| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265721 | A. Building<br>B. Wing | 05/09/2024 |

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| Gregory Ridge Health Care Center | 7001 Cleveland Avenue<br>Kansas City, MO 64132 |

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|---|---|
| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003<br><br>Based on interview and record review, the facility failed to ensure there was appropriate documentation in the medical record for one sampled resident (Resident #2) related to his/her transfer and discharge out of seven sampled residents. The facility census was 108 residents.<br><br>1. Review of Resident #2's Pre Admission Screening and Resident Review (PASRR-a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) dated 10/22/21, showed:<br><br>-The resident was evaluated for placement in a long term care nursing facility.<br><br>-Public Administrator was the resident's legal guardian.<br><br>-The resident had psychiatric symptoms of delusions, hallucinations, paranoia, disorganized thoughts, agitation, irritability and was uncooperative with cares.<br><br>-The resident had persistent psychosis despite changes in antipsychotic medications and continued to experience paranoia, disorganized thoughts and manipulative behavior regarding taking medications.<br><br>-The resident had multiple hospitalization s for psychiatric treatment, most recently for treatment of schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation).<br><br>-Resident had a history of being dangerously combative towards staff at treatment centers and facilities-staff were informed to exercise caution when interacting with the resident.<br><br>Review of the resident's Face Sheet showed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors), mood disorder (a group of mental conditions characterized by persistent disturbance of mood, especially in the form of depression or euphoria or a combination of these), and anxiety disorder (mental conditions characterized by excessive fear of or apprehension about real or perceived threats, leading to altered behavior and often to physical symptoms such as increased heart rate or muscle tension).<br><br>(continued on next page) |

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

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

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 9/16/23, showed the resident:<br><br>-Was alert and oriented with minimal confusion.<br><br>-Was independent with bed mobility, ambulation, dressing, eating, toileting and was continent.<br><br>-Had no mood symptoms, but had psychosis, hallucinations, delusions, behavioral symptoms and verbal behaviors that affected activity participation.<br><br>-Received antipsychotic and anti-anxiety medications during the lookback period.<br><br>Review of the resident's Care Plan dated 10/2/23, showed the resident had a history of mental illness with frequent psychiatric hospitalization s, had behavioral challenges that required protective oversight in a secure setting, had a mood problem and manifestations of behaviors such as hallucinations and delusions that may create disturbances that affect others (and could be physically aggressive toward staff and residents).<br><br>-He/She had a guardian to assist in decision making due to his/her mental illness and at this time, the resident's PASARR deemed the resident to be safe for admission to a long term care facility. Care plan interventions showed staff would:<br><br>-Administer and monitor medications as ordered and administer as needed medications when non-pharmacological interventions were not effective.<br><br>-Monitor and document side effects/effectiveness of medication and notify the physician.<br><br>-Monitor, document and report any risks for harm to self or others, acute sadness, loss of interest/pleasure in activities, feelings of worthlessness/guilt, change in appetite/eating, change in sleeping patterns, diminished ability to concentrate and change in psychomotor skills. Report changes to the physician per behavior monitoring protocols.<br><br>-Observe for signs and symptoms of mania racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, marked change in need for sleep, agitation or hyperactivity.<br><br>-Monitor and record mood to determine if problems seem to be related to external causes, and assist the resident in addressing the root cause of changes in his/her behavior or mood.<br><br>-Give positive feedback for good behavior.<br><br>-If the resident was disturbing others, encourage him/her to go to a private area to voice concerns/feelings to assist in decreasing episodes of disturbing others.<br><br>-Notify the resident's guardian as needed for involvement. Provide one to one interventions as needed.<br><br>-Provide long-term psychiatric/psychological management and counseling as needed.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Psychiatrist will consult for medication adjustments as needed/ordered.<br><br>-Pharmacy will review medications monthly and as needed.<br><br>Review of the resident's Mental Status Exam dated 10/6/23, showed:<br><br>-The resident was assessed for complaints of sleep, mood, anxiety, delusions and medication reconciliation. The resident continued to have delusions and aggressive behaviors on his/her current medications.