobility, transfers, bathing, locomotion, and toileting; <p>(continued on next page)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had safety concerns regarding balance and gait, muscle weakness, and fatigue;</p> <p>-He/She required assist of one staff with eating;</p> <p>-He/She used a mechanical lift for transfers;</p> <p>-His/Her bed should be in lowest position;</p> <p>-He/She had as needed, medications for psychosocial interventions;</p> <p>-He/She was always incontinent of bowel and bladder;</p> <p>-He/She preferred to be called J;</p> <p>-He/She displayed behaviors of sad and crying, agitation, and aggression.</p> <p>Review of electronic medical record showed:</p> <p>-4/22/24 3:17 P.M. , Registered Nurse (RN) A wrote resident admitted from hospital via ambulance. Resident was combative unable to obtain weight. Resident was alert to self-confused and yelling. Resident had Lewy body dementia; and hallucinations.</p> <p>-04/23/24 05:48 AM, Licensed Practical Nurse (LPN) E wrote resident continued to be combative and tearful at times of cares. Resident alert to name.</p> <p>-4/23/24 5:58 P.M., RN C wrote resident continued to be combative and tearful at times of cares. Resident alert to name. Resident attempted to hit and bite when moved and turned. Reassurance given. Sister had been at bedside for the whole day.</p> <p>-4/24/24 3:51 A.M., LPN E wrote Resident was combative with cares during rounds. Yelling, biting and hitting staff before changing. When staff approached resident, resident started to scream. Resident yelled so loudly he/she was waking up other residents on the same hall. Nurse attempted to give as needed physician ordered Haldol, which resident spit out at nurse. Nurse then administered as needed Zyprexa IM 2.5mg in Left Glute.</p> <p>-4/25/24, 5:50 A.M., LPN C wrote that resident was in low-fowlers (a position in which patient is seated in semi-sitting position 45-60 degree angle); alert to self. Resident combative with CMT at bedtime medication pass, combative with nurse when attempting assessment; yelling, cursing, hitting, kicking, and biting.</p> <p>-4/27/24, 5:43 A.M., LPN E wrote that resident was extremely combative with cares that morning. It took 3 staff members during bed check to change resident. Nurse attempted to redirect resident and reassure resident but was unsuccessful. Resident was punching, biting and yelling at staff.</p> <p>-4/28/24, 6.00 P.M., RN B wrote that resident was administered Zyprexa after resident was biting and kicking and hitting staff while getting an radiographic image (x-ray). Resident was also noted to be trying to get out of bed, bed repositioned to low and fall mats placed on both sides of bed.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-5/1/24 9:20 A.M., LPN A wrote resident was combative, refusing care, yelling at staff and family. resident's son and sister were both visiting. Family requested medication to help calm resident down. PRN Zyprexa given. About 1 hour later he/she was still resistant with cares and yelling at staff, he/she did not get his/her morning medications because she refused. About 2 hours after injection resident was sleeping peacefully.</p> <p>Observation on 5/7/24 at 10:03 A.M., showed resident was sitting in bed with side rails up leaning forward grimacing with eyes closed. Resident mumbling inaudible words and scrunching shoulders and forehead. Certified Nurse Aide (CNA) A came into resident's room to provide cares and change gown, resident began having tears run down cheeks.</p> <p>During an interview on 5/7/24 at 10:44 A.M., Resident representative said:</p> <ul style="list-style-type: none"> -No care plan meeting has occurred regarding resident's care needs; -He/She had received no phone call or team collaboration from the facility; -Resident is very aggressive and he/she felt facility had not made any effort to learn resident's care needs; -He/She was aware resident can be difficult to care for due to his/her behaviors as family had been providing all his/her care at home prior to long term care placement. <p>During an interview on 5/8/24 at 9:54 A.M., Social Service Designee (SSD) said:</p> <ul style="list-style-type: none"> -The MDS coordinator wrote most of the care plans, however he/she was terminated and it was unclear who was writing them now; -He/She only wrote code status and trauma sections of care plans; -Comprehensive care plans should be written within 14 days after a resident admits to facility; -He/She leads and schedules care plan meetings; -He/She did the resident's baseline care plan with resident's sister; -Resident did not have a completed comprehensive care plan. <p>During an interview on 5/8/24 at 2:25 P.M., Certified Medication Technician (CMT) B said:</p> <ul style="list-style-type: none"> -Facility had not provided any dementia training; -He/She had previously worked with dementia patients at another facility; -He/She had no training on how to approach this resident; <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She did talk to resident's sister and learned interactions went better if staff walked into room and said Hey J instead of resident's name;</p> <p>-He/She noted resident was accepting of cares when approached using hey J;</p> <p>-No other facility staff had told him/her what worked and did not work when interacting with resident;</p> <p>-Resident is often screaming, cussing, and displaying hitting behaviors;</p> <p>-Behaviors should be charted daily;</p> <p>-When resident was provided drinks of water it would helped to calm him/her down as most of time he/she was thirsty;</p> <p>-Facility system to pass along information learned about resident was to share at shift changes with oncoming shifts;</p> <p>-He/She did not have access to update or write in the resident's care plan.</p> <p>During an interview on 5/8/24 at 2:38 P.M., Certified Nurse Aide (CNA) A said:</p> <p>-Resident was a fighter;</p> <p>-Resident would hit, bite, and yell;</p> <p>-He/She had not received any training on how to approach this resident;</p> <p>-There was nothing that worked for resident's behaviors;</p> <p>-Staff talked to resident and he/she would still yell at staff;</p> <p>-He/She did not know resident's diagnosis;</p> <p>-He/She could talk to resident politely and he/she would still yell at him/her;</p> <p>-Nobody had told him/her any tricks that worked when interacting with resident;</p> <p>-He/She had training on dementia care from another facility a few months ago;</p> <p>-He/She did not know of any approaches he/she should take with dementia residents when providing them care.</p> <p>During an interview on 5/9/24 at 11:40 A.M., the Administrator said:</p> <p>-He/She had not done any training with staff on dementia care since he/she became administrator in March;</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had no documentation of facility provided dementia care training.</p> <p>During an interview on 5/9/24 at 11:47 A.M., Business Office Manager said:</p> <p>-He/She could not locate any facility information regarding provided dementia training inservices.</p> <p>During an interview on 5/9/24 at 3:12 P.M., Administrator said:</p> <p>-Staff are informed of resident's with dementia care preferences during shift preferences;</p> <p>-Currently facility did not have a MDS person to update care plans;</p> <p>-Social Services Designee had been updating his/her part of care plans</p> <p>-Each department should update their parts of a resident's care plan;</p> <p>-MDS staff should oversee the quality of the care plan;</p> <p>-If there is a change with resident the MDS staff person should document any changed interventions that were implemented;</p> <p>-Any nursing staff can update the care plan;</p> <p>-Staff do not have access to modifying resident care plans;</p> <p>-Staff refer to the resident kardex for specific information;</p> <p>-Baseline care plans need to be completed within 48 hours of admission;</p> <p>-Initial comprehensive care plans need to be completed within 7 days of their MDS assessment;</p> <p>-He/She did not provide dementia training to staff.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102</p> <p>Based on observations, interviews, and record review, the facility failed to ensure staff administered medications with a medication rate of less than 5% when facility staff made six medication errors out of 25 opportunities and a medication error rate of 24%. . This affected six of the 17 sampled residents, (Resident #6, #34, #39, #47, #51 and #56). The facility census was 66.</p> <p>Review of the facility's undated policy for medication administration, showed, in part:</p> <ul style="list-style-type: none"> - Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection; - Administer medications as ordered and in accordance with manufacturer specifications. <p>Review of the facility's policy for instillation of eye medication, dated March, 2015, showed:</p> <ul style="list-style-type: none"> - The purpose is to introduce medication into the eye for treatment or for examination purposes; - Wipe away any secretions present; - Tilt resident's head backward, draw down lower lid. Have resident look up; - To prevent dropper tip from touching eye or lids, nurse should support hand on resident's forehead or bridge of nose. Introduce drop on center of eye lid (outward facing) lower lid (the eye drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately three to five minutes); - Instruct resident to close eye. Gently press tissue against lacrimal duct (tear duct), (press the tear duct for one minute after eye drop administration or by gentle eye closing for approximately three minutes after the administration). <p>1. Review of Resident #39's physician order sheet (POS), dated May, 2024 showed:</p> <ul style="list-style-type: none"> - Start date: 3/9/23 - Dorzolamide-timolol ophthalmic (eye) drops, 22.3-6.8 milligrams per milliliter (mg./ml.), one drop in both eyes twice daily for cataracts (clouding of the normally clear lens of he eye). <p>Review of the resident's medication administration record (MAR), dated May, 2024 showed:</p> <ul style="list-style-type: none"> - Dorzolamide-timolol ophthalmic (eye) drops, 22.3-6.8 mg./ml., one drop in both eyes twice daily for cataracts. <p>Observation on 5/8/24 at 7:15 A.