

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 12/23/2024
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 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** 51303</p> <p>Based on observation, interview and record review, the facility failed to promote dignity for three sampled residents (Resident ##66, #78, and #98) by entering their room without knocking out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's policy Dignity and Respect revised 6/29/23 showed:</p> <ul style="list-style-type: none"> -The facility was to ensure every resident was treat with dignity and respect. -Every resident had the right to be treated with dignity and respect. <p>Review of the facility's policy Resident Rights revised 7/5/23 showed:</p> <ul style="list-style-type: none"> -The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility must protect and promote rights of each resident. -Personal privacy include accommodations, medical treatment written and telephone communications, personal care, visits, and meetings of family and resident groups. <p>1. Review of resident #66's Admission Record showed he/she was initially admitted to the facility on [DATE].</p> <p>Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 9/27/24 showed he/she was moderately cognitively intact.</p> <p>During an interview on 12/17/24 at 2:22 P.M. the resident said he/she felt disrespected because staff did not knock prior to entering his/her room.</p> <p>Observation on 12/17/24 at 2:23 P.M. showed Certified Medication Technician (CMT) B did not knock before entering for medication administration.</p> <p>Observation on 12/19/24 at 9:34 A.M. showed Certified Nursing Assistant (CNA) A entered the resident's room without knocking and gathered the residents dirty laundry.</p> <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>Observation on 12/20/24 at 9:08 A.M. showed the Maintenance Director and Maintenance Assistant entered the resident's room without knocking.</p> <p>2. Review of Resident #78's Admission Record showed he/she was admitted to the facility on [DATE].</p> <p>Review of the resident's Annual MDS dated [DATE] showed he/she was moderately cognitively impaired.</p> <p>During an interview on 12/17/24 at 10:19 A.M. the resident said:</p> <ul style="list-style-type: none"> -Staff would come busting through the door and did not knock. -He/She thought this was disrespectful. <p>Observation 12/17/24 at 10:32 A.M. Certified Nurse Aide (CNA) A entered the resident's room without knocking and stripped the bed.</p> <p>Observation on 12/20/24 at 9:12 A.M. the Environmental Services Assistant Supervisor entered the resident's room without knocking.</p> <p>3. Review of Resident #98's Admission Record showed he/she was initially admitted on [DATE].</p> <p>Review of the resident's annual MDS dated [DATE] showed he/she was cognitively intact.</p> <p>During an interview on 12/17/24 at 2:01 P.M. resident said staff did not knock before they would enter the room and were not always respectful.</p> <p>Observation on 12/20/24 at 09:07 A.M. Maintenance Director and Maintenance Assistant entered room without knocking.</p> <p>4. During an interview on 12/23/24 at 8:46 A.M. CMT C said:</p> <ul style="list-style-type: none"> -Staff round on residents every hour as a CMT. -Staff had been in-serviced on resident rights. -He/She would report a violation of resident rights to the charge nurse. -Staff were to knock and wait for an answer before entering resident's rooms. <p>During an interview on 12/23/24 at 8:50 A.M. CNA H said:</p> <ul style="list-style-type: none"> -Staff had been in-service on resident rights. -Staff were to knock and wait for answer before entering resident's rooms. <p>During an interview on 12/23/24 at 9:49 A.M. Licensed Practical Nurse (LPN) B said:</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>-He/She was in-serviced on resident rights upon hire.</p> <p>-Staff were to knock and wait for answer before entering resident's rooms.</p> <p>During an interview on 12/23/24 at 4:02 P. M. the Director of Nursing (DON) said:</p> <p>-Staff were in-serviced on resident rights.</p> <p>-Staff were to knock and wait for answer before entering resident's rooms.</p> <p>-He/She expected residents rights to be respected.</p>

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51303</p> <p>Based on interview and record review, the facility failed to provide written invitations and hold care plan meetings to ensure resident focused person-centered care for one sampled resident (Resident #26) out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of policy Comprehensive Care Plans revised 10/31/24 showed:</p> <ul style="list-style-type: none"> -The facility was to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment. -Person-centered care means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. -The care planning process would include an assessment of the resident's strengths and needs and would incorporate the resident's personal and cultural preferences in the development of goals of care. -The comprehensive care plan would be prepared by an interdisciplinary team, that included, but not limited to: <ul style="list-style-type: none"> --The Attending physician or non-physician practitioner. --The Resident Assessment Instrument (RAI - helps the facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan) Coordinator. --The Social Service Director (SSD). --The Registered nurse with responsibility for the resident. --The resident and the resident's representative, to the extent practicable. <p>1. Review of Resident 26's Admission Record showed the resident was admitted to the facility on [DATE].</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/15/24 showed he/she was cognitively intact.</p> <p>During an interview on 12/18/24 at 9:23 A.M. the resident said:</p> <ul style="list-style-type: none"> -He/She was not aware of care plan meetings or involved in the setting of goals. <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had not seen his/her care plan.</p> <p>-He/She would like to participate in the care planning process.</p> <p>During an interview on 12/19/24 at 8:44 A.M. Licensed Practical Nurse (LPN) B said:</p> <p>-Residents were to be invited to care plan meetings.</p> <p>-The Social Service Director (SSD) sent the invitations for care plan meetings to the guardians.</p> <p>-Staff were not made aware of when the care plan meetings were held.</p> <p>During an interview on 12/19/24 at 08:52 A.M. the SSD said:</p> <p>-He/She emailed invitations to the residents' guardians.</p> <p>-He/She would verbally notify the residents.</p> <p>-He/She would coordinate with the MDS Coordinator to see when the resident's quarterly care plan meeting would be scheduled.</p> <p>-He/She would usually document the verbal invitation to the resident in the resident's chart.</p> <p>Review of the resident's electronic medical record on 12/19/14 showed:</p> <p>-No documentation of written or verbal care plan invitations being provided to the resident.</p> <p>-No documentation of detailed care plan meetings being held which included the resident.</p> <p>During an interview on 12/23/24 at 9:26 A.M. the MDS Coordinator said:</p> <p>-The SSD sent the invitations for the care plan meetings.</p> <p>-The residents were to be invited.