

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265721	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Gregory Ridge Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 Cleveland Avenue 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955</p> <p>Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #9) was free from abuse. On 7/12/24 a Certified Nursing Assistant (CNA) E pushed the resident into a corner and pinned him/her so he/she could not move out of 26 sampled residents. The facility census was 109 residents.</p> <p>On 7/24/24, the facility Administration was notified of the past noncompliance which occurred on 7/12/24. Facility staff were educated on abuse and neglect protocols and customer service. The deficiency was corrected on 7/14/24.</p> <p>Review of the facility's Abuse and Neglect Policy, reviewed and revised on 6/12/24, showed:</p> <ul style="list-style-type: none"> -Abuse was defined as a willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. -Physical abuse included handling a resident with any more force than was reasonable for a resident's proper control, treatment, or management. -Mistreatment was inappropriate treatment or exploitation of a resident. <p>1. Review of the facility's Registered Nurse (RN) investigation, dated 7/13/24, showed:</p> <ul style="list-style-type: none"> -The incident of alleged abuse occurred on 7/12/24 at 11:00 P.M. -Persons involved were CNA E and the resident. -Video surveillance was obtained which showed CNA E charged at the resident and pushed him/her into a wall. -The local police department was contacted and responded to the building. -CNA E was sent home. -The resident was assessed with no injury. <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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/23/24 at 11:16 A.M., the resident said:</p> <ul style="list-style-type: none"> -CNA E liked to aggravate him/her. -CNA E was hateful. -CNA E tried to push him/her into his/her room. -He/She did not know how it happened. -He/She felt sad as if he/she had lost a kitten. <p>Observation and record review on 7/23/24 at 12:25 P.M. of a 29 second video (undated or time stamped) recording without audio showed:</p> <ul style="list-style-type: none"> -The resident was standing in a corner between the wall and a door to the shower room. -There was a trash can next to the resident. -LPN A (agency) had his/her back to the camera and was standing at a med cart. -At approximately seven seconds into the video Resident #3 came into the frame and opened the door to the shower room but did not go in. -At approximately 17 seconds into the video Resident #9 pushes the trash can and Resident #3 turned around and started to walk away as CNA E came into the frame and pushed Resident #9 into the corner. -Resident #3 walked out of the frame. -Resident #14 opened the shower room door from the inside. -The video ended at 29 seconds with Resident #9 being held in the corner of the room by CNA E. <p>During an interview on 7/23/24 at 12:52 P.M., LPN A said:</p> <ul style="list-style-type: none"> -He/She saw the resident standing by the trash can. -The resident was standing where he/she was not supposed to be standing. -CNA E told the resident to move. -CNA E came from no where and pushed the resident into the corner of the room with his/her body and just stood there. -CNA E held the resident in the corner for a few seconds. <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-CNA E told LPN A the resident pushed the trash can at him/her and he/she had to hold the resident in the corner for self-defense.</p> <p>-The resident was not injured and did not ask for pain medications.</p> <p>Review of Resident #14's annual MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>During an interview on 7/24/24 at 11:46 A.M., Resident #14 said:</p> <p>-He/She was in the shower room and heard something banging on the shower room door.</p> <p>-He/She opened the door and saw Resident #9 kicking the door.</p> <p>-He/She could not get out of the shower room as it was blocked.</p> <p>-He/She heard Resident #9 say, you can't touch me as CNA E was trying to get the resident away from the door.</p> <p>-Resident #9 was not crying, just yelling a lot.</p> <p>During an interview on 7/25/24 at 3:26 P.M., the Administrator said:</p> <p>-On 7/12/24, a little before midnight, the Director of Nursing (DON)called and told him/her about the incident and said to watch the video.</p> <p>-He/She watched the video and saw CNA E push the resident into the wall.</p> <p>-In an interview CNA E said he/she reacted to the resident pushing the trash can at him/her.</p> <p>During an interview on 7/25/24 at 4:25 P.M., CNA E said:</p> <p>-It all started in the TV room.</p> <p>-He/She saw the resident pick up a chair and threw it at him/her.</p> <p>-Later on, he/she saw the resident messing with the trash barrels.</p> <p>-He/She went over to keep the resident from messing with them.</p> <p>-The resident pushed a barrel into him/her and believed the resident was going to tip over the barrel.</p> <p>-He/She was trying to keep the resident from tipping it over.</p> <p>-He/She moved the resident against the shower room door and told him/her not to be tipping over the trash barrels.