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Certified Medication Technician (CMT) A administered one drop in each eye and did not apply lacrimal pressure.</p> <p>2. Review of Resident #51's POS, dated May, 2024 showed:</p> <p>- Start date: Polymyxin b sulf-trimethoprim ophthalmic (eye) drops 1 mg./ml., two drops in both eyes four times daily until eye infection is healed.</p> <p>Review of the resident's MAR, dated May, 2024 showed:</p> <p>- Polymyxin b sulf-trimethoprim ophthalmic (eye) drops 1 mg./ml., two drops in both eyes four times daily until eye infection is healed.</p> <p>Observation and interview on 5/8/24 at 7:22 A.M., showed:</p> <p>- CMT A attempted to put one drop in the left eye and missed it then put one drop in the right eye;</p> <p>- The resident informed CMT A he/she missed the left eye;</p> <p>- CMT A placed a drop in the left eye and the tip of the eye dropper touched the resident's eye lashes;</p> <p>- At 7:26 A.M., CMT A placed the second drop in the resident's right eye and touched the tip of the eye dropper to the resident's eye lashes;</p> <p>- CMT A placed a second drop in the resident's left eye and touched the tip of the eye dropper to the resident's eye lashes;</p> <p>- CMT A did not apply lacrimal pressure.</p> <p>During an interview on 5/9/24 at 9:38 A.M., CMT A said:</p> <p>- The tip of the eye dropper should not touch the resident's eye lashes or eye lids;</p> <p>- He/she thought you were supposed to apply lacrimal pressure and thought it might be for 30 seconds.</p> <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator and the Director of Nursing (DON) said:</p> <p>- The tip of the eye dropper should not touch the resident's eye lids or eye lashes;</p> <p>- The DON did not know about applying lacrimal pressure.</p> <p>3. Review of the facility's policy for instillation of nose drops, dated March, 2015 showed:</p> <p>- The purpose is to relieve nasal congestion;</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Assist resident to sitting position with head tilted backward; - Ask the resident to blow his/her nose. Clean secretions from nasal area with tissue wipes prior to instillation of medication; - Instill medication in the amount ordered; - Instruct resident to remain in position for a few minutes and gently inhale. Instruct them not to blow nose. <p>Review of the package leaflet for Flonase nasal spray, revised March, 2016, showed, in part:</p> <ul style="list-style-type: none"> - Shake the bottle gently; - Blow your nose to clear the nostrils; - Close one side of the nostril. Tilt your head forward slightly and carefully insert the nasal applicator into the other nostril; - Start to breathe in through your nose, and while breathing in press firmly and quickly down one time on the applicator to release the spray; - Repeat in the other nostril; - Wipe the nasal applicator with a clean tissue and replace the cap. <p>4. Review of Resident #6's POS, dated May, 2024 showed:</p> <ul style="list-style-type: none"> - Start date: 3/29/24 - Fluticasone (Flonase) nasal spray, 50 micrograms (mcg.), one spray in each nostril twice daily for allergy symptoms. <p>Review of the resident's MAR, dated May, 2024 showed:</p> <ul style="list-style-type: none"> - Fluticasone (Flonase) nasal spray, 50 mcg., one spray in each nostril twice daily for allergy symptoms. <p>Observation on 5/8/24 at 7:35 A.M., showed:</p> <ul style="list-style-type: none"> - CMT A did not shake the Flonase bottle, did not have the resident blow his/her nose, did not close either side of the resident's nostril and instilled one spray in each nostril. <p>During an interview on 5/9/24 at 9:38 A.M., CMT A said:- He/should follow the manufacturer's guidelines for the administration of Flonase nasal spray and the prescription (have the resident blow their nose, shake the bottle, close one side of the nostril).</p> <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator and DON said:</p> <ul style="list-style-type: none"> - Staff should follow the manufacturer's guidelines when administering the nasal sprays. <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>44395</p> <p>5. Review of Resident #34's physician order sheet for May 2024 showed:</p> <ul style="list-style-type: none"> -Benzotropine 1 mg, give one tablet three times a day for movement disorder. Ordered 6/4/21. -Fluoxetine 20 mg give one capsule with a 40 mg capsule to equal 60 total mg daily for obsessive compulsive disorder (OCD: uncontrollable and recurring thoughts (obsessions), and repetitive behaviors (compulsions)) Ordered 6/4/21. -Fluoxetine 40 mg give one capsule with one 20 mg capsule to equal 60 total mg daily for OCD. Ordered 6/4/21 -Hydroxyzine 10 mg give one tablet daily for anxiety (a feeling of fear, dread and uneasiness). Ordered 6/4/21 -Risperidone 1 mg give one tablet twice a day for schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves.) Ordered 3/9/22 -Carbidopa/levodopa 25 mg/100 mg give one and one half tablets four times a day for Parkinson's disease (A disorder of the central nervous system that affects movement, often including tremors). Ordered 10/14/22 -Vitamin E 400 units give one tablet daily for supplement. Ordered 10/30/23 -Vitamin B 12 500 micrograms (mcg) give two tablets once a day for supplement. Ordered 6/26/21 <p>During observation on 5/08/24 at 7:54 A.M. showed</p> <ul style="list-style-type: none"> -CMT A removed resident #34's medications from the medication cart. -He/she sat a medication administration cup on top of the medication cart and began popping medication from bubble packs into the medication cup. -He/she popped Benzotropine 1 mg, one tablet, Fluoxetine 20 mg one capsule, Fluoxetine 40 mg one capsule, Hydroxyzine 10 mg one tablet and Risperidone 1 mg, one tablet . -CMT A bumped the medication cup with his/her hand knocking it over, Fluoxetine 40 mg capsule fell to the floor, Risperidone 1 mg tablet fell to the floor and Hydroxyzine 10 mg tablet fell on the top of the cart. -CMT A picked up the two medications from the floor and laid them on top of the medication cart with the tablet of Hydroxyzine. -CMT A popped Carbidopa/levodopa 25 mg/100 mg one and one half tablets into the medication cup, poured Vitamin E 400 units one tablet from the resident specific bottle, into the medication cup and poured Vitamin B 12 500 (mcg) two tablets from the resident specific bottle into the medication cup. <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-With bare hands CMT A picked up the Fluoxetine 40 mg capsule ,Risperidone 1 mg tablet and Hydroxyzine 10 mg tablet from the top of the cart and placed them into the medication cup.</p> <p>-CMT A handed the medication cup and a cup of water to the resident.</p> <p>-Resident #34 placed the medication into his/her mouth and swallowed with water.</p> <p>During an interview on 05/09/24 at 11:59 A.M. CMT A said:</p> <p>-Gloves must be worn if touching a pill. Pills cannot be touched with bare hands.</p> <p>-If a pill falls onto the cart use gloved hands to pick it up, or a something to sweep it into the medication cup.</p> <p>-Medication that falls on the floor must be destroyed and cannot be given to the resident.</p> <p>-There is no five second rule in long term care</p> <p>-He/she did not realize she dropped pills on the floor and cart, picked them up and administered them to the resident.</p> <p>Review of Novo Nordisk (manufacturer of Flex Pen) December 2022 fact sheet showed:</p> <p>-Before each injection, prime your pen by performing an airshot. Turn the dose selector to select 2 units. Holding your pen with the</p> <p>needle pointing up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.</p> <p>Press and hold the green push button. Make sure a drop of insulin appears at the needle tip.</p> <p>Review of Resident #56's Quarterly Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff) dated 2/16/24 showed:</p> <p>-Brief Interview of Mental Status (BIMS) of 15, indicated no cognitive loss.</p> <p>-Need for set up assistance with Activities of Daily Living (ADL's: tasks performed in a day to care for oneself)</p> <p>-Diagnoses of: Diabetes (disease that affects how your body turns food into energy.)</p> <p>Review of the resident's physician orders dated May 2024 showed:</p> <p>-Novolog U-100 Insulin(medication used to treat diabetes) , 100 units (U) per milliliter (ml) per sliding scale. If blood sugar is :</p> <p>150 milligrams (mg) / deciliter (dl) to 200 mg/dl give 3 units</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>201 mg/dl to 250 mg/dl give 5 units</p> <p>251 mg/dl to 300 mg/dl give 8 units</p> <p>301 mg/dl to 350 mg/dl give 11 units</p> <p>351 mg/dl to 400 mg/dl give 14 units</p> <p>401 mg/dl to 450 mg/dl give 17 units</p> <p>451 mg/dl to 500 mg/dl give 20 units</p> <p>if greater than 500 mg/dl notify the physician.</p> <p>During an observation on 5/08/24 at 7:24 A.M. showed:</p> <ul style="list-style-type: none"> -Licensed Practical Nurse (LPN) A obtained a bedside glucose reading of 157 mg/dl -LPN A checked the resident's electronic medical record for his/her insulin order. -LPN A obtained the resident's Novolog flex pen from the cart, removed the cap, cleansed the hub, applied a new needle, turned the dial on the base of the pen to 3 units. -LPN A administered the injection into the resident's abdomen, disposed of the needle, removed his/her gloves, cleansed his/her hands with alcohol hand scrub and charted the administration of the insulin. -LPN A cleansed the insulin pen and returned it to the cart. -LPN A did not prime the insulin pen prior to administration. <p>2. Review of Resident #47's Annual MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> -BIMS of 15, indicated no cognitive loss. -Set up assistance for ADL's. -Diagnoses of Diabetes, congestive heart failure (a condition in which the heart cannot pump blood well enough to give the body a normal supply)., cardiac pacemaker (small, battery-powered device that prevents the heart from beating too slowly <p>Review of the resident's comprehensive care plan dated 2/27/24 showed:</p> <ul style="list-style-type: none"> -The resident is at risk for fluctuating blood glucose levels, administer insulin as ordered <p>Review of the resident's physician order sheet for May 2024 showed:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Insulin glargine (Lantus) Insulin pen (medication used to treat diabetes) ; 100 units per ml, give 10 units subcutaneous (just under the skin) twice a day for diabetes.