</p> <p>-If residents had not attended the guardian would be notified and the SSD, charge nurse, Director of Nursing (DON) or Administrator would follow up with the resident.</p> <p>During an interview on 12/23/24 at 9:49 A.M. with LPN B said:</p> <p>-The SSD sent the invitations for care plan meetings.</p> <p>-The residents were to be invited.</p> <p>During an interview on 12/23/24 at 4:02 P.M. the DON said:</p> <p>-He/She expected residents to participate in the development and implementation of the person-centered care plan.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was able to purchase items his/her family and/or guardian provided money to purchase in a timely manner for one sampled resident (Resident #108) out of 23 sampled residents. The facility census was 111 residents.</p> <p>1. Review of Resident #108's face sheet showed he/she was admitted to the facility on [DATE] and he/she had a guardian.</p> <p>Review of the resident's Progress Notes dated 11/6/24 showed:</p> <p>-He/She had been in the administrator's office asking if the funds to purchase a tablet and earphones had been received.</p> <p>-No further documentation related to the resident's funds or the status of purchasing a tablet and earphones.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/20/24 showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Had physical, verbal, and other behaviors 1-3 days during the lookback period.</p> <p>Review of the resident's Interdisciplinary Team Notes dated 11/21/24 showed:</p> <p>-A care plan meeting was held with the resident to discuss his/her cares.</p> <p>-The resident requested new clothes from guardian as well as a tablet with headphones.</p> <p>-Care plan meeting notes were faxed to the guardian.</p> <p>-No further documentation related to the resident's funds or the status of purchasing a tablet and headphones.</p> <p>Review of the resident's Behavior Notes dated 12/5/24 showed:</p> <p>-The resident had a behavior throwing a shoe at a staff member.</p> <p>-The guardian was called and said to hold off on getting the resident a tablet until his/her behaviors stop.</p> <p>During an interview on 12/19/24 at 1:19 P.M. the resident's guardian said:</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Money was sent to the resident's account on 11/4/24 for the purchase of a tablet. The amount sent was \$200.</p> <p>-He/She was not aware the resident did not have the tablet yet.</p> <p>-He/She did not tell staff to withhold the tablet from the resident for any reason or to not purchase the tablet and/or headphone for the resident due to resident behaviors.</p> <p>-He/She did not have record of staff calling the guardian's office to discuss with anyone in the office or get authority from anyone in the office to withhold purchasing the resident's tablet and/or headphones.</p> <p>-He/She would have expected the headphones and tablet would have been purchased shortly after receiving the funds.</p> <p>Review of the resident's Resident Trust Fund Account showed:</p> <p>-A deposit for \$200 was made to the resident's account on 11/21/24.</p> <p>-As of 12/23/24 the money was still in the resident's account.</p> <p>During an interview on 12/20/24 at 10:45 A.M., the resident said:</p> <p>-He/She did not have a tablet or Bluetooth headset.</p> <p>-He/She was supposed to get one last month but he/she hasn't received it yet.</p> <p>During an interview on 12/20/24 at 10:45 A.M., the Activity Directory said:</p> <p>-The resident was supposed to get a tablet and Bluetooth headset from the money his/her guardian sent him/her.</p> <p>-He/She was going to purchase the items the next time he/she went to Walmart, which was in mid-January.</p> <p>-He/She only goes to Wal-Mart once a month, so he/she did not have the item on the list to purchase in December.</p> <p>During an interview on 12/23/24 at 3:11 P.M., the Social Services Director said:</p> <p>-Activities Director was supposed to purchase the resident's tablet.</p> <p>-He/She was not involved in the process and did not find out about it until recently when the resident told him/her.</p> <p>During an interview on 12/23/24 at 3:18 P.M., the Activity Director said:</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She will get the resident's tablet at the next Walmart store run which should be the second week of January.</p> <p>-He/She did not know about the tablet until a couple of weeks ago, after he/she had already made the December store run.</p> <p>-He/She was told last week to purchase the resident a tablet but it was not purchased when he/she went to Walmart.</p> <p>During an interview on 12/23/24 at 3:40 P.M., the Director of Nursing (DON) said:</p> <p>-He/She did not recall putting in the note indicating he/she had talked to the resident's guardian to not purchase the resident's tablet.</p> <p>-If the funds were received, the tablet should have been purchased right away, within a week or two.</p> <p>-The Administrator was responsible for purchasing the resident's tablet.</p> <p>MO00246720</p>

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</p> <p>Based on interview and record review, the facility failed to prevent commingling (the mixing of funds belonging to one person with funds belonging to another) of resident funds with any person other than the resident by allowing negative balances in the resident trust fund account for six supplemental residents (Residents #53, #58, #79, #100, #167 and #169) sampled for resident trust funds review and failed to complete or maintain reconciliation of the resident trust fund account to the bank statements. This deficient practice had the potential to affect all residents who have a resident trust fund. The facility census was 111 residents.</p> <p>Review of the facility's policy titled Resident Trust dated as reviewed on 2/2/24 showed:</p> <ul style="list-style-type: none"> -Resident trust fund money would be safeguarded by the facility, using complete and separate accounting principles and prevent commingling of resident funds. -The facility shall keep an accurate and maintained accounting system for the residents that choose to have their personal funds managed. -A reconciliation of the bank statement, checkbook and the electronic health records module must be completed monthly. -The reconciliation would be completed by the company's staff accountant responsible for the facility's financials. -The reconciliation must be done by someone other than the Resident Trust Clerk. -On the first day of every month, the Resident Trust Clerk was to prepare a list of all checks that were written from the resident trust account during the prior month. -The list should include the date, check number, payee, and amount of the check. -An email would be sent to the corporate accountant responsible for the facility's reconciliation once it was updated. -The bank statement should be sent to the accountant as soon as it is received. -A reconciliation of the bank statement, checkbook and the electronic health records funds module must be completed monthly by the corporation's staff accountant. -When the reconciliation was complete, the management accountant would send a copy of the completed reconciliation and bank statement to the Resident Trust Clerk, which should be filed in the monthly resident trust folder or binder. <p>1. Review of the facility's resident trust fund account balance as of 12/17/24 showed the following negative balances:</p> <p>(continued on next page)</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #79 -\$4.26</p> <p>-Resident #100 -\$4.83</p> <p>-Resident #53 -\$1.99</p> <p>-Resident #58 -\$5.00</p> <p>2. Review of Resident #167's resident trust fund transactions dated 9/11/24-10/29/24 showed:</p> <p>-On 10/7/24, the resident had a negative balance of -\$4.23.