</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 - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955</p> <p>Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for two sampled resident (Resident #12 and Resident #13) out of 26 sampled residents. The facility census was 109 residents.</p> <p>Review of the facility's Medication Administration dated 4/6/17, revised on 6/26/24 and Reordering policy dated 5/18/24 showed:</p> <ul style="list-style-type: none"> -Medications are to be given per doctor's orders. -All medications are recorded on the Medication Administration Record (MAR) and signed immediately after the resident has taken the medications. -The nurse or Certified Medication Technician (CMT) will check each medication to the MAR noting the correct name of the medication, correct resident name, correct dose, correct time, and correct route of administration. -Report and document any adverse side effects or if the medication is refused. -Correct any discrepancies and report to nurse manager. -To accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications in a timely manner to meet the needs of each resident. -Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. -Each time a nurse is administering medications and observes six or less doses left of one kind, that nurse will reorder the medication, time permitting. -The nurse and/or CMT that was assigned to each medication cart will perform a medication cross match weekly. -In the event of new orders, the facility is allowed 24 hours to begin a medication unless otherwise specified by the physician. <p>1. Review of Resident #12's Admission Record showed he/she was admitted on [DATE] and readmitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Seizures. -Schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions and relate to others). <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 - Few</p>	<p>Review of the resident's Order Summary Report, MAR, dated July 2024 showed:</p> <p>-Haloperidol 5 mg Tablet give one tablet by mouth in the morning related to schizophrenia, started on 8/28/21.</p> <p>--Haloperidol 5 mg Tablet morning dose was not documented as not given four doses between 7/2/24 to 7/5/24.</p> <p>---Administration notes show the medication is on order waiting on pharmacy to deliver.</p> <p>-Haloperidol 5 mg Tablet give one tablet by mouth in the afternoon related to schizophrenia, started on 8/27/21.</p> <p>--Haloperidol 5 mg Tablet afternoon dose was not documented as not given three doses between 7/2/24 to 7/5/24.</p> <p>---Administration notes show the medication is on order waiting on pharmacy to deliver.</p> <p>-Vimpat 200 mg Tablet give one tablet orally two times a day related to seizures, started on 5/21/24.</p> <p>--Vimpat 200 mg Tablet both daily doses were not documented as not given on 7/16/24 and 7/21/24 and one afternoon dose was missed on 7/10/24.</p> <p>---Administration notes show the medication is on order waiting on pharmacy to deliver.</p> <p>Review of the resident quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 7/10/24 showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Had diagnosis of seizures, schizophrenia, schizoaffective disorder bipolar type and depression.</p> <p>During an interview on 7/23/24 at 1:27 P.M., the resident said:</p> <p>-He/She had not been getting his/her medication.</p> <p>-He/She would like to get his/her medication so he/she does not have problems being off the medications.</p> <p>2. Review of Resident #13's Admission Record showed he/she was admitted on [DATE] with the diagnosis of Diabetes Mellitus II (a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).</p> <p>Review of the resident's Care Plan dated 6/30/21 showed he/she:</p> <p>-Had Diabetes Mellitus II.</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 - Few</p>	<p>-Administer medications as ordered by doctor.</p> <p>-Identify areas of non-compliance or other difficulties in resident diabetic management.</p> <p>Review of the resident's annual MDS dated [DATE] showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Had diagnosis of diabetes.</p> <p>Review of the resident's Order Summary Report dated June 2024 showed:</p> <p>-Accuchecks (test the level of sugar in the blood) two times a day for diabetes related to Type II Diabetes Mellitus without complications, started on 5/16/24.</p> <p>-Accucheck in A.M. and record findings in the morning related to Type II Diabetes Mellitus without complications, started 5/26/24.</p> <p>-Check blood sugars daily in the morning. Call doctor for blood sugar greater than 400 one time daily for diabetes, started 2/13/24.</p> <p>-Januvia Oral 50 mg Tablet give 100 mg by mouth one time a day for diabetes related to Type II Diabetes Mellitus without complications, started on 5/17 /24.</p> <p>-Lantus Subcutaneous Solution 100 Unit/milliliters (ml)(insulin) inject 10 units subcutaneously (is the insertion of medications beneath the skin by injection or infusion) at bedtime for diabetes. Obtain accucheck prior to administering Lantus, started on 3/11/24.</p> <p>Review of the resident's MAR dated June 2024 showed:</p> <p>-Accuchecks were not documented as being completed at 8:00 A.M. or 4:00 P.M. on 6/2/24, 6/3/24, 6/8/24, 6/9/24, 6/21/24, 6/23/24,6/28/24 and 6/29/24.