</p> <p>-Victoza pen injector (medication used to treat diabetes) ; 0.6 mg/0.1 ml give 1.8 mg subcutaneous once a day for diabetes</p> <p>Observations on 05/08/24 at 7:42 A.M. showed:</p> <p>-LPN A obtained the resident's bedside glucose at 160 mg/dl.</p> <p>-LPN A checked the resident's electronic medical record for his/her insulin order.</p> <p>-LPN A obtained the resident's Lantus flex pen and Victoza pen from the cart.</p> <p>-LPN A removed the cap of the Lantus flex pen, cleansed the hub, applied a new needle, turned the dial on the base of the pen to 10 units.</p> <p>-LPN A removed the cap of the Victoza pen, cleansed the hub, applied a new needle, turned the dial to 18 units.</p> <p>-LPN A administered the Lantus injection into the resident's upper left arm. LPN A laid the pen on the top of the cart,</p> <p>-LPN A administered the Victoza injection into the resident's left upper arm.</p> <p>-LPN A disposed of the used needles, removed his/her gloves, cleansed his/her hands with alcohol hand scrub and charted the administration of the insulin.</p> <p>-LPN A cleansed the Lantus and Victoza pen and returned them to the medication cart.</p> <p>-LPN A did not prime the insulin pen prior to administration.</p> <p>During an interview on 05/08/24 at 8:02 A.M. LPN A said:</p> <p>-He/She dials the insulin the correct dose and administers it per the physician order.</p> <p>-He/she does not need to prime the insulin pen.</p> <p>During an interview on 5/9/24 at 3:12 P.M. with the Director of Nursing and the Administrator:</p> <p>-The DON said staff cannot touch medication bare handed. Medication cannot be administered after it has fallen on the floor.</p> <p>-The Administrator said she does not expect staff to touch medication with bare hands or administer medication off the floor.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were free of significant medication errors when staff failed to prime insulin pens for two residents resulting in three significant medication errors out of the 25 sampled medications. The facility census was 66.</p> <p>Review of the facility's undated policy for medication administration, showed:</p> <ul style="list-style-type: none"> - Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection; - Administer medications as ordered in accordance with manufacturer specifications. <p>Review of Novo Nordisk (manufacturer of Flex Pen) December 2022 fact sheet showed:</p> <ul style="list-style-type: none"> -Before each injection, prime your pen by performing an airshot. Turn the dose selector to select 2 units. Holding your pen with the needle pointing up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Press and hold the green push button. Make sure a drop of insulin appears at the needle tip. <p>1. Review of Resident #56's Quarterly Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff) dated 2/16/24 showed:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) of 15, indicated no cognitive loss. -Need for set up assistance with Activities of Daily Living (ADL's: tasks performed in a day to care for oneself) -Diagnoses of: Diabetes (disease that affects how your body turns food into energy.) <p>Review of the resident's physician orders dated May 2024 showed:</p> <ul style="list-style-type: none"> -Novolog U-100 Insulin(medication used to treat diabetes) , 100 units (U) per milliliter (ml) per sliding scale. If blood sugar is : 150 milligrams (mg) / deciliter (dl) to 200 mg/dl give 3 units 201 mg/dl to 250 mg/dl give 5 units 251 mg/dl to 300 mg/dl give 8 units <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>301 mg/dl to 350 mg/dl give 11 units</p> <p>351 mg/dl to 400 mg/dl give 14 units</p> <p>401 mg/dl to 450 mg/dl give 17 units</p> <p>451 mg/dl to 500 mg/dl give 20 units</p> <p>if greater than 500 mg/dl notify the physician.</p> <p>During an observation on 5/08/24 at 7:24 A.M. showed:</p> <p>-Licensed Practical Nurse (LPN) A obtained a bedside glucose reading of 157 mg/dl</p> <p>-LPN A checked the resident's electronic medical record for his/her insulin order.</p> <p>-LPN A obtained the resident's Novolog flex pen from the cart, removed the cap, cleansed the hub, applied a new needle, turned the dial on the base of the pen to 3 units.</p> <p>-LPN A administered the injection into the resident's abdomen, disposed of the needle, removed his/her gloves, cleansed his/her hands with alcohol hand scrub and charted the administration of the insulin.</p> <p>-LPN A cleansed the insulin pen and returned it to the cart.</p> <p>-LPN A did not prime the insulin pen prior to administration.</p> <p>2. Review of Resident #47's Annual MDS dated [DATE] showed:</p> <p>-BIMS of 15, indicated no cognitive loss.</p> <p>-Set up assistance for ADL's.</p> <p>-Diagnoses of Diabetes, congestive heart failure (a condition in which the heart cannot pump blood well enough to give the body a normal supply)., cardiac pacemaker (small, battery-powered device that prevents the heart from beating too slowly</p> <p>Review of the resident's comprehensive care plan dated 2/27/24 showed:</p> <p>-The resident is at risk for fluctuating blood glucose levels, administer insulin as ordered</p> <p>Review of the resident's physician order sheet for May 2024 showed:</p> <p>-Insulin glargine (Lantus) Insulin pen (medication used to treat diabetes) ; 100 units per ml, give 10 units subcutaneous (just under the skin) twice a day for diabetes.</p> <p>-Victoza pen injector (medication used to treat diabetes) ; 0.6 mg/0.1 ml give 1.8 mg subcutaneous once a day for diabetes</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 05/08/24 at 7:42 A.M. showed:</p> <ul style="list-style-type: none"> -LPN A obtained the resident's bedside glucose at 160 mg/dl. -LPN A checked the resident's electronic medical record for his/her insulin order. -LPN A obtained the resident's Lantus flex pen and Victoza pen from the cart. -LPN A removed the cap of the Lantus flex pen, cleansed the hub, applied a new needle, turned the dial on the base of the pen to 10 units. -LPN A removed the cap of the Victoza pen, cleansed the hub, applied a new needle, turned the dial to 18 units. -LPN A administered the Lantus injection into the resident's upper left arm. LPN A laid the pen on the top of the cart, -LPN A administered the Victoza injection into the resident's left upper arm. -LPN A disposed of the used needles, removed his/her gloves, cleansed his/her hands with alcohol hand scrub and charted the administration of the insulin. -LPN A cleansed the Lantus and Victoza pen and returned them to the medication cart. -LPN A did not prime the insulin pen prior to administration. <p>During an interview on 05/08/24 at 8:02 A.M. LPN A said:</p> <ul style="list-style-type: none"> -He/She dials the insulin the correct dose and administers it per the physician order. -He/she does not need to prime the insulin pen. <p>During an interview on 5/9/24 at 3:12 P.M. with the Director of Nursing and the Administrator ;</p> <p>The Director of Nursing said she would expect staff to follow manufacturers guidelines for medication.</p> <p>The Administrator said insulin pens should be primed every use. She had been taught to prime with 2-3 units every use.</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observation, record review, and interview, the facility failed to ensure staffing was sufficient to serve residents their meals in a timely manner. This affected three of the 17 sampled residents (Resident #216, #16, and #8). The facility census was 66.</p> <p>Review of facility policy, assistance with meals, dated March 2016, showed:</p> <ul style="list-style-type: none"> -Residents will receive assistance with meals in a manner that meets the individual needs of each resident. -Nursing staff and or feeding assistants will serve resident trays and will help residents who require assistance with eating. -Nursing staff will remove food trays from food cart and deliver the trays to each resident's room. -Nursing staff and/or feeding assistants will feed those residents needing full assistance. -Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. <p>1. Review of Resident #216's face sheet showed:</p> <ul style="list-style-type: none"> -Resident admitted to facility on 4/22/24 -Diagnoses included: neurocognitive disorder with lewy bodies (a type of progressive dementia that leads to decline in thinking, reasoning, and independent function), generalized osteoarthritis (a condition in which three or more joint groups are affected when cartilage that cushions end of bones deteriorates), and chronic pain syndrome. <p>Review of MDS showed resident did not have MDS completed.</p> <p>Review of care plan, dated 5/8/24, showed:</p> <ul style="list-style-type: none"> -Resident did not have any goals related to eating. <p>Review of baseline care plan, dated 4/22/24, showed:</p> <ul style="list-style-type: none"> -He/She required one nursing assistant for meals. <p>Review of physician's orders dated 4/8/24 to 5/8/24, showed:</p> <ul style="list-style-type: none"> -Resident was on regular diet. <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 5/7/24 at 10:04 A.M. showed resident's breakfast tray was sitting across the room from resident on bedside over bed table, cover had not been removed from food, food had not been touched and was cold.</p> <p>During an interview on 5/7/24 at 10:56 A.M., Resident Representative said:</p> <ul style="list-style-type: none"> -Facility did not make attempts to feed resident; -No staff comes to feed resident or assist resident to eat; -Resident's family members had been going to facility to ensure resident had been fed; -Family member tried to get there before breakfast and stay until after dinner to ensure resident was getting to eat. <p>Observation on 5/8/24 at 8:39 A.M. showed resident's breakfast was sat on table in front of her, food was covered and cold, food had not been touched, resident was not assisted to eat breakfast.</p> <p>Observation on 5/8/24 at 9:32 A.M. showed resident's breakfast remained on bedside table in front of her, no staff had assisted him/her to eat breakfast.