<br><br>-His/her cognitive status appeared to be within normal range. The resident was able to comprehend, share information and respond appropriately to questions asked, his/her concentration, long and short-term memory was intact, but his/her insight and judgement was impaired.<br><br>-Documentation showed in general, the resident was alert and interactive, groomed and cooperative, his/her thought processes were logical, intact and his/her mood and affect were appropriate.<br><br>-The psychiatrist made a change to the resident's medication with continued monitoring.<br><br>Review of the resident's Nursing Notes showed:<br><br>-Nursing staff documented the resident had several refusals to take his/her medications, refusing assessments, vital signs and being uncooperative with staff requests from 9/8/23 to 10/21/23.<br><br>-On 9/13/23 the physician documented staff reported physical aggression toward staff by the resident. The Psychiatrist was notified and ordered PRN (as needed) medication to assist with unstable mood. Staff has been assigned to sit and monitor the resident to prevent further behaviors. The resident has been referred for behavior therapy.<br><br>-On 9/26/23 contact with the Guardian who was trying to get medical records from the previous facility regarding the resident.<br><br>-On 9/29/23 resident showed aggression toward staff and residents. The physician was notified and ordered PRN (as needed) Ativan, 2 milligrams (gm) injection twice daily for 14 days.<br><br>-On 10/2/23 the resident punched and scratched staff in the face after the resident was told he/she had to wait for the lunch tray to be delivered. Resident was unable to be re-directed and staff physically had to restrain the resident using trained technique. The Psychiatrist was notified and ordered PRN medication to assist with unstable mood. Resident referred for behavior therapy. Contact with the Guardian regarding resident's aggression and notified the facility placed a physical hold on the resident due to his/her level of aggression toward staff and the resident not being redirectable.<br><br>-On 10/8/23 resident was pacing and running up/down the halls, swinging arms, throwing fists, kicking walls and talking loudly to self but was not aggressive toward any staff or residents. Refused staff redirection (able to calm self) continued to pace and talk to self during shift.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 10/9/23 resident pacing halls yelling and cussing loudly, fighting and punching into the air, swinging arms and hands towards staff, tearing decorations off of the walls, punching halls outside of doors. Staff unable to redirect. He/She went to room and continued to cuss and talk loudly.<br><br>-On 10/12/23 resident physically aggressive toward staff and residents, hitting and kicking. Staff called for assistance and resident calmed when additional staff came to the unit. He/She went to his/her room and calmed with no further aggression noted.<br><br>-On 10/20/23 resident began displaying erratic behavior, pacing in room, mumbling to self. Resident calmed down and said he/she refused to take his/her medications due to delusional rationale. Staff called for orders to send the resident to the hospital and orders were given. The emergency services and local Police Department came to transport resident to the hospital.<br><br>-On 11/11/23 resident was readmitted to the facility from the hospital. Staff placed the resident on one to one monitoring for oversight protection. No behaviors noted at this time.<br><br>-On 11/20/23 the resident refused to take his/her medications and staff notified the physician and awaited new orders.<br><br>-On 11/22/23 contact to guardian that resident attempted to strike another resident and refused to take his/her medication. Notification also made to the physician. Resident was sent to the hospital for evaluation and treatment. The resident returned the same day to the facility with no new orders. The resident had no behavioral concerns.<br><br>-On 11/28/23 showed that since 9/8/23 the resident has refused medications six times with two psychiatric hospital admissions, both unsuccessful with medication adjustments. The resident continued to display physical aggression with psychotic behaviors such as punching the air, talking to self, showering while clothed, and destruction of facility property. Contact with the resident's guardian and the guardian suggested possible placement in a Department of Mental Health (DMH) facility due to the resident's diagnoses and continued behaviors. Resident was sent to the hospital for evaluation and treatment.<br><br>Review of the resident's Administrator Note dated 11/28/23 showed:<br><br>-The facility was transferring the resident to the hospital for evaluation and treatment post a paranoid episode where the resident believed he/she was being poisoned by the food, believed he/she was [AGE] years old and it was currently 1980. The resident became physically aggressive toward staff and the physical restraint technique was implemented and a PRN was ordered to manage his/her behavior. They notified the resident's guardian who requested they send the resident to the behavioral hospital and to see if there were any DMH facilities that would accept the resident for placement.