</p> <p>-On 10/29/24, the resident had a negative balance of -\$4.23.</p> <p>Review of the resident's discharge assessment dated [DATE] showed the resident discharged from the facility with his/her return not anticipated.</p> <p>3. Review of Resident #169's trust fund statement for July 2024 through September 2024 showed:</p> <p>-On 7/30/24, the resident withdrew \$2.00, leaving him/her with a -\$2.00 balance.</p> <p>-On 8/14/24, \$2.00 was deposited into the resident's account, leaving him/her with a \$0.00 balance.</p> <p>-On 8/14/24, the resident withdrew \$2.00, leaving him/her with a -\$2.00 balance.</p> <p>-On 8/14/24, the resident withdrew another \$2.00 leaving him/her with a -\$4.00 balance.</p> <p>Review of the facility's list of residents with a resident trust fund account discharged for the past three months dated 12/16/24 showed the resident was discharged to another nursing home on 9/17/24.</p> <p>4. The bank statements, resident trust fund balances and the reconciliation of the bank statements for every month for the past 12 months were requested from the facility daily from 12/16/24-12/20/24 and on 12/23/24.</p> <p>The facility provided reconciled bank statements for November 2023, December 2023, August 2024, and October 2024 and failed to provide the remaining eight months requested.</p> <p>5. During an interview on 12/16/24 at 10:05 A.M., the Business Office Manager (BOM) said:</p> <p>-He/She had been the BOM for one week.</p> <p>-The negative amounts were due to the residents withdrawing cash when they did not have the funds.</p> <p>-Corporate was responsible for completing the bank reconciliations and would have all the documentation.</p> <p>During an interview on 12/18/24 at 1:55 P.M., the BOM said:</p> <p>(continued on next page)</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-They should use the current account balance when distributing money to the residents to prevent negative balances.</p> <p>-They should not give money to the resident if the resident doesn't have any money in the resident trust fund account.</p> <p>-The report was small, so he/she could see how the amounts could mixed up and the wrong amounts could be read for the residents' balances.</p> <p>-He/She was now highlighting the residents who do not have very much money in their account on the current account balance report.</p> <p>During an interview on 12/18/24 at 2:37 P.M., the Administrator said:</p> <p>-He/She would expect the resident trust fund bank statements to be reconciled monthly.</p> <p>-The BOM resigned 6/1/24.</p> <p>-A regional person took over the business office for about a month.</p> <p>-He/she was told to deposit the checks and maintain the residents' banking for a while.</p> <p>-Then they had a BOM that covered two of their corporation's buildings, but that person stopped coming in the beginning of November 2024.</p> <p>-They had issues with switching their internet systems.</p> <p>-The current BOM just started and is going through training.</p> <p>-They had a system in place that should have prevented negative amounts in the resident trust fund accounts.</p> <p>-The resident trust fund account was supposed to be reconciled before 9:00 A.M. daily so they could have accurate amounts when residents requested their money.</p> <p>-The internet was down so they had to do hand-written reconciliations.</p> <p>-If something was not posted by the facility by accident, they would replace it since it was not the residents' fault.</p> <p>-They should not have any negative balances.</p>		

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</p> <p>Based on interview and record review, the facility failed to follow their policy by failing to provide the resident with an up-to-date accounting of his/her trust account balance and return the resident's funds timely for one supplemental resident (Resident #168) out of three supplemental residents sampled for discharged residents. The other two residents sampled had negative balances. The facility census was 111 residents.</p> <p>Review of the facility's policy titled Resident Trust reviewed on 2/2/24 showed:</p> <ul style="list-style-type: none"> -Upon discharge, the facility shall provide an up-to-date accounting of the resident's trust account balance. -The resident shall be issued a check for all remaining personal funds in his/her account within five days of discharge. <p>1. Review of Resident #168's trust statement through 9/30/24 showed a balance of \$2,406.51.</p> <p>Review of the facility's list of residents with a resident trust fund account discharged for the past three months dated 12/16/24 showed the resident discharged to home on 10/1/24.</p> <p>Review of Resident #168's transactions since the 9/30/24 statement showed:</p> <ul style="list-style-type: none"> -The resident was sent a refund on 11/5/24 (31 days late for state requirements and facility policy and five days late for federal requirements) for \$1,584.51 -The resident was charged \$886.00 for October 2024 room and board (even though the resident discharged on [DATE]) on 11/20/24. <p>During an interview on 12/18/24 at 10:05 A.M., the Business Office Manager (BOM) said:</p> <ul style="list-style-type: none"> -He/She had been the BOM for only about a week and a half. -He/She did not think the resident's money was returned timely to the resident. -They should send the money to whoever it was determined it should be sent to such as the resident or the resident's guardian. <p>During an interview on 12/18/24 at 2:37 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -They had a policy they were supposed to follow when a resident who has a trust fund account was discharged . -They needed to determine who the money should go to such as the resident or their guardian. <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The BOM resigned 6/1/24.</p> <p>-A regional person took over the business office for about a month.</p> <p>-Then he/she was told to deposit the checks and maintain the resident banking for a while.</p> <p>-Then they had a BOM that covered two of their corporation's buildings, but that person stopped coming in the beginning of November 2024.</p> <p>-Then they had issues with switching their internet systems.</p> <p>-The current BOM just started and is going through training.</p>