</p> <p>During an interview on 5/8/24 at 12:06 P.M., Resident's sister said:</p> <ul style="list-style-type: none"> -He/She had been visiting and feeding resident; -Resident could not feed him/herself. <p>Review of electronic medical record on 5/8/24, showed:</p> <ul style="list-style-type: none"> -No documentation of resident meal intakes. <p>During an interview on 5/7/24 at 10:08 A.M., Certified Nurse Aide (CNA) B said:</p> <ul style="list-style-type: none"> -Normally family is at facility to feed resident; -If someone did not feed resident, resident did not eat. <p>During an interview on 5/8/24 at 2:25 P.M., Certified Medication Technician (CMT) B said:</p> <ul style="list-style-type: none"> -Resident did not feed him/herself, he/she was an assist, most days resident's sister was in facility to feed resident; -For residents that eat their meals in their rooms, facility did not have enough staff to get assistance to residents to help them eat; -He/She tried to ensure that no more than two residents who are assisted diners stay in their rooms to eat; <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She did not have time to document resident's meal intake due to staffing shortages.</p> <p>-Facility did not have enough staff to meet resident needs.</p> <p>During an interview on 5/8/24 at 2:38 P.M., CNA A said:</p> <p>-Resident required assistance to eat;</p> <p>-The resident's son or sister will come to feed resident a little after breakfast.</p> <p>2. Review of Resident #16's Quarterly MDS, dated [DATE] showed:</p> <p>-He/She had moderately impaired cognition;</p> <p>-He/She had clear speech, was usually able to make self-understood, and usually able to understand others;</p> <p>-He/She had impairment to range of motion on both sides of lower extremities;</p> <p>-He/She required substantial/maximal assistance with eating;</p> <p>-Diagnoses included: stroke, diabetes (too much sugar in the blood), and osteoarthritis (condition when flexible, protective tissue at the ends of bones wears down).</p> <p>Observation on 5/6/24 at 1:03 P.M. showed Resident #16 received his/her lunch tray at 12:40 P.M., the meal sat on table with lid on it and at 1:03 P.M. staff came in and started assisting resident to eat. Staff did not offer to warm up resident's food that had been sitting in room over 23 minutes.</p> <p>Observation on 5/8/24 at 8:04 A.M. in the kitchen showed last tray was served for breakfast.</p> <p>Observation on 5/8/24 at 9:15 A.M. showed staff attempted to assist resident to eat but he/she did not want anything, 1 hour and 11 minutes after last tray left the kitchen for breakfast service.</p> <p>During an interview on 5/8/24 at 10:45 A.M., Licensed Practical Nurse (LPN) A said:</p> <p>-Something happened to resident's dinner trays last night because he/she did not get anything to eat;</p> <p>-He/She fixed resident a peanut butter and jelly sandwich.</p> <p>During an interview on 5/8/24 at 2:06 P.M., CMT B said:</p> <p>-Twenty-three minutes was not an acceptable time frame for the resident to have waited before staff asked him/her if they wanted to eat their meal.</p> <p>-He/She heard resident did not receive supper tray on 5/7/24.</p> <p>3. Review of Resident #8's Quarterly MDS, dated [DATE] showed:</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She had intact cognition;</p> <p>-He/She had clear speech, was able to make self-understood and understand others;</p> <p>-He/She had impaired range of motion of one side of lower extremity;</p> <p>-He/She required set up or clean-up assistance with eating;</p> <p>-Diagnoses included anxiety and depression.</p> <p>During an interview on 5/8/24 at 9:07 A.M., resident said:</p> <p>-He/She did not get any supper last night and there was several other residents that did not receive their trays including Resident #16.</p> <p>-He/She finally told the charge nurse who went and fixed him/her a peanut butter and jelly sandwich.</p> <p>During an interview on 5/8/24 at 10:45 A.M., LPN A said:</p> <p>-Something happened to Resident #16's dinner trays last night because he/she did not get anything to eat;</p> <p>-He/She fixed resident a peanut butter and jelly sandwich.</p> <p>During an interview on 5/8/24 at 2:25 P.M., CMT B said:</p> <p>-He/She was aware resident did not get his/her supper tray passed last night along with two other residents;</p> <p>-He/She was not sure why except maybe the aides just did not get the trays passed.</p> <p>During an interview on 5/9/24 at 10:17 A.M., Dietary Manager said:</p> <p>-He/She was made aware that residents were missed for their meal on 5/7/24's meal due to trays being given to the wrong resident or were lost.</p> <p>-Kitchen staff made an alternate dinner of deli sandwich, chips, fruit, and drink;</p> <p>-Residents were served alternative meal as main meal had already been discarded;</p> <p>-He/She had system in place to ensure room trays were not moved by having a room tray list that is used by staff in kitchen;</p> <p>-There was a lot of turn over off staff, part of problem had new people that had just started and had new residents, and new staff were not aware of the new residents. It was more of a training and orientation issue with staff.</p> <p>(continued on next page)</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/9/24 at 3:12 P.M., Administrator said:</p> <ul style="list-style-type: none"> -Residents who require feeding assistance should be assisted in a timely manner; -He/She was aware of five residents who did not get a meal served on 5/7/24 dinner tray pass; -His/Her normal dietary staff took a leave of absence and were out of the country; -He/She had issues with getting people to do their job correctly in the kitchen; -Kitchen staff said they had already put food up; -LPN A was in building and cooked burgers, and make peanut butter and jelly sandwich for those residents; -He/She had a lot to do with educating staff on patient rights. -He/She was aware that insufficient staffing had caused issues with getting residents up and down for meals and meal service. <p>MO233672</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observation and interviews, the facility failed to ensure staff served food to the residents that was palatable, attractive, and served at a safe and appetizing temperature to the residents when hot food was not served at an appetizing temperature to seven of the 17 sampled residents (Resident #8, #2, #58, #27, #56, #55, and #212). The facility census was 66.</p> <p>Review of facility policy, food and drink, dated 1/30/24, showed:</p> <ul style="list-style-type: none"> -Food prepared by methods that provides nutritive value, flavor and appearance; -Food and drink that is palatable, attractive, and served at a safe and appetizing temperature <p>Review of food safety policy, dated 1/30/24, showed:</p> <ul style="list-style-type: none"> -Facility must store, prepare, distribute, and serve food in accordance with professional standards for food safety. -Ensuring safe food handling once food is brought to facility, including safe temperatures of food and handling of leftovers <p>Review of facility policy, food safety, undated, showed:</p> <p>Holding Hot foods:</p> <ul style="list-style-type: none"> -To ensure safety, hot foods must be held at 140 degrees Fahrenheit (F) or above. -Place foods in steam table or cabinets designed for holding hot foods immediately after cooking or heating. The maximum length of time that foods can be held on a steam table is a total of 4 hours. -Reheat all food to 165 degrees F for 15 seconds. Food may be reheated only once. -Never heat cold or lukewarm foods in steam tables or other equipment designed to hold hot foods. -Stir the foods frequently to evenly distribute the temperature. The top portion of the foods will cool to room temperature if not stirred. -Cover and protect containers to maintain heat and to protect from contamination. <p>Facility did not provide a policy on food serving temperatures.</p> <p>1. Review of Resident #8's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/3/24 showed:</p> <ul style="list-style-type: none"> -He/She had intact cognition; <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She had clear speech, was able to make self-understood and understand others;</p> <p>-He/She had impaired range of motion of one side of lower extremity;</p> <p>-He/She required set up or clean-up assistance with eating;</p> <p>-Diagnoses included anxiety and depression.</p> <p>During an interview on 5/6/24 at 12:48 P.M., Resident said:</p> <p>-When receiving room tray all his/her foods were sloshed together;</p> <p>-When he/she received a breadstick, it was not separated and put in wax paper, it was placed on his/her plate and became soggy by time he/she was able to eat it;</p> <p>-Food was cold when he/she received it;</p> <p>-Kitchen did not cover drinks that were served;</p> <p>-The drinks spilled all over his/her tray and on his/her food.</p> <p>2. Review of Resident #2's Quarterly MDS, dated [DATE] showed:</p> <p>-Cognition intact;</p> <p>-He/She had clear speech, was able to make self-understood and understand others;</p> <p>-He/She required set up or clean-up assistance with eating;</p> <p>- Diagnoses included seizure disorder and depression.</p> <p>During an interview on 5/6/24 at 11:03 A.M., Resident said</p> <p>-He/She eats in his/her room and food is cold when he/she received it;</p> <p>-Facility did not cover drinks and they are spilled on his/her tray;</p> <p>-He/She did not receive bread with his/her meal;</p> <p>-Plates are generally uncovered.</p> <p>3. Review of Resident #58's Admission MDS, dated [DATE], showed:</p> <p>-He/She had moderately impaired cognition;</p> <p>-He/She had clear speech, was able to make self-understood and understand others;</p> <p>-He/She required set up or clean up assistance with eating;</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Diagnoses included: spinal stenosis of cervical region (neck pain from changes to vertebrae of neck), arthritis (swelling and tenderness of one or more joints), and cognitive communication deficit (difficulty with thinking and how someone uses language).