

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 03/18/2025
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 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** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for one sampled resident (Resident #1). The facility failed to transcribe a physician's order for Eliquis (an anti-blood clotting medication) 5 milligrams (mg) twice a day (BID) orally (PO) from the resident's hospital discharge orders on 12/31/24 and subsequently failed to administer the medication as ordered out of four sampled residents. The facility census was 112 residents.</p> <p>Review of the facility's Transcription of Orders/Following Physician's Order policy revised on 5/18/24 showed:</p> <ul style="list-style-type: none"> -The purpose of this policy was to outline procedures in accurately transcribing physician's orders and to ensure all physician's orders were followed. -Upon receiving a physician's order via telephone, fax, written order, transcribed order of other, it would be documented in the resident's electronic medical records (EMR) in the orders section. -If the medication is unable to be started within 24 hours of the order, the prescribing physician should be notified and further orders obtained. -The Licensed Nurse will review medication administration records (MARS) and electronic treatment administration records (TARS) on a routine basis to monitor medications that were not administered to the resident due to unavailability, refusal, omission, etc. <p>1. Review of Resident #1's admission Record face sheet showed he/she was admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>The facility was unable to provide the Patient Discharge Medication Report from the resident's hospital discharge on [DATE].</p> <p>Review of the resident's physician's Order Summary Report for the facility dated 12/31/24 showed the resident did not have an order for Eliquis.</p> <p>Review of the Pharmacy Manifest dated 1/1/25 at 4:48 P.M. showed:</p> <ul style="list-style-type: none"> -The pharmacy had delivered Eliquis 5 mg tablets, quantity 32 tablets for the resident. -The signature of Licensed Piratical Nurse (LPN) A that medications were delivered. <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 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 Medication Administration Record (MAR) for 1/1/25-1/31/25 showed the resident did not receive any Eliquis.</p> <p>During an interview on 3/12/25 at 2:00 P.M., LPN A said:</p> <ul style="list-style-type: none"> -When a resident admits back to the facility, the nurse would put the orders in from the hospital for medications and follow up care. -The orders were then sent to medical records who would scan them as a back up in case something was missed. -Sometimes the residents did not come back with paperwork. -Usually the nurse would follow up with the doctor's office or hospital if the resident did not come back with orders. -Sometimes orders would come through the social worker. -If a doctor wanted a resident to go on a medication, they were supposed to send a copy of the order back with the resident. -The doctor's office should either call and give verbal orders or fax them, but they did not always do it. -All medicine came to the facility from the pharmacy at the front desk and from there it was dispersed to the various units. -There the medications were separated for each hall and staff from the halls would come and get their medication, or if someone from the front was going to the halls, they might deliver them to the halls -Sometimes a medication would come in and if there was no order for the medication, the nurse would call and find out if there was an order. -He/She would have given the Eliquis to a nurse or Certified Medication Technician (CMT) for that unit. -It would be on the nurse to find out if there was an order in Point Click Care (PCC) (an electronic charting system). -Residents should have paperwork when they came back from the hospital or appointments, but sometimes they did not. -The nurse should call the hospital or office to find out the orders in that case. -The nurse was responsible for entering the orders correctly. -He/She did not remember who he/she gave the Eliquis pills to for the resident's unit. <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 3/12/25 at 2:30 P.M. the Regional Nurse said:</p> <ul style="list-style-type: none"> -When a resident went out to a medical appointment or to the emergency department, he/she should come back with the paperwork for what he/she was seen for. They should bring paperwork from every appointment. -The charge nurse would review for new orders. -This should be audited by the Director of Nursing (DON) or nurse manager to check and make sure the orders were followed. -The facility had an interim DON and he/she had not done any audits since 12/24. -The physicians should also be notifying the resident's guardian if any changes were made. -The nurse who received the Eliquis from the pharmacy was unable to remember which staff person he/she gave it to. -The facility was unable to pinpoint which staff person took the Eliquis to the men's unit. <p>During an interview on 3/17/25 at 11:35 A.M. Physician B said:</p> <ul style="list-style-type: none"> -He/She had a copy of the resident's discharge summary from 12/31/24. The medication reconciliation stated Eliquis 5 mg, twice daily for 30 days, quantity of 60, no refills. -There was an order in the resident's discharge orders on 12/31/24 which was sent to the pharmacy. -It was unclear if the Eliquis was started after the resident was discharged on 12/31/24. -The resident was sent back to the facility with the prescription. -There was a concern for the resident might develop a pulmonary embolism. -The resident's Discharge summary dated [DATE] stated it was recommended the resident continue taking Eliquis 5 mg BID. -The resident had not had any outcome from not receiving the Eliquis. <p>During an interview on 3/17/25 at 10:00 A.M. the Nurse Practitioner said:</p> <ul style="list-style-type: none"> -He/She would get the hospital discharge record from PCC. -The facility should put the discharge record in PCC. -If it was sent back with the resident, the nurse should scan it and their office could get it that way. -The discharge documents should either be scanned or faxed to their office and placed in PCC. <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>-The resident was not taking Eliquis to his/her knowledge. Their office had not prescribed it.</p> <p>During an interview on 3/18/25 at 1:00 P.M. Physician A said:</p> <p>-His/her office did not order Eliquis for the resident.</p> <p>-It was his/her expectation that the facility would enter orders from the hospital appropriately and communicate with his/her office.</p> <p>During an interview on 3/18/25 at 2:00 P.M. the interim DON said:</p> <p>-He/She was working when the resident returned from the hospital, but he/she didn't remember when the resident came back.</p> <p>-It depended what time the resident arrived who would put the orders in the computer.</p> <p>-The residents typically would have paperwork from the hospital with them.</p> <p>-When a resident was admitted , they typically do vital signs, skin and body assessments before the orders are entered.</p> <p>-Whoever was working would enter the orders.</p> <p>During an interview on 3/18/25 at 2:20 P.M., the Administrator said:</p> <p>-Staff escorting a resident should ask for the hospital or office paperwork.</p> <p>-Sometimes the escort is not a CNA and may not know to ask for the paperwork.</p> <p>-The nurse that received the paperwork should enter the orders.</p> <p>MO00250874</p>		