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469</p> <p>Based on observation, interview, and record review, the facility failed to provide privacy for residents who wished to use the facility telephone for two sampled residents (Resident #19, Resident #112) out of 23 sampled residents. This had the potential to affect all residents who used the telephone in the facility. The facility census was 111 residents.</p> <p>Review of the facility's policy, Resident Rights, dated 7/5/23 showed:</p> <ul style="list-style-type: none"> -Residents were to have been treated with consideration, respect, and in full recognition of his/her dignity and individuality, including privacy and in care for his/her personal needs. -The resident has the right to have reasonable access to the use of a telephone where calls could have been made without being overheard. --The policy included an undated handwritten notation use of phone if want privacy - may use administrator work phone. Plans to move the phone to Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) office for medical (unit) - utilize nursing station (inside) for behavioral units. <p>1. Review of Resident #19's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Schizoaffective disorder (a mental health condition including Schizophrenia (a person who has delusions (a belief or altered reality that was persistently held despite evidence to the contrary), hallucinations (a perception of having seen, heard, touched, tasted or smelled something that was not there), or disorganized speech) and mood disorders. -Bipolar disorder (when a person has mood swings with periods of high energy and lows (depression). -Anxiety. -Autistic Disorder (a lifelong developmental disability that affect how people interact with the world and communicate). -Borderline intellectual functioning (When a person is below average cognitive ability). -Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after an experience or had witnessed a terrifying event). <p>Review of the resident's annual MDS dated [DATE] showed he/she was cognitively intact.</p> <p>Observation on 12/16/24 at 2:00 P.M. showed two residents on the locked Mens' unit standing around the nurses' station trying to use the one facility own phone trying to call out to their families.</p> <ul style="list-style-type: none"> -The facility telephone and internet were down. <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/18/24 at 3:00 P.M. showed three male residents standing around the nurses' station as one male resident was on the telephone.</p> <ul style="list-style-type: none"> -There was only one telephone the residents could use located at the nurses' station in the middle of the hallway. -The other residents were within two feet of the resident on the telephone and could hear everything he/she said. <p>During an interview on 12/20/24 at 3:07 P.M. the resident said:</p> <ul style="list-style-type: none"> -The phone/internet had been out of service for three days. -He/She had his/her own phone but used the facility phone to call his/her guardian. -Other residents stand by the phone and would hear everything that you say, it made him/her nervous. -There was no privacy when you talked on the phone in the hallway. -They were not able to use any other phones in the facility. -They were not able to borrow a staff member's phone. <p>2. Review of Resident #112's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Bipolar. -Anxiety. -He/She had a guardian. <p>Review of the resident's care plan dated 10/18/24 showed he/she was at risk for anxiety/nervousness.</p> <p>Review of the resident's quarterly MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact. -He/She had hallucinations. -He/She had delusions. -He/She had anxiety. -He/She was Bipolar. <p>(continued on next page)</p>

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/16/24 at 1:20 P.M. the resident said:</p> <ul style="list-style-type: none"> -He/She had been unable to use the phone as the lines were down and has not been able to call family for three days. -There was only one phone at the Nurses' station in the hallway where anyone walking by could hear your conversations. -Sometimes he/she had to call the guardian to request something and did not need the other residents to hear what he/she said. -It makes him/her nervous when he/she could not talk to family at least every other day. <p>During an interview on 12/19/24 at 8:10 A.M. Certified Medication Technician (CMT) A said:</p> <ul style="list-style-type: none"> -The facility phones and internet had been down a couple of days. -Resident #19 had complained about the phones being out of service. -A couple of the residents have their own cell phones but most of the residents had to use the one phone at the Nurses' station in the middle of the hallway. -Anyone in the hall could hear their conversation. -The phone in the hallway was not private. <p>During an interview on 12/19/24 at 10:29 A.M. Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> -There was a phone in the hallway that the residents use to call out. -The phone did not always work. -It had not worked the last couple of days. -If a resident used the phone in the hallway anyone in the hallway could have heard the conversation. -There was only one phone on the locked Men's unit and it was not private. <p>During an interview on 12/23/24 at 10:45 A.M., LPN A said:</p> <ul style="list-style-type: none"> -The phone outside the nurse's station on the women's unit was the only phone for the unit. -The residents used to have privacy for their phone calls, but they broke the phone, so now they can only use the phone at the nurse's station with a Certified Nursing Assistant (CNA) standing at the door to watch. <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Residents on the women's unit can use the phone in the nurse's station with a staff person nearby to make sure they don't get into anything or tear up anything.</p> <p>-There is not a room in the women's unit residents can use for private calls due to the residents frequently breaking the phone.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the Director of Nursing (DON) said:</p> <p>-On the women's unit staff could unlocked the Nurses' station and the resident's could go in there for a private phone call.</p> <p>-On the men's unit they use the phone in the Nurses' station while standing in the hallway.</p> <p>-The men's unit was not private.</p> <p>-If the phone lines or internet was down he/she did not have an alternative form of communication so the residents could have contacted their families.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576</p> <p>Based on observation, interview and record review, the facility failed to ensure the right to open mail privately for two sampled residents, (Resident #99 and #14) out of 23 sampled residents. This potentially affected all residents who receive mail at the facility. The facility census was 111 residents.</p> <p>Review of the facility's policy, Resident Rights, dated 7/5/23 showed:</p> <ul style="list-style-type: none"> -Residents were to have been treated with consideration, respect, and in full recognition of his/her dignity and individuality, including privacy and in care for his/her personal needs. -The resident has the right to have reasonable access to the use of a telephone where calls could have been made without being overheard. <p>1. Review of Resident #99's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility staff for care planning) dated 11/22/24 showed he/she was cognitively intact.</p> <p>During an interview on 12/20/24 at 2:15 P.M., the resident said:</p> <ul style="list-style-type: none"> -He/She can't open his/her mail privately. -The activity person passed out the mail and he/she had to open the mail in front of him/her. -He/She understands that mail can have contraband in it and the facility needs to know what residents are getting. -He/She would prefer to open his/her personal mail privately. <p>2. Review of the resident's Quarterly MDS dated [DATE] showed his/her cognition was intact.