</p> <p>During an interview on 5/6/24 at 10:33 A.M., Resident said:</p> <p>-Food was not good and had no taste;</p> <p>-Food was not hot;</p> <p>-Food was not the right consistency.</p> <p>4. Review of Resident #27's Quarterly MDS, dated [DATE] showed:</p> <p>-He/She had moderately impaired cognition;</p> <p>-He/She had clear speech, was able to usually make self-understood and usually understand others;</p> <p>-He/She had impaired range of motion of upper and lower extremities on one side;</p> <p>-He/She required supervision or touching assistance with eating;</p> <p>-Diagnoses included stroke, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and the ability to carry out the simplest tasks), dementia (the inability to think), anxiety, depression, and hemiplegia (paralysis affecting one side of the body).</p> <p>During an interview on 5/6/24 at 3:16 P.M., Resident said:</p> <p>-Food was not good, did not taste good;</p> <p>-Meat was tough.</p> <p>5. Review of Resident #56's Quarterly MDS, dated [DATE] showed:</p> <p>-He/She had intact cognition;</p> <p>-He/She had clear speech, was able to make self-understood and understand others;</p> <p>-He/She required set up or clean-up assistance with eating;</p> <p>-Diagnoses included cancer, anxiety, depression, pneumonia (an infection that affects one or both lungs), anxiety, respiratory failure (a serious condition that makes it difficult to breathe on your own) and chronic obstructive pulmonary disease ((COPD) obstruction of air flow that interferes with normal breathing).</p> <p>During an interview on 5/6/24 at 10:41 A.M. said:</p> <p>-Food was on cool side;</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Meat was tough to chew;</p> <p>-Chicken was dry.</p> <p>6. Review of Resident #55's Quarterly MDS, dated [DATE], showed:</p> <p>-He/She had moderately impaired cognition;</p> <p>-He/She had clear speech, was able to make self-understood and usually understood others;</p> <p>-He/She was independent with eating;</p> <p>-Diagnoses included: dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life., malnutrition, and generalized muscle weakness.</p> <p>During an interview on 5/7/24 at 3:08 P.M. said:</p> <p>-Food was horrible;</p> <p>-It was served cold;</p> <p>-There was nothing worse than looking forward to something and sticking your finger in it and it being cold;</p> <p>-He/She looked forward to hashbrown at breakfast and it was a grease bomb.</p> <p>7. Review of Resident #212's face sheet, dated 5/7/24, showed:</p> <p>-He/She admitted to facility on 4/22/24;</p> <p>-Diagnoses included dependence on renal dialysis (a treatment that removed extra fluid and waste products from the blood when kidneys are not able to), diabetes (a condition resulting in too much sugar in the blood, generalized muscle weakness, difficulty in walking, and need for assistance with personal care.</p> <p>During an interview on 5/7/24 at 9:40 A.M. said:</p> <p>-Breakfast is basically cold every time he/she got served.</p> <p>8. During a continuous observation in the kitchen on 5/8/24 from 6:10 A.M.-8:14 A.M. showed:</p> <p>-At 6:06 A.M. Oatmeal was temperature checked while cooking on stove at 205.6 degrees;</p> <p>-At 6:27 A.M., Sausage patties and links were removed from oven, sausage patties temperature checked at 189.3 degrees and sausage links at 162.0 degrees;</p> <p>-At 6:30 A.M., Sausage patties added to steam table;</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-At 6:31 A.M., Sausage links placed back in oven;</p> <p>-At 6:32 A.M., Bacon added to steam table;</p> <p>-At 6:34 A.M., Container of leftover ground up mechanical sausage placed in oven. Dietary Manager told Housekeeping Supervisor that they reheated leftovers for mechanical diets and there is some sausage that was always ground up. He/She reheated it and then after that day they throw out the ground up sausage.</p> <p>-At 6:38 A.M., Sausage links removed from oven and temperature checked at 165.6, and was added to steam table;</p> <p>-At 6:44 A.M., Container of eggs removed from oven, temperature checked at 209.6 degrees;</p> <p>-At 6:59 A.M., Mechanical sausage pulled out and temperature checked at 92.0 degrees, placed back in oven;</p> <p>-At 7:02 A.M., boiled eggs temperature checked in pot on stove showed 178.6 degrees, added to steam table;</p> <p>-At 7:22 A.M., Mechanical soft sausage removed from oven and temperature checked 209.8 degrees;</p> <p>-At 7:33 A.M., First breakfast tray served to dining room;</p> <p>-At 8:14 A.M., Last breakfast tray served.</p> <p>Observation of test tray at end of meal service on 5/8/24 at 8:15 A.M., showed:</p> <p>-Oatmeal was 104.5 degrees;</p> <p>-Mechanical soft sausage was 94.7 degrees;</p> <p>-Sausage patty was 119.5 degrees;</p> <p>-Sausage link was 118.4 degrees;</p> <p>-Baked eggs was 102.7 degrees;</p> <p>-Bacon was 87.4</p> <p>-Mechanical soft sausage was found to be dry and crispy with black hard crunch pieces that tasted burnt</p> <p>-No foods served on test tray was at appropriate serving temperature of 135 degrees.</p> <p>During an interview on 5/8/24 at 2:25 P.M., Certified Medication Technician B said:</p> <p>-Residents have complained about food temperatures a few weeks ago regarding food being cold;</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She heard kitchen was getting a big plate warmer that can be pushed around;</p> <p>-A resident burned their arms on tomato soup when he/she spilled it on themselves.</p> <p>During an interview on 5/8/24 at 2:38 P.M., Certified Nurse Aide A said:</p> <p>-Sometimes he/she had to go reheat food for residents;</p> <p>-By the time hall trays get served those residents food was cold;</p> <p>-There is no help during morning breakfast past so staff struggled the most to get resident's trays served to them in a timely manner;</p> <p>-He/She tried to get assisted residents meals served first to their rooms.</p> <p>During an interview on 5/9/24 at 9:55 A.M., Dietary Aide B said:</p> <p>-When residents complain about temperature of their foods the kitchen serves them a new tray of food;</p> <p>-Only time he heard food was being served cold was during room tray passes;</p> <p>-Dietary staff covered room trays but if staff did not pass out room trays we do not know how long it takes for food to get to residents on halls.</p> <p>During an interview on 5/9/24 at 10:05 A.M., Housekeeping Supervisor said:</p> <p>-Hot food should be served hot;</p> <p>-Hot food should be served on resident's place no less than 120 degrees;</p> <p>-He/She was not aware of issues of food being served cold;</p> <p>-He/She was just on day two of cross training in dietary department.</p> <p>-Hall trays were an issue as there was a lot of hall trays;</p> <p>-Dietary department was waiting on an extra cart and meal plate covers.</p> <p>During an interview on 5/9/24 at 10:17 A.M., Dietary Manager said:</p> <p>-He/She was made aware from resident council notes that food was going out cold;</p> <p>-Hot food should be served hot, cold food should be served cold;</p> <p>-He/She had completed staff retraining that facility will not dip food onto plate until resident was in dining room;</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She has ordered insulated domes with metal heat plate insert system that will be used for room trays to help maintain room trays at acceptable serving temperatures;</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47195</p> <p>Based on observation, record review, and interviews the facility failed to store, prepare, and serve food in accordance with professional standards of food service safety when staff with facial hair failed to wear beard coverings, failed to wash hands, failed to date and label all foods, failed to have thermometers in refrigerator and freezer, and failed to maintain a clean and sanitary kitchen. This had the potential to impact all residents in the facility. The facility census was 66 residents.</p> <p>Review of facility policy, food and drink, undated, showed:</p> <ul style="list-style-type: none"> -Purpose: ensure that the nutritive value of food is not compromised or destroyed because of prolonged: -Food storage, light, and air exposure; -Cooking of foods in a large volume of water or; -Holding on a steam table. -Procedure: -Each resident receives and the facility provides - -Food prepared by methods that provides nutritive value, flavor, and appearance. -Food and drink that is palatable, attractive, and served at a safe and appetizing temperature. -Food is prepared in a form designed to meet individual needs. -Food that accommodates resident allergies, intolerance's, and preferences. -Alternative options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice. -Drinks, including water and other liquids are consistent with resident needs and preferences and sufficient to maintain resident hydration. <p>1. Review of facility policy, food safety, undated, showed:</p> <ul style="list-style-type: none"> -Dietary staff must wear hair restraints (example hairnet, hat and/or beard restraint) to prevent hair from contacting food. <p>Observation on 5/6/24 at 9:46 A.M. showed Dietary Aide B who had a beard was not wearing a beard restraint.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 5/8/24 at 6:08 A.M. showed Housekeeping Supervisor was training in the dietary department and was not wearing beard covering. He/She had facial hair.</p> <p>Observation on 5/8/24 at 6:10 A.M. showed dietary aide B entered kitchen and covered hair with a hat. He/She did not apply beard restraint to facial hair.