<br><br>Review of the resident's MDS record showed the resident was discharged to the hospital on 11/28/23, return anticipated.<br><br>Review of the resident's Nursing Notes showed:<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 12/28/23 the Social Service Designee contacted the resident's guardian who notified him/her that the resident was still in the hospital. The resident was physically aggressive with hospital staff, giving one staff a concussion on 12/23/23. The Social Service Designee discussed the resident's current status (the resident has been discharged from the facility for more than 30 days) and it is possible the resident's bed would be filled.<br><br>Review of the resident's Administrator Note dated 1/3/24 showed:<br><br>-The Administrator spoke with the resident's guardian to discuss the resident's current status. The resident had been discharged from the facility for more than 36 days and is having increased concerns while in the hospital. The Administrator notified the guardian that the resident's bed could be filled by another referral since the resident had been gone for over 30 days. The guardian reported no concerns with the resident's discharge.<br><br>Review of the resident's facility medical record showed:<br><br>-There were no further notes in the resident's medical record regarding the resident discharging from the facility or if/when he/she would be returning to the facility.<br><br>-The was no documentation showing the resident was discharged from the hospital and returned to the facility after 1/3/24.<br><br>-There were no readmission assessments or notes after 11/11/24 when the resident last readmission occurred.<br><br>-There was no discharge summary in the resident's medical record nor was there any documentation showing the resident was provided with a 30 day bed hold notice upon discharge to the hospital on 11/28/23.<br><br>-There was no letter pertaining to the resident's discharge and his/her appeal rights.<br><br>Review of the resident hospital record Emergency Department Note 1/19/24 7:24 P.M. showed:<br><br>-The Director of Nursing (DON) was contacted at the facility number and said the resident had been gone so long that the resident was discharged . When the resident arrived back to the facility there were no beds for there resident and the could not be accepted. The facility had an interim Administrator and the prior Administrator was no longer there. The DON provided the Administrator personal phone number and the social worker personal phone number. The DON said he/she did not know about any notice provided to the resident and to contact the facility social worker. The resident/guardian was not issued a discharge letter.<br><br>During an interview on 5/10/24 at 10:45 A.M. the DON said:<br><br>-The resident was initially admitted to the facility on [DATE].<br><br>-The resident had several psychiatric hospitalization s during his/her stay in the facility due to his/her combative and unsafe behaviors.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident was discharged to the hospital for behavioral evaluation and treatment on 11/28/23 due to the resident having increased physical aggression towards residents, staff, refusing all of his/her medications and he/she began destroying facility property.<br><br>-The resident's guardian was notified of the resident's behaviors and agreed to sending the resident to the hospital.<br><br>-The resident had not been back to the facility since 11/28/23 and to his/her knowledge, the resident's guardian was trying to find placement in other local towns and was not going to return the resident to the facility on ce he/she was discharged from the hospital.<br><br>-The resident was not coming back to the facility and to his/her knowledge, the resident never came back to the facility after 11/28/24.<br><br>During an interview on 5/10/24 at 1:39 P.M. The guardian said:<br><br>-The facility sent the resident to the hospital behavioral health center for evaluation and treatment on 11/28/23 due to resident behaviors.<br><br>-Somehow the hospital staff were informed that the facility would not be accepting the resident back because they no longer had a bed available for the resident on the same sex unit (where the resident resided).<br><br>During an interview on 5/10/24 at 2:31 P.M. the DON said:<br><br>-When he/she spoke with the Social Worker at the hospital (unknown date), the hospital Social Worker told her that they were looking to place the resident at a DMH facility because she was no longer appropriate for long term care.<br><br>-He/She had no knowledge of the hospital discharging the resident back to the facility and did not recall receiving any correspondence or discharge documentation from the hospital for the resident's readmission.<br><br>During an interview on 5/10/24 at 2:41 P.M. Hospital Social Worker said:<br><br>-The resident was initially admitted from the facility on 11/28/23.