</p> <p>During an interview on 12/23/24 at 2:55 P.M., the resident said:</p> <ul style="list-style-type: none"> -He/She can't open his/her mail privately. -This does bother him/her that he/she has to open his/her personal mail in front of the activity person who passes out the mail or any other staff passing out mail. -He/She would be ok if it was addressed to him in care of the facility and not directly to him/her. <p>3. During an interview on 12/20/24 at 10:23 A.M., Certified Nursing Assistant (CNA) M said:</p> <ul style="list-style-type: none"> -Mail was handed out by someone in administration. <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The residents have to open their mail in front of the person handing the mail out.</p> <p>-He/she thought the residents should be able to open their mail without staff watching.</p> <p>During an interview on 12/23/24 at 10:59 A.M., CNA N said:</p> <p>-The Activity Director or Social Service worker deliver the mail to residents.</p> <p>-The resident's need to open their mail in front of that person delivering it.</p> <p>-He/she believed this was so residents don't say they didn't receive it or to be sure there is no contraband in it.</p> <p>During an interview on 12/23/24 at 11:23 A.M., the Activity Director said:</p> <p>-The mail was delivered to the facility at the receptionist desk.</p> <p>-The receptionist lets him/her know when the mail arrives.</p> <p>-If a resident received a package or a box he/she inventories it for the resident.</p> <p>-The residents need to open mail in front of him/her or if another staff passing out mail in front of them so there are no contraband items brought in.</p> <p>During an interview on 12/23/24 at 11:33 A.M., Licensed Practical Nurse (LPN) B said:</p> <p>-Residents need to open their mail in front of the person delivering it to be sure that they received it and be sure they are not getting things they shouldn't or not supposed to have.</p> <p>-Some residents will say a family or friend sent them something and then say they had not received it yet.</p> <p>During an interview on 12/23/24 at 3:17 P.M., the Social Services Director (SSD) said the residents do open their own mail, but in front of the activities person or who passed it out.</p> <p>During an interview on 12/23/24 at 4:02 P.M., The Director of Nurses (DON) said:</p> <p>-The residents should be able to open their mail privately without staff watching them unless they have a guardian who has placed restrictions.</p> <p>-Resident # 99 was his/her own responsible party and should be able to open mail without being watched.</p> <p>-Resident #14 had a guardian who was ok with him/her opening mail privately.</p> <p>MO00246531</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>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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents had a safe homelike environment by not ensuring the ceiling tiles were not damaged, the floor tiles were not damaged, the ceiling did not leak, failed to ensure there was not mouse excrement on the floor, for five sampled residents, (Resident #108, #23, #25, #102, #72) and for one supplemental resident (Resident #43) out of 23 sampled residents and 12 supplemental residents. The facility failed to ensure the medication room on the Men's Locked Unit was kept clean and hand hygiene products were available for staff. The facility census was 111 residents.</p> <p>Policy requested and not provided by the end of survey.</p> <p>1. Review of Resident #108's Face Sheet showed he/she was admitted to the facility on [DATE].</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/20/24 showed he/she was cognitively intact.</p> <p>Observation on 12/18/24 at 9:40 A.M., 12/18/24 at 2:54 P.M., 12/19/24 at 1:20 P.M., 12/20/24 at 3:03 P.M., and 12/23/24 at 11:15 A.M. showed:</p> <ul style="list-style-type: none"> -The resident's mattress was on the floor without a bedframe. -The head of the resident's bed was next to the wall approximately three feet from the entrance of the bathroom. -The baseboard next to the head of the mattress had a thick line of small brown pellets that appeared to be mouse droppings. -The floor was discolored from urine near the head of the mattress next to the baseboard leading from the bathroom door to the bed. -The baseboards along the wall near the exit door to the room was lined with mouse droppings. -A smashed sticky mouse trap behind the room door. -The flooring along the baseboards appeared to have floor wax covering and trapping insects and smashed mouse droppings. <p>During an interview on 12/18/24 at 9:40 A.M., the resident said:</p> <ul style="list-style-type: none"> -He/She had seen mice in his/her room. -Mice run around everywhere on the unit. <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>-His/Her mattress was on the floor, mice would get into his/her bed.</p> <p>During an interview on 12/20/24 at 3:03 P.M., the Activities Director said:</p> <p>-He/She had seen mice on the unit.</p> <p>-The mouse situation was bad.</p> <p>-An exterminator was there weekly and put out traps, but it did not help.</p> <p>2. Observation on 12/17/24 at 2:00 P.M., 12/18/24 at 10:30 A.M. and 1:55 P.M., 12/19/24 at 10:41 A.M., and 12/20/24 at 10:27 A.M. showed:</p> <p>-An unmarked, locked door at the front of the unit near the exit door. A covered linen cart was in the corner between the locked door and the exit door.</p> <p>-A yellow stained towel was on the floor across the threshold of the door.</p> <p>3. Review of Supplemental Resident #43's quarterly MDS dated [DATE] showed the resident was cognitively intact.</p> <p>Observation on 12/20/24 at 11:00 A.M. showed:</p> <p>-The light above the resident's bed would not illuminate.</p> <p>-The blinds to his/her window were too small for the window leaving 3 inch gaps on each side allowing light to penetrate. The window was not covered with a curtain or any other type of window dressing.</p> <p>-The heating and cooling register below the window was thick with dust and debris.</p> <p>-Mouse droppings were on the floor along the baseboards with a torn, smashed sticky mouse trap on the floor in the corner of the room.</p> <p>During an interview on 12/20/24 at 11:04 A.M. the resident said:</p> <p>-He/She had reported to multiple staff the light above his/her bed would not turn on over the course of at least three months.</p> <p>-He/She did not like the blinds not covering the whole window or not having curtains because lots of light got in and he/she felt as though it was possible for people to be able to see in through the blinds.</p> <p>-He/She did not think staff cleaned the heating and cooling register.</p> <p>-There were always mouse droppings on the floor.</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>-He/She did not know the last time anyone changed out the torn, crumpled sticky mouse trap, it had been over a month.</p> <p>During an interview on 12/20/24 at 11:20 A.M., Registered Nurse (RN) A said:</p> <p>-He/She was not aware the resident's overbed light was not working. He/She would report it to maintenance.</p> <p>-He/She did not know who cleaned the registers or how often.</p> <p>-He/She was aware of the mice issues. He/She thought the pest control company came often, maybe weekly.