</p> <p>During an interview on 5/9/24 at 9:55 A.M., Dietary Aide B said:</p> <ul style="list-style-type: none"> -He/She did not wear beard restraints; -Dietary Manager told him/her today that he/she would order beard restraints; -Facility had not had beard restraints in the past. <p>During an interview on 5/9/24 at 10:05 A.M., Housekeeping Supervisor said:</p> <ul style="list-style-type: none"> -He/She should have wore beard restraint; -He/She did not know if beard nets were available in kitchen; -He/She knew hairnets were available. <p>During an interview on 5/9/24 at 10:17 A.M., Dietary Manager said:</p> <ul style="list-style-type: none"> -Dietary staff with facial hair should wear beard coverings; -He/She had beard coverings available in the kitchen. <p>During an interview on 5/9/24 at 3:12 P.M., Administrator said:</p> <ul style="list-style-type: none"> -Dietary staff should wear beard coverings and hairnets; -Hairnets are available in kitchen; -He/She did not know if beard coverings were available to staff. <p>2. Review of facility policy, Food Safety, dated 1/30/24, showed:</p> <ul style="list-style-type: none"> -The facility must store, prepare, distribute, and serve food in accordance with professional standards of food service safety. -Employees should never use bare hand contact with any foods, ready to eat or otherwise. -Staff should have access to proper hand washing facilities with available soap (regular or antimicrobial), hot water and disposable towels and/or heat/air drying methods. Antimicrobial gel (hand hygiene agent that does not require water) cannot be used in place of proper hand washing techniques in a food service setting. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The use of disposable gloves is not a substitute for proper hand washing.</p> <p>-Hands must be washed before putting on gloves and after removing gloves as well as between tasks, between handling raw meats and ready to eat foods and between handling soiled and clean dishes, etc.</p> <p>-Staff should maintain nails that are clean and neat, and wearing intact disposable gloves in good condition that are changed appropriately to reduce the spread of infection.</p> <p>Observation on 5/6/24 at 12:02 P.M. showed:</p> <p>-All staff served residents in dining room with gloves on;</p> <p>-Staff did not cleanse hands or change gloves between serving resident lunch trays;</p> <p>-Staff touched cabinets the trays were sat on, touched meal tickets, and helped residents cut up food without sanitizing.</p> <p>Continuous observation in the kitchen on 5/8/24 at 5:37 A.M.-8:14 A.M., showed:</p> <p>-At 6:10 A.M., Dietary Aide A entered kitchen, did not wash hands;</p> <p>-At 6:14 A.M., Dietary Aide A had not yet washed hands, he/she took cereal dispensers out to dining room, grabbed pitcher and started filling coffee to take out to coffee pumps into dining room;</p> <p>-At 6:17 A.M., Dietary Manager washed his/her hands, turned faucet off with his/her clean bare hands, and then dried hands with paper towel;</p> <p>-At 6:19 A.M., Dietary Aide A grabbed washcloth and wiped off prep table, then grabbed premade coffee filter and placed in coffee pot;</p> <p>-At 6:20 A.M., Dietary Aide A placed clean cups on top of cup container, he/she had not washed hands since he/she entered kitchen;</p> <p>-At 6:31 A.M., Dietary Aide A prepped food trays, made himself a cup of coffee and drinking coffee cup, and sat coffee cup on three tiered cart, wheels cart to dining room with clean glasses;</p> <p>-At 6:33 A.M., Dietary Aide A returned to kitchen drinking his/her coffee, did not wash hands;</p> <p>-At 6:36 A.M., Dietary Aide A put away clean pot, he/she had not washed hands since entering kitchen;</p> <p>-At 6:37 A.M., Dietary Aide A and Housekeeping Supervisor leave kitchen;</p> <p>-At 6:42 A.M., Dietary Aide A re-enters kitchen, did not wash hands;</p> <p>-At 6:50 A.M., Dietary Aide A touched face and glasses with bare hands;</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-At 6:58 A.M., Dietary Aide A spraying off cookie sheet and placed through dishwashing sanitizer machine;</p> <p>-At 7:00 A.M., Dietary Aide A used unwashed and ungloved hands to pull out clean cookie sheet from dishwasher sanitizer;</p> <p>-At 7:01 A.M., Housekeeping Supervisor re-entered kitchen, did not wash hands;</p> <p>-At 7:05 A.M., Dietary Aide A took drink cart out to dining room with two chocolate gallons of milk and one gallon white milk and three drink pitchers;</p> <p>-At 7:29 A.M., Dietary Aide A observed in dining room serving drinks;</p> <p>-At 7:29 A.M., Dietary Aide A re-entered kitchen and observed washing hands for first time;</p> <p>During an interview on 5/9/24 at 9:55 A.M., Dietary Aide B said:</p> <p>-He/She should wash hands before you serve food and after you serve food;</p> <p>-He/She should wash hands when he/she arrived to work and when entering kitchen;</p> <p>-He/She did not was hands when arriving to work on 5/8/24.</p> <p>During an interview on 5/9/24 at 10:05 A.M., Housekeeping Supervisor said:</p> <p>-Hand washing should occur between handling raw food, dirty dishes, and frequently;</p> <p>-He/She should wash hands when entered and exited kitchen, after handling cell phones, after smoking.</p> <p>During an interview on 5/9/24 at 10:17 A.M., Dietary Manager said:</p> <p>-Hand washing in kitchen should happen often;</p> <p>-Hand washing should occur when staff come onto shift and when dietary staff come in and out of kitchen;</p> <p>-He/She should not turn off faucet with bare hands after washing his/her hands;</p> <p>During an interview on 5/9/24 at 3:12 P.M., Administrator said:</p> <p>-Dietary staff should wash their hands prior to serving, during cooking, when entering and exiting the kitchen, and after any contamination of their hands;</p> <p>-Dietary staff should not turn off faucet with their bare cleanly washed hands;</p> <p>-During food service staff should sanitize between serving residents their trays;</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-It was not appropriate for staff to wear the same set of gloves between residents while serving meal trays.</p> <p>3. Review of food policy, storage of food in refrigeration, dated 1/30/24, showed:</p> <p>-All containers must be labeled with the contents and date food item was placed in storage;</p> <p>Review of facility policy, food safety, dated 1/30/24, showed:</p> <p>-Store, prepare, distribute, and serve food in accordance with professional standards of food service safety;</p> <p>-Food brought in must be dated and stored;</p> <p>-Food must be discarded after three days;</p> <p>-Facility refrigerators and/or freezers must be in good working condition to keep foods at or below 41 degrees Fahrenheit (F) and the freezer must keep frozen foods in a frozen state;</p> <p>-Cover and date foods.</p> <p>Review of facility policy, food and drink, undated, showed:</p> <p>-Purpose: ensure that the nutritive value of food is not compromised or destroyed because of prolonged:</p> <p>-Food storage, light, and air exposure.</p> <p>Observation in kitchen on 5/6/24 at 10:05 A.M. showed:</p> <p>Walk in cooler:</p> <p>-Undated and opened bag of mild cheddar cheese 5 lb bag;</p> <p>-Undated and opened container of beef base 16 oz;</p> <p>-Undated and opened white sliced cheese wrapped in plastic wrap;</p> <p>-Undated and opened gallon of 1% chocolate milk;</p> <p>Spice Cabinet:</p> <p>-Opened oregano 32 ounces (oz) dated 10/24/2022;</p> <p>-Undated and opened ground pepper 32 oz;</p> <p>-Undated and opened and hand written label of season salt was in a reused bottle;</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Ensure food needing refrigeration is properly stored to prevent food-borne illness.</p> <p>Review of facility policy, Food Safety, dated 1/30/24, showed:</p> <p>-Store, prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>-Facility's refrigerators and/or freezers must be in good working condition to keep foods at or below 41 degrees F and the freezer must keep frozen foods frozen solid.</p> <p>During an interview on 5/6/24 at 10:23 A.M., Dietary Aide A said:</p> <p>-He/She took temperatures of food when it was done and on steam table and when it was cooked;</p> <p>Observation on 5/6/24 at 10:20 A.M. showed there was no thermometers visible in walk in cooler or freezer.</p> <p>During an interview on 5/6/24 at 10:23 A.M., Dietary Manager said:</p> <p>-He/She did have thermometers in refrigerator and freezer but did not know where they were at.</p> <p>During an interview on 5/6/24 at 10:24 A.M., Dietary Aide A said:</p> <p>-Thermometers were probably towards back of shelf behind boxes, but did not know where thermometers were located.</p> <p>During an interview on 5/9/24 at 3:12 P.M., Administrator said:</p> <p>-There should be thermometers available in freezer and refrigerator.</p> <p>5. Review of facility policy, food safety, dated 1/30/24, showed:</p> <p>-Facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>Facility did not provide a policy on dietary sanitation and cleanliness.</p> <p>Observation in the kitchen on 5/6/24 at 10:05 A.M. showed:</p> <p>-The coils of the fan in the cooler had caked on dust;</p> <p>-Area behind stove had caked on dust on coils, ledges, and cords.</p> <p>Continuous observation of kitchen on 5/8/24 from 5:49 A.M.-8:14 A.M. showed:</p> <p>-Floors in kitchen had not been swept, had crumbs laying all over floor.</p> <p>During an interview on 5/6/24 at 9:54 A.M., Dietary Manager said:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She had no cleaning log for kitchen tasks;</p> <p>-Kitchen staff have tasks that are completed every day;</p> <p>-Floors are mopped and trash was taken out;</p> <p>-He/She had deep cleaning days.</p> <p>During an interview on 5/9/24 at 3:12 P.M., Administrator said:</p> <p>-Cleanliness of facility is a work in progress;</p> <p>-Facility did not have cleaning checklists, but they should;</p> <p>-He/She expected the kitchen to be clean and sanitary.</p>

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NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Platte City		STREET ADDRESS, CITY, STATE, ZIP CODE 220 O'Rourke Drive Platte City, MO 64079	

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>31102</p> <p>Based on interviews and record review, the facility failed to have a Quality Assurance and performance Improvement (QAPI) plan and failed to have a plan that contained all required elements. This affected all the residents in the facility. The facility census was 66.</p> <p>The facility did not provide a policy for QAPI.</p> <p>During an interview on 5/9/24 at 9:06 A.M., the Administrator said:</p> <ul style="list-style-type: none"> - She started as the Administrator on 3/14/24; - At this time she was unable to locate any policies and procedures for QAPI; - They have only had one QAPI meeting. Members who attended were all the department heads, the staffing coordinator and the dietary/housekeeping supervisor; - She talked to the Medical Director monthly.