<br><br>-They treated the resident and the resident was stabilized by 1/19/24 and was having no further behaviors and so they were ready to discharge the resident back to the facility.<br><br>-When they discharged the resident back to the facility on [DATE], they were told that they did not have a bed for the resident and the facility sent the resident back to the hospital via the emergency roiagnom on the same day.<br><br>-Their legal department had to get involved because the facility was not accepting the resident for readmission.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She contacted the resident's Guardian who said that the facility was not going to accept the resident back and they needed to try to find another placement for the resident.<br><br>-They have been trying to find a level II placement for the resident but have been unsuccessful to date.<br><br>During an interview on 5/9/24 at 3:11 P.M., the Social Service Designee said:<br><br>-They sent the resident to the hospital on 11/28/23 because the resident was a threat to others. He/She was physically aggressing on and fighting the staff, all of the residents on his/her unit were afraid of him/her and the resident was a danger and threat to others.<br><br>-He/She did not believe they were going to accept the resident back, but he/she was not sure about that.<br><br>During an interview on 5/9/24 at 3:58 P.M. with the Administrator and DON, the DON said :<br><br>-There had been some discussion between the former Administrator, guardian and hospital staff after the resident was in the hospital (past 30 days of hospitalization ).<br><br>-The former Administrator said they would not accept the resident back into the facility due to the danger to the residents and staff and because the resident was still having violent acts in the hospital.<br><br>-The former Administrator did not continue to write any notes regarding the re-admission or decision not to readmit the resident.<br><br>-He/She was unable to find a copy of the bed hold document that was supposed to be provided to the resident upon his/her transfer to the hospital.<br><br>-There was no documentation in the resident medical record regarding the resident discharge. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003<br><br>Based on interview and record review, the facility failed to ensure one sampled resident (Resident #2) or his/her guardian received a notice of the bed hold policy out of 7 sampled residents. The facility census was 108 residents.<br><br>Review of the facility Bed Hold policy and procedure dated 7/27/2018, showed:<br><br>-When a resident is admitted to the facility, they receive a copy of the bed hold policy.<br><br>-When a resident is discharged to the hospital or goes on therapeutic leave, the facility will provide to the resident or legal representative, a copy of the bed hold policy.<br><br>-Following a hospitalization or therapeutic leave, the resident will be admitted if they require the services of the facility and is eligible for Medicare or Medicaid services.<br><br>-When a resident is admitted to the facility following a hospitalization or therapeutic leave and did not have a bed hold or exceeds the bed hold days, the resident will be returned to their previous room if available. If their previous room is not available, they should be given the first available room.<br><br>1. Review of Resident #2's Face Sheet showed he/she was admitted on [DATE] with diagnoses including schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors), mood disorder (a group of mental conditions characterized by persistent disturbance of mood, especially in the form of depression or euphoria or a combination of these), anxiety disorder (mental conditions characterized by excessive fear of or apprehension about real or perceived threats, leading to altered behavior and often to physical symptoms such as increased heart rate or muscle tension), high blood pressure, and hyperthyroidism (the production of too much thyroxine hormone).<br><br>Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment tool to be completed by facility staff for care planning) dated 9/16/23, showed the resident:<br><br>-Was alert and oriented with minimal confusion.<br><br>-Was independent with bed mobility, ambulation, dressing, eating, toileting and was continent.<br><br>-Had no mood symptoms, but had psychosis, hallucinations, delusions, behavioral symptoms and verbal behaviors that affected activity participation.<br><br>-Received antipsychotic and anti-anxiety medications during the look back period.<br><br>Review of the resident's Care Plan dated 10/2/23, showed the resident had a legal guardian.<br><br>Review of the resident's Administrator Note dated 11/28/23 showed:<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The facility was transferring the resident to the hospital for evaluation and treatment post a paranoid episode where the resident believed he/she was being poisoned by the food, believed he/she was [AGE] years old and it was currently 1980. The resident became physically aggressive toward staff and the physical restraint technique was implemented and a as needed medication was ordered to manage his/her behavior. They notified the resident's guardian who requested they send the resident to the behavioral hospital and to see if there were any Department of Mental Health (DMH) facilities that would accept the resident for future placement.