</p> <p>-He/She did not know the resident did not like having blinds that did not cover the whole window, was not sure anyone from the outside could see in the windows.</p> <p>Observation on 12/23/24 at 11:14 A.M. with the resident showed:</p> <p>-The sticky mouse trap was in the same location, torn and crumpled.</p> <p>-The overbed light did not work.</p> <p>-The register continued to be covered in dust and debris.</p> <p>-The blinds continued to not cover the entire window and there was an absence of window curtains. The windows were drafty.</p> <p>During an interview on 12/23/24 at 11:14 A.M. the resident said he/she said nothing had changed since the previous weekend. Staff came in to see the light did not work, but nothing had been done about it so far.</p> <p>39469</p> <p>4. Review of Resident #25's quarterly MDS dated [DATE] showed he/she was cognitively intact.</p> <p>Observation on 12/16/24 at 1:30 P.M. showed:</p> <p>-Three floor tiles in the area of the resident's bed were stained yellow.</p> <p>-Two floor tiles were loose.</p> <p>-Two ceiling tiles in the area of the resident's bed were stained gray and bowed down from the ceiling.</p> <p>-There was mice excrement on the floor along the wall in the area of the resident's bed.</p> <p>During an interview on 12/16/24 at 1:30 P.M. the resident said:</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>-He/she had seen three mice in his/her room in the last two weeks.</p> <p>-He/She believed the mice came into the room through a hole under the heating unit.</p> <p>-He/She had talked to the maintenance man about the mice issue.</p> <p>-The maintenance man put sticky traps out to catch the mice in the room.</p> <p>-Housekeeping cleaned the room daily.</p> <p>-There was still mouse excrement on the floor daily.</p> <p>-The ceiling tiles had been stained and bowed down from the ceiling for months.</p> <p>5. Review of Resident #23's quarterly MDS dated [DATE] showed he/she was cognitively intact.</p> <p>Observation on 12/16/24 at 1:42 P.M. showed:</p> <p>-There were three tiles in the area of his/her bed that were not glued to the floor.</p> <p>-There were two holes in the floor the size of half of a golf ball.</p> <p>-The floor tiles were stained yellow.</p> <p>-There was mouse excrement on the floor in the corner by his/her bed.</p> <p>-There was a small hole in the baseboard in the corner where he/she believed mice came into the room.</p> <p>-There was a small hole under the heating unit where he/she believed the mice came into the room.</p> <p>During an interview on 12/16/24 at 1:42 P.M. the resident said:</p> <p>-He/She had tripped on the loose floor tiles a couple of times.</p> <p>-He/She had talked to maintenance but they did not fix the loose floor tiles.</p> <p>-Housekeeping cleaned daily</p> <p>-He/She did not think they had ever stripped the wax off of the floor tiles.</p> <p>-He/She had talked to maintenance but they did not fix the holes in the baseboard in the corner or under the heating unit.</p> <p>Observation on 12/17/24 at 10:00 A.M. of the resident's room showed:</p> <p>-Two ceiling tiles from the resident's bathroom were in a pile of broken and wet pieces on the bathroom floor.</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>-There was a puddle of liquid about 18 inches round in front of the sink in the resident's bathroom.</p> <p>-There were two tiles hanging from the ceiling in each of the two residents areas.</p> <p>-There was a large sheet over the heating unit that was yellowed with a liquid that had dripped from the ceiling.</p> <p>During an interview on 12/17/24 at 10:00 A.M. the resident said:</p> <p>-They were not able to use the restroom in their room because of the pile of ceiling tile and the puddle of water in front of the sink.</p> <p>-He/She and his/her roommates had to walk down the hallway to use the bathroom in the shower room.</p> <p>-He/She had to move his/her possessions out of the window sill because of the leak.</p> <p>-Maintenance was aware of the problem.</p> <p>-He/She believed someone in the room above them had made the toilet overflow and it flooded the ceiling in their room.</p> <p>-Someone overflowing the toilet and then the water coming into their ceiling had happened a couple of times before.</p> <p>-The leak happened between 12/16/24 at 9:00 P.M. and 12/17/24 at 9:00 A.M.</p> <p>6. During an interview on 12/23/24 at 10:00 A.M. the Business Office Manager said:</p> <p>-He/She had seen two mice in his/her office last week.</p> <p>-One of the mice ran over his/her foot.</p> <p>-The facility had recently changed pest control companies.</p> <p>-The pest control company had been coming out weekly.</p> <p>-The pest control company had put out sticky traps.</p> <p>-The traps have not worked.</p> <p>7. Observation on 12/23/24 at 10:15 A.M. showed a mouse ran down the hallway and into room [ROOM NUMBER] under the resident's bed.</p> <p>-The resident was not in the room at the time.</p> <p>During an interview on 12/23/24 at 10:30 A.M. Floor Technician A said:</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>-He/She went into room [ROOM NUMBER] to get the mouse out.</p> <p>-There were actually two mice in the room.</p> <p>-They had a lot of issues with the mice everywhere in the building.</p> <p>-They did not have enough staff at this time to strip and wax the floors as they should have been done.</p> <p>During an interview on 12/23/24 at 10:45 A.M. the Maintenance Director said:</p> <p>-They often have issues with the ceiling and floor tiles in the residents' rooms.</p> <p>-In the lower level the ceiling tiles were often wet.</p> <p>-The residents above the lower level rooms often would put things in the toilet such as paper towels, flush them then the toilet would over flow and leaked into the rooms below.</p> <p>-There was an overflow that leaked into Resident #23 and Resident #25's room last week and just happened again the other day.</p> <p>-There were three areas in that room that the ceiling tiles became wet.</p> <p>-Several ceiling tiles in the bathroom fell on the floor.</p> <p>-There was also a puddle of water on the floor in the bathroom so the residents were not able to use their bathroom for a few hours.</p> <p>-The residents in that room had to use the bathroom down the hall in the shower room.</p> <p>-If residents were in the shower staff would have had to unlock the public bathroom for them to use.</p> <p>-He/She had replaced the ceiling tiles.</p> <p>-Sometimes the leak was from a toilet that had over flowed sometimes it was a leak from old pipes.</p> <p>-This was an old building and a leak happened often.</p> <p>-They had loose tiles on the floor.</p> <p>-He/She replaced the loose tiles as needed.</p> <p>-He/She and the maintenance staff try to spot check the resident's rooms monthly but that was not always done as they did not have enough staff.</p> <p>-They fixed the most pressing issues first.</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>-They have not had enough time or staff to strip the wax off of the floors and reseal them for a long time so they did look dirty.</p> <p>-They did have an issue with mice as the weather turned cold they came into the building from the field behind the building.</p> <p>-When he/she had seen holes in the wall he/she would stuff steel wool into the hole.</p> <p>-They had recently changed pest control companies.