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>31102</p> <p>Based on interviews and record review, the facility failed to ensure they developed and implemented appropriate plans of action to correct identified quality deficiencies as part of their Quality Assessment and Assurance (QAA) committee. This affected all the residents in the facility. The facility census was 66.</p> <p>The facility did not provide a policy in regards to their QAA process or committee.</p> <p>The facility was unable to provide record of the the QAA and Quality Assurance/Performance Improvement (QAPI) plan.</p> <p>During an interview on 5/9/24 at 9:06 A.M., the Administrator said:</p> <ul style="list-style-type: none"> - She started as the Administrator on 3/14/24; - She was unable to locate the policy and procedures for QAPI; - They have only had one QAPI meeting. Members who attended were all the department heads plus the staffing coordinator and the dietary/housekeeping supervisor. She talks to the Medical Director monthly.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</p> <p>Based on observation, interview and record review, the facility failed to have an Infection Prevention program to include policies and procedures for infection control. Additionally, the facility staff failed to follow acceptable infection control practices to prevent the spread of infection for three residents (Resident #34, #9 and #35) when staff failed to ensure administered medications did not come in contact with unclean surfaces for one resident (Resident #34), failed to wash hands between areas of clean and dirty when providing personal care, failed to clean up bodily fluids from the floor before walking through it and laying a mat over it, for one resident (Resident #9) and touched medications with bare hands for two residents (Resident #34 and #35). The facility census was 66.</p> <p>The facility did not provide a policy on infection prevention and control.</p> <p>1. During an interview on 05/08/24 at 2:03 PM the Administrator said:</p> <ul style="list-style-type: none"> -The facility does not have anyone responsible for infection prevention program at this time. -The Director of Operations was running reports of residents on antibiotics off site. -The Assistant Director Of Nursing will be responsible for doing all the Infection prevention program. -Many policies are missing. She is working with the Director of Nursing and Director of Operations to update and ensure there are policies and procedures put into place. <p>2. Review of Resident #34 Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 3/8/24 showed:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) of 11, indicated some cognitive loss; -Independent to set up assistance for Activities of Daily Living (ADL's: activities in a day to care for oneself); -Diagnoses of Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), Schizophrenia (a serious mental health condition that affects how people think, feel and behave), Major Depressive Disorder (a persistently low or depressed mood) , Obsessive Compulsive Disorder (OCD: a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts (obsessions), engages in repetitive behaviors (compulsions), or both) and back pain. <p>Review of the resident's Comprehensive Care Plan dated 3/15/24 showed:</p> <ul style="list-style-type: none"> -He/She takes psychoactive (substances that effect mental processes) medications medication for anxiety and Parkinson's disease. Administer medications as ordered. <p>Review of Resident #34's physician order sheet for May 2024 showed:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Benzotropine 1 mg, give one tablet three times a day for movement disorder. Ordered 6/4/21.</p> <p>-Fluoxetine 20 mg give one capsule with a 40 mg capsule to equal 60 total mg daily for obsessive compulsive disorder (OCD: uncontrollable and recurring thoughts (obsessions), and repetitive behaviors (compulsions)) Ordered 6/4/21.</p> <p>-Fluoxetine 40 mg give one capsule with one 20 mg capsule to equal 60 total mg daily for OCD. Ordered 6/4/21</p> <p>-Hydroxizine 10 mg give one tablet daily for anxiety (a feeling of fear, dread and uneasiness). Ordered 6/4/21</p> <p>-Risperidone 1 mg give one tablet twice a day for schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves.) Ordered 3/9/22</p> <p>-Carbidopa/levodopa 25 mg/100 mg give one and one half tablets four times a day for Parkinson's disease (A disorder of the central nervous system that affects movement, often including tremors). Ordered 10/14/22</p> <p>-Vitamin E 400 units give one tablet daily for supplement. Ordered 10/30/23</p> <p>-Vitamin B 12 500 micrograms (mcg) give two tablets once a day for supplement. Ordered 6/26/21</p> <p>During observation on 5/08/24 at 7:54 A.M. showed</p> <p>-Certified Medication Technician (CMT) A removed resident #34's medications from the medication cart.</p> <p>-He/she sat a medication administration cup on top of the medication cart and began popping medication from bubble packs into the medication cup.</p> <p>-He/she popped Benzotropine 1 mg, one tablet, Fluoxetine 20 mg one capsule, Fluoxetine 40 mg one capsule, Hydroxizine 10 mg one tablet and Risperidone 1 mg, one tablet .</p> <p>-CMT A bumped the medication cup with his/her hand knocking it over, Fluoxetine 40 mg capsule fell to the floor, Risperidone 1 mg tablet fell to the floor and Hydroxizine 10 mg tablet fell on the top of the cart.</p> <p>-CMT A picked up the two medications from the floor and laid them on top of the medication cart with the tablet of Hydroxizine.</p> <p>-CMT A popped Carbidopa/levodopa 25 mg/100, mg one and one half tablets into the medication cup, poured Vitamin E 400 units one tablet from the resident specific bottle, into the medication cup and poured Vitamin B 12 500 microgram (mcg) two tablets from the resident specific bottle into the medication cup.</p> <p>-With bare hands CMT A picked up the Fluoxetine 40 mg capsule ,Risperidone 1 mg tablet and Hydroxizine 10 mg tablet from the top of the cart and placed them into the medication cup.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-CMT A handed the medication cup and a cup of water to the resident.</p> <p>-Resident #34 placed the medication into his/her mouth and swallowed with water.</p> <p>During an interview on 05/09/24 at 11:59 A.M. CMT A said:</p> <p>-Gloves must be worn if touching a pill. Pills cannot be touched with bare hands.</p> <p>-If a pill falls onto the cart use gloved hands to pick it up, or a something to sweep it into the medication cup.</p> <p>-Medication that falls on the floor must be destroyed and cannot be given to the resident.</p> <p>31102</p> <p>3. Review of Resident #9's Quarterly MDS, dated [DATE] showed;</p> <p>- Cognitive skills severely impaired;</p> <p>- Required substantial to maximal assistance with showers, personal hygiene, toilet use and transfers;</p> <p>- Always incontinent of bowel and bladder;</p> <p>- Diagnoses included non traumatic brain dysfunction (causes damage to the brain by internal factors, such as a lack of oxygen, exposure to toxins, or pressure from a tumor), congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body), anxiety, depression, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and the ability to carry out the simplest tasks), and psychotic disorder (a mental disorder characterized by a disconnection from reality).</p> <p>Review of the resident's care plan, dated 3/13/24 showed:</p> <p>- The resident required assistance with activities of daily living (ADL's) due to weakness, decreased cognition related to Alzheimer's disease. Assist the resident with cares. Provide extensive assistance for bed mobility, transfers, locomotion on the unit and off the unit, dressing, toileting, and personal hygiene. The resident is not able to walk.