</p> <p>-Accuchecks were not documented as being completed at 4:00 P.M. on 6/13/24 and 6/14/24.</p> <p>-Januvia Oral 50 mg Tablet give 100 mg was not given on 6/29/24 and 6/30/24 due to medication being on order.</p> <p>-Lantus Subcutaneous Solution 100 Unit/ml inject 10 units subcutaneously at bedtime was documented as being refused on 6/2/24, 6/9/24 and 6/16/24.</p> <p>-Lantus Subcutaneous Solution 100 Unit/ml inject 10 units subcutaneously at bedtime was not documented as being given on 6/8/24, 6/14/24, 6/15/24 and 6/26/24.</p> <p>--NOTE: No accuchecks results were recorded to see what the resident's blood sugar was at prior to administering the resident's bedtime Lantus.</p> <p>Review of the resident's Order Summary Report dated July 2024 showed:</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 - Few</p>	<p>-Accuchecks two times a day for diabetes related to Type II Diabetes Mellitus without complications, started on 5/16/24.</p> <p>-Accucheck in A.M. and record findings in the morning related to Type II Diabetes Mellitus without complications, started 5/26/24.</p> <p>Check blood sugars daily in the morning. Call doctor for blood sugar greater than 400 one time daily for diabetes, started 2/13/24.</p> <p>-Januvia Oral 50 mg Tablet give 100 mg by mouth one time a day for diabetes related to Type II Diabetes Mellitus without complications, started on 5/17 /24.</p> <p>-Lantus Subcutaneous Solution 100 Unit/ml inject 10 units subcutaneously at bedtime for diabetes. Obtain accucheck prior to administering Lantus, started on 3/11/24.</p> <p>Review of the resident's MAR dated July 2024 showed:</p> <p>-Accuchecks were documented as being refused by resident at 8:00 A.M. on 7/1/24, 7/7/24, 7/8/24, 7/12/24, 7/13/24, 7/14/24 and 7/24/24, and 4:00 P.M. on 7/5/24, 7/7/24, 7/8/24, 7/13/24, 7/19/24, and 7/22/24.</p> <p>-Accuchecks were not documented as being completed at 8:00 A.M. on 7/8/24 and at 4:00 P.M. on 7/4/24, 7/5/24, 7/8/24, 7/14/24, 7/19/24 and 7/22/24.</p> <p>-Januvia Oral 50 mg Tablet give 100 mg was not given on 7/1/24, 7/2/24, 7/3/24, 7/8/24, 7/9/24 and 7/20/24 due to medication being on order.</p> <p>-Lantus Subcutaneous Solution 100 Unit/ml inject 10 units subcutaneously at bedtime was not documented as being given on 7/5/24.</p> <p>--NOTE: No accuchecks results were recorded to see what the resident's blood sugar was at prior to administering the resident;s bedtime Lantus.</p> <p>Review of the resident's Progress Note dated 7/16/24 showed he/she:</p> <p>-Had a visit with the Nurse Practitioner (NP).</p> <p>-Reported to NP that his/her blood sugars were improved.</p> <p>-No documentation the the NP was notified the resident's accucheck refusals.</p> <p>During an interview on 7/23/24 at 1:43 P.M., the resident said:</p> <p>-The facility runs out of his/her diabetes medication often and that causes him/her to have high blood sugars.</p> <p>-He/She feels better when he/she get the diabetic medication as ordered.</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 - Few</p>	<p>During an interview on 7/25/24 at 2:25 P.M., CMT B said:</p> <ul style="list-style-type: none"> -He/She reorders medications when the resident has seven doses left. -If a resident is out of a medication, he/she will tell the nurse, so the nurse can notify the physician of the missed medication. -He/She calls the pharmacy to reorder all his/her resident's medication that way he/she knows the pharmacy received the order. -He/She does not like the electronic MAR and does not know how to reorder the medication on the MAR. The facility administration had offered to train him/her on reordering medications electronically, but he/she does not want to learn how to do that. -CMTs do the resident's accuchecks as ordered. <p>During an interview on 7/25/24 at 2:37 P.M., LPN B said:</p> <ul style="list-style-type: none"> -Medications are to be reordered within seven days of the last dose. -He/She has no problems getting medications from the pharmacy. -If a resident misses a dose, he/she would call the physician and follow any new orders if given. -He/She would then call the pharmacy to see why and when the missed medication was going to be delivered. -Monitor the resident for any adverse reactions to missing the medication. -Document outcomes in the resident's medical record. <p>During an interview on 7/25/24 at 2:53 P.M., Regional RN said:</p> <ul style="list-style-type: none"> -Nurses and CMTs are to reorder medications in a timely manner so the resident does not run out of his/her medications. -Should a resident run out of a medication the CMT was to notify the nurse so the nurse can notify the physician. -Both the nurse or CMT can call the pharmacy and see why and when the medication was going to be delivered. -Nurse should check the emergency kit to see if the medication can be pulled from the kit. -Nurses and CMTs do a weekly change over on the medication carts and low medications should be reordered at that time. -Document in the resident's medical record why the medication was missed. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265721	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Gregory Ridge Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 Cleveland Avenue Kansas City, MO 64132	

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>MO00238748</p>