<br><br>Review of the resident's MDS record showed the resident was discharged to the hospital on 11/28/23, return anticipated.<br><br>Review of the resident's Nursing Notes showed:<br><br>-On 12/28/23 the Social Service Designee (SSD) contacted the resident's guardian who notified him/her that the resident was still in the hospital. The SSD discussed the resident's current status (the resident has been discharged from the facility for more than 30 days) and it is possible the resident's bed would be filled.<br><br>Review of the resident's Administrator Note dated 1/3/24 showed:<br><br>-The Administrator spoke with the resident's guardian to discuss the resident's current status. The resident had been discharged from the facility for more than 36 days and is having increased concerns while in the hospital. The Administrator notified the guardian that the resident's bed could be filled by another referral since the resident had been gone for over 30 days. The guardian reported no concerns with the resident's discharge.<br><br>Review of the resident's facility medical record showed:<br><br>-There were no further notes in the resident's medical record regarding the resident discharging from the facility or if/when he/she would be returning to the facility.<br><br>-The was no documentation showing the resident was discharged from the hospital and returned to the facility after 1/3/24.<br><br>-There were no readmission assessments or notes after 11/11/24 when the resident last readmission occurred.<br><br>-There was no discharge summary in the resident's medical record nor was there any documentation showing the resident was provided with a 30 day bed hold notice upon discharge to the hospital on 11/28/23.<br><br>During an interview on 5/10/24 at 1:39 P.M. the resident's guardian said:<br><br>-The facility sent the resident to the behavioral health center for evaluation and treatment on 11/28/23 due to increased behaviors.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Somehow the hospital staff were informed that the facility would not be accepting the resident back because they no longer had a bed available for the resident on their same sex unit (where the resident resided).<br><br>-Once the hospital was ready to discharge the resident, it was past the facility's 30-day bed hold timeframe.<br><br>-The hospital staff took the resident to the facility and dropped the resident off at the door of the facility. He/She did not recall the date this occurred.<br><br>-The facility staff sent the resident back to the hospital via ambulance on the same day and the resident has been in the hospital ever since then, still receiving treatment.<br><br>-At this time they do not plan to send the resident back to the facility.<br><br>-The facility provided no documentation of the bed hold policy.<br><br>During an interview on 5/10/24 at 2:41 P.M. Hospital Social Worker said:<br><br>-The resident was initially admitted from the facility on 11/28/23.<br><br>-They treated the resident and he/she was stabilized by 1/19/24 and was having no further behaviors and so they were ready to discharge the resident back to the facility.<br><br>-When they discharged the resident back to the facility on [DATE], they were told that they did not have a bed for the resident and the facility sent the resident back to the hospital via the emergency roiagnom on the same day.<br><br>-Their legal department had to get involved because the facility was not accepting the resident for readmission.<br><br>-He/she contacted the resident's guardian who said that the facility was not going to accept the resident back and they needed to try to find another placement for the resident.<br><br>-They have been trying to find a placement for the resident but have been unsuccessful to date.<br><br>During an interview on 5/9/24 at 3:58 P.M. with the Administrator and Director of Nursing (DON), the DON said:<br><br>-There had been some discussion between the former Administrator, guardian and hospital staff after the resident was in the hospital (past 30 days of hospitalization ).<br><br>-The former Administrator said they would not accept the resident back into the facility due to the danger to the residents and staff and because the resident was still having violent acts in the hospital.<br><br>-The former Administrator did not continue to write any notes regarding the re-admission or decision not to readmit the resident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265721 | A. Building<br>B. Wing | 05/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gregory Ridge Health Care Center | 7001 Cleveland Avenue<br>Kansas City, MO 64132 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/she was unable to find a copy of the bed hold document that was supposed to be provided to the resident upon his/her transfer to the hospital.<br><br>-There was no documentation regarding the bed hold policy was given to the resident guardian for the guardian to make decisions and it would have been the responsibility of the Administrator.<br><br>MO00235790 |