</p> <p>Observation on 5/7/24 at 9:41 A.M., showed:</p> <p>- The resident sat in his/her Broda chair (reclining geri chair) in the assist dining room and was leaning over on the left side of the chair with his/her eyes closed. There was a puddle of urine under the resident's Broda chair;</p> <p>- Certified Nurses Aide (CNA) A took the resident back to his/her room;</p> <p>- CNA A and CNA D did not wash their hands and applied gloves;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - CNA A and CNA D used the gait belt (a safety device and mobility aid used to provide assistance during transfers, ambulation or repositioning) and transferred the resident from the Broda chair to his/her bed; - There was a puddle of urine under the resident's Broda chair; - CNA A and CNA D removed the resident's wet pants and the saturated and soiled incontinent brief; - CNA D provided incontinent care for the resident; - The clean incontinent brief fell on to the floor and CNA D picked it up and placed it on the resident and fastened it; - CNA D walked through the urine on the resident's floor and CNA A placed the fall mat over the urine on the floor beside the resident's bed. CNA A and CNA D did not clean the seat of the resident's Broda chair; - CNA A removed his/her gloves and washed his/her hands; - CNA D removed his/her gloves, did not wash his/her hands and left the room. <p>During an interview on 5/8/24 at 2:38 P.M., CNA A said:</p> <ul style="list-style-type: none"> - Should not have used the brief after it had fallen on the floor, we should have used a new incontinent brief; - He/she should have cleaned the seat of the resident's Broda chair and cleaned the urine from the floor before placing the fall mat on the floor. - Should wash his/her hands when entering the resident's room, between glove changes and before leaving the room. <p>During an interview on 5/9/24 at 10:29 A.M., CNA D said:</p> <ul style="list-style-type: none"> - We should not have used the clean incontinent brief after it had fallen on the floor; - Should have cleaned the urine from the floor before we placed the fall mat on the floor and cleaned the seat of the resident's Broda chair; - Should wash hands between glove changes and before leaving the resident's room. <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator and the DON said:</p> <ul style="list-style-type: none"> - Staff should have cleaned the urine from the floor or had housekeeping clean it before they placed the fall mat on the floor; - Staff should have cleaned the seat of the Broda chair; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Staff should not have used the clean incontinent brief once it had fallen on the floor;</p> <p>- They would expect the staff to wash their hands when they enter the resident's room, should wash their hands during peri care and should wash their hands or sanitize between glove changes.</p> <p>Review of the facility's undated policy for medication administration, showed, in part:</p> <p>- Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection;</p> <p>- Administer medications as ordered and in accordance with manufacturer specifications;</p> <p>- Remove medication from source, taking care not to touch medication with bare hands.</p> <p>Review of Resident #35's physician order sheet (POS), dated May 2024 showed:</p> <p>- Start date: 4/25/24 - Linzess 145 mcg, one capsule daily for irritable bowel syndrome (a common digestive disorder that causes abdominal pain and changes in bowel habits);</p> <p>- Start date: 4/19/24 - Rivastigmine tartrate 1.5 mg, one capsule twice daily for Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and the ability to carry out the simplest tasks).</p> <p>Review of the resident's medication administration record (MAR), dated May 2024 showed:</p> <p>- Linzess 145 mcg. one capsule daily for irritable bowel syndrome;</p> <p>- Rivastigmine tartrate 1.5 mg. one capsule twice daily for Alzheimer's disease.</p> <p>Observation on 5/8/24 at 6:55 A.M., showed:</p> <p>- CMT A did not wash his/her hands and used her bare hands and pulled the capsules apart and placed them in pudding;</p> <p>- At 7:11 A.M., CMT A administered the medication to the resident.</p> <p>During an interview on 5/9/24 at 9:38 A.M., CMT A said:</p> <p>- He/she should not touch medications with his/her bare hands.</p> <p>During an interview on 5/9/24 at 3:12 P.M., the Administrator and the DON said:</p> <p>- Staff should not handle medications with their bare hands.</p> <p>-Staff should not administer medication that had fallen on the floor.</p> <p>-Medication that fell to the floor should be disposed of and new medication obtained.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>44395</p> <p>Based interview, the facility failed to establish an infection prevention and control program (IPCP) that included an antibiotic stewardship program that addressed antibiotic use protocols and a system to monitor antibiotic use. The facility census was 66.</p> <p>The facility did not provided a policy regarding infection control and prevention.</p> <p>Review of Resident #50 Quarterly Minimum Data Set (MDS:a federally mandated assessment tool completed by facility staff) dated 3/1/24 showed:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) of 15, indicated no cognitive deficit. -Dependent for Activities of Daily Living (ADL's: tasks performed in a day to care for oneself) <p>Occasionally Incontinent of bowel and bladder.</p> <ul style="list-style-type: none"> -Diagnoses of cerebral infarction (loss of blood flow to part of the brain: a stroke), cardiovascular disease (heart disease), muscle spasms. cystitis (urinary tract infection). <p>Review of the resident's comprehensive Care Plan dated 3/13/24 showed:</p> <ul style="list-style-type: none"> -Report any signs and symptoms of urinary tract infection (urgency, burning, pain, nausea, chills, fever, low back pain, foul odor, blood in urine, concentrated urine). <p>Review of the resident's May Physician Order Sheets showed:</p> <ul style="list-style-type: none"> -Urgent Urinalysis with culture and sensitivity order date 5/2/24 -Amoxicillin-potassium-clavulanate 875 milligrams (mg)/125 mg tablet, twice a day for seven days for Urinary Tract Infection. Order date 5/7/24. <p>During an interview on 5/08/24 at 2:03 PM the Administrator said:</p> <ul style="list-style-type: none"> -The Director of Operations was running reports off site of residents on antibiotics -No one was completing the mapping or tracking of infections. -There is no Antibiotic Stewardship Program at this time. -An Assistant Director of Nursing had been hired, had not started, but would be responsible for the IPCP and Antibiotic Stewardship.

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>47195</p> <p>Based on record review and interview, the facility failed to ensure they maintained documentation to show they provided training to their staff regarding what constitute abuse, neglect, exploitation and misappropriation of resident property, procedures for reporting incidents of abuse, neglect, exploitation, or misappropriation of resident property and dementia management and resident abuse prevention. The facility census was 66.</p> <p>The facility did not provide documentation to show they provided training to all staff on abuse, neglect, exploitation and misappropriation of resident property when requested.</p> <p>During an interview on 5/8/24 at 5:31 A.M., Nurse Aide (NA) A said:</p> <p>-He/She had worked at facility a couple of months;</p> <p>-He/She had not had any abuse and neglect training at the facility;</p> <p>-His/Her training involved staff showing him around to every resident, showing him/her supplies, learning what he/she needed to fill out, and telling him/her what he/she could and could not do.</p> <p>During an interview on 5/9/24 at 2:25 P.M., Certified Medication Technician (CMT) B said he/she had not had any training at facility.</p> <p>During an interview on 5/9/24 at 2:38 P.M., Certified Nurse Aide (CNA) A said he/she did have training on abuse and neglect as part of his/her training at facility.</p> <p>During an interview on 5/9/24 at 11:40 A.M., Administrator said:</p> <p>-He/She had not done any abuse and neglect training since he/she became administrator in March;</p> <p>-He/She saw that training had been provided in October 2023 but could not locate any inservice sheets showing staff had been trained.</p> <p>During an interview on 5/9/24 at 11:47 A.M Business Office Manager said he/she could not locate inservices on abuse and neglect.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>47195</p> <p>Based on interview and record review, the facility failed to ensure the nurse aides (NA) had a minimum of 12 hours of in-service education (which included abuse, neglect, and dementia care) per year by not providing documentation of these in-services for three of three randomly selected nurse aides. The facility census was 66.</p> <p>Review of facility policy, Abuse Prevention Program, dated 1/30/24, showed:</p> <p>-Mandated staff training/orientation programs that include such topics as abuse prevention, identification, and reporting of abuse, stress management, dealing with violent behavior, or catastrophic reactions, and dementia management.</p> <p>Facility did not provide documentation of abuse and neglect or dementia education.</p> <p>During an interview on 5/8/24 at 5:31 A.M., NA A said:</p> <p>-He/She had not had any abuse and neglect training;</p> <p>-He/She had not received any dementia care training.</p> <p>During an interview on 05/09/24 at 1:29 P.M., NA C said:</p> <p>-He/She has not had any training on Abuse and Neglect at this facility;</p> <p>-He/She had training on dementia care.</p> <p>During an interview on 5/15/24 at 2:31 P.M., NA E said:</p> <p>-He/She did not get any training on abuse and neglect or dementia care.</p> <p>During an interview on 5/9/24 at 11:40 A.M., Administrator said:</p> <p>-He/She could not locate any documentation of inservices or education on abuse and neglect or dementia care.</p> <p>-He/She had not done any training with staff since he/she had become administrator in March.</p> <p>During an interview on 5/9/24 at 11:47 A.M., Business Office Manager said:</p> <p>-He/She could not locate any inservices on abuse and neglect or dementia care.</p>		