</p> <p>-In the last month the pest control company had come out weekly to put out sticky traps in each room.</p> <p>-They still had mice.</p> <p>-Housekeeping cleaned the floors daily but there was still mice excrement on the floors.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the Director of Nursing (DON) said:</p> <p>-The pest control company was coming into the facility weekly to set out sticky traps.</p> <p>-There was still a mouse problem throughout the building.</p> <p>-A couple of the resident's had received education about not feeding the mice.</p> <p>-Housekeeping cleaned the rooms daily and the mouse excrement should have been cleaned up.</p> <p>-The Maintenance department had enough staff to keep the building in good repair.</p> <p>-The Maintenance department replaced the ceiling and floor tiles as needed, there should not have been any loose tiles</p> <p>51150</p> <p>8. Review of Resident #102's Admission Record showed the resident was cognitively intact.</p> <p>Observation on 12/16/24 at 9:30 A.M. showed:</p> <p>-Mice droppings in the resident's room on the floor and in the resident's bathroom.</p> <p>-Mice glue traps on the resident's bathroom floor.</p> <p>During an interview on 12/16/24 at 9:32 A.M., the resident said:</p> <p>-He/she often saw mice in the facility and in his/her room.</p> <p>-He/she saw mice during the day and during the evening hours at least every other day, if not daily.</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>9. Review of Resident #72's Admission Record showed the resident was cognitively intact.</p> <p>Observation on 12/17/24 at 1:27 P.M. showed:</p> <ul style="list-style-type: none"> -Mice droppings in the resident's room on the floor and in the resident's bathroom. -The resident's room was unkept and cluttered. <p>During an interview on 12/17/24 at 1:27 P.M., the resident said:</p> <ul style="list-style-type: none"> -He/she often saw mice in his/her room and bathroom. -He/she had a mouse in his/her bed one night that tried crawling up his/her pajama pants. -He/she had seen numerous mice in the dining area and in other areas of the facility. -He/she saw mice droppings on his/her oxygen equipment when he/she returned from the hospital in October 2024. <p>MO00246720</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>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** 32720</p> <p>Based on observation, interview, and record review, the facility failed to keep one sampled resident (Resident #9) free from abuse. On 12/8/24 Certified Nursing Assistant (CNA) K kicked at Resident #9. Resident #89 grabbed Resident #9 by the neck out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's Abuse and Neglect policy dated 1/5/23 showed:</p> <ul style="list-style-type: none"> -Physical abuse included purposely beating, striking, or injuring a resident. It included but was not limited to hitting and kicking. -Verbal abuse included using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner in a resident's presence. Examples included yelling at a resident. -Employees are trained through orientation and ongoing training on issues related to abuse prohibition practices such as dealing with aggressive residents, and recognizing signs of burnout, frustrations, or stress that may lead to abuse. -On a regular basis, supervisors will monitor the ability of staff to meet the needs of residents and staffs understanding of individual resident care needs. Situations such as inappropriate language, insensitive handling, and impersonal care will be corrected as they occur. <p>Review of the facility's Resident Rights policy dated 7/5/23 showed residents have the right to be free from mental and physical abuse.</p> <p>1. Review of Resident #9's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Impulse disorder (a psychiatric condition that makes it difficult to control actions or reactions). -Borderline intellectual functioning (below average cognitive functioning). -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). -Bipolar (mood disorders characterized usually by alternating episodes of depression and mania). -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). -Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a shocking, scary, or dangerous event). <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>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/26/24 showed the resident was cognitively intact with no behaviors.</p> <p>Review of Resident #89's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems). -Intellectual disabilities. -Schizophrenia. -Bipolar. -Asperger's syndrome (a developmental disorder that makes it difficult to interact with others and understand social cues). <p>Review of Resident #89's quarterly MDS dated [DATE] showed he/she:</p> <ul style="list-style-type: none"> -Was cognitively intact. -Had verbal behaviors 1-3 days during the look back period. -Had no physical behaviors. <p>Observation of the facility video of the incident on 12/8/24 showed:</p> <ul style="list-style-type: none"> -The video was undated and not time stamped. -A resident was standing at the nurse's station with his/her back to the camera using the telephone. The charge nurse was in the nurse's station behind the clear partition and CNA K and CNA L were standing at the nurse's station next to the resident on the telephone with their backs to the camera leaning on the medication cart. -CNA L and CNA K appeared to be talking to the nurse behind the partition while the one resident was on the telephone and other residents were walking up and down the hall. -Resident #9 walked up behind CNA K, CNA K turned to face the resident. The resident began pointing to a box (later identified as the cigarette box for the unit) and down the hall. CNA L then turned around to face the resident. -Resident #9 and CNA K's facial expressions and body language demonstrated both were talking in heated, elevated, agitated tones. CNA K was forcefully pointing his/her finger towards the resident. CNA L also began talking in a heated, elevated tone. The nurse remained behind the clear partition in the nurse's station. <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>-Resident #89 is seen walking into frame behind Resident #9, then walks off.</p> <p>-Resident #9 is still talking in an agitated state when the nurse comes out from behind the nurse's station and gets between Resident #9 and CNA K. CNA L walks out of the camera frame.</p> <p>-The resident that was on phone then walked out of camera frame and Resident #89 walks up behind Resident #9.</p> <p>-Resident #9 and CNA K are still talking to each other in elevated agitated tones with the charge nurse standing between them.</p> <p>-Resident #9 rips off his/her jacket and lunges towards CNA K attempting to throw punches at CNA K.</p> <p>-Resident #89 comes up behind Resident #9 and attempts to put his/her forearm around the resident's neck as if to place in a choke hold.</p> <p>-Unidentified staff come into frame to pull Resident #89 off of Resident #9. The nurse was still between Resident #9 and CNA K.</p> <p>-CNA K begins lunging at Resident #9 with the charge nurse between the two, holding onto CNA K.</p> <p>-The charge nurse is then seen physically restraining CNA K to keep him/her from Resident #9 as two unidentified staff are each holding an arm on Resident #9.</p> <p>-CNA K is then seen kicking at Resident #9.</p> <p>Review of the resident's Progress Behavior note dated 12/8/24 showed the resident told the Administrator the staff on his/her unit jumped on him/her. An investigation immediately ensued.</p> <p>Review of the facility investigation dated 12/12/24 showed:</p> <p>-An undated screenshot of a text message at 9:11 P.M. from the charge nurse, Licensed Practical Nurse (LPN) C, indicating the resident took a cigarette from him/her then went to the CNA to get a cigarette. The charge nurse told the resident he/she already had a cigarette from him/her. The CNA and the resident went to the smoke area. When they came back to the nurse's station with other aides, they were talking back and forth and the resident and staff were loud. The resident became aggressive and tried to attack. Two CNAs held the resident's hands while he/she moved the other CNA from the situation. An as needed medication (PRN) was administered to the resident and the resident calmed down.</p> <p>-Resident #9 and Resident #89 were not interviewed.</p> <p>-CNA L and CMT E were not interviewed.</p> <p>Review of LPN C's written statement dated 12/11/24 showed:</p> <p>-On 12/8/24 a CNA L and the resident came to the nurse's station and asked for a cigarette.</p> <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>-The resident was told he/she had already received a cigarette.</p> <p>-On return from the smoke room the resident was agitated, talking loudly, and one of the CNA K was also loudly talking.</p> <p>-The resident tried to attack the CNA K.</p> <p>-Two CNA L and CNA J held the resident while he/she held the other CNA K and moved the CNA K.</p> <p>**NOTE**LPN C was attempted contact for interview on 12/23/24, 12/24/24 and 12/26/24. LPN C did not return the call. Certified letter mailed for contact.</p> <p>During an interview on 12/17/24 at 2:18 P.M., Resident #9 said:</p> <p>-Staff told him/her they were going to take his/her cigarettes away during a recent incident a week or so ago.</p> <p>-He/She pushed the staff with his/her belly.</p> <p>-The staff and two residents were hitting him/her.</p> <p>During an interview on 12/19/24 at 10:59 A.M., Resident #89 said:</p> <p>-Resident #9 was talking and suddenly got mad and attacked a staff member.</p> <p>-The staff member and Resident #9 were both hitting each other.</p> <p>-He/She hit Resident #9 to get the resident off of CNA K.</p> <p>Review of CNA K's written statement dated 12/10/24 showed:</p> <p>-Resident #9 said he/she was allowed to have his/her cigarettes if he/she asked for them.</p> <p>-When Resident #9 had the cigarettes taken away, he/she began making threats towards the staff and fighting the staff.</p> <p>During an interview on 12/20/24 at 3:58 P.M., CNA K said:</p> <p>-Resident #9 was upset about cigarettes. He/She had asked a nurse about getting them when he/she should not have.</p> <p>-He/She told the resident he/she could not have them.</p> <p>-He/She and the resident began arguing verbally about it.</p> <p>-He/She denied the resident attempted to hit him/her and he/she did not attempt to hit the resident.</p> <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>Review of CNA J's written statement dated 12/8/24 showed:</p> <p>-CNA L said to the resident You have to calm down or else we're gonna have to call a Code Green! (Code [NAME] is a signal to other staff to assist with a behavioral episode).</p> <p>-He/She called the Code [NAME] three times on the walkie talkie. By the third call, he/she witnessed the resident start punching CNA K.</p> <p>-He/she then jumped up and as he/she was running to separate everyone, Resident #89 grabbed Resident #9 by the neck as he/she was swinging at CNA K.</p> <p>-He/she separated everyone the best he/she could, telling the other residents to go to their rooms as he/she was attempting to get Resident #9 in a two-man hold.</p> <p>-At this time they were still yelling for a Code [NAME] for extra help. A few minutes passed when he/she yelled for the Certified Medication Technician (CMT) to run for help since no one can hear us! Finally some help came.</p> <p>- Resident #9 made it seem as if he/she was a trigger, so he/she removed him/herself.</p> <p>During an interview on 12/20/24 at 3:27 P.M., CNA J said:</p> <p>-He/She did not normally work back on the secured care unit.</p> <p>-He/She had been in another room with two other residents when another CNA (CNA L) told him/her the nurse was giving Resident #9 cigarettes.</p> <p>-He/She and CNA L went to talk to CNA K in the closed smoke room about the cigarettes. CNA K showed him/her the cigarette box was almost empty.</p> <p>-Resident #9 was outside the smoke door but was able to get into the smoke room and was getting upset.</p> <p>-They were able to calm the resident down and all of them left the smoke room.</p> <p>-Toward the end of the shift, he/she heard staff call for a Code [NAME] he/she went to see what/who it was regarding.</p> <p>-He/She saw CNA K and CNA L were trying to calm Resident #9 down, but then Resident #9 started to hit CNA K.</p> <p>-Resident #89 came up from behind Resident #9 and him/her in a choke hold and he/she had to pull Resident #89 off of Resident #9. He/She did not see CNA K hit or kick Resident #9, but things were happening so fast and he/she was focused on calming Resident #9 down.</p> <p>-Resident #9 was put in a two person hold and Resident #89 was educated to not intervene in the future because it could trigger him/her or other residents.</p> <p>(continued on next page)</p>

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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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/23/24 at 12:05 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -He/She did not feel as though what was on the video was abuse. -The staff were not interacting with the resident appropriately. It appeared both sides were agitated and not talking calmly. -There was no audio to the video, so he/she could not tell what was actually being said. -He/She could not tell if CNA K was kicking at the resident but was giving him/her the benefit of the doubt that perhaps he/she could have been kicking to get the smoke box out of the way. <p>--NOTE: The smoke box was not in view of the camera and was not in between the resident and CNA K at the time CNA K kicked at the resident.</p> <ul style="list-style-type: none"> -The investigation provided was the complete investigation. <p>During an interview on 12/23/24 at 4:02 P.M., the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> -Abuse investigations were completed by him/her and the Administrator. -He/She had seen the video of the altercation between Resident #9 and Resident #89 and CNA K. -The investigation provided was the complete investigation. -Investigations should include interviews with all witnesses, including any staff and residents identified or involved in the incident. <p>During an interview on 12/23/24 at 12:05 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -The investigation provided was the complete investigation. -No witness statements or interviews were included in the investigation. <p>During an interview on 12/23/24 at 4:02 P.M., the DON said:</p> <ul style="list-style-type: none"> -Resident to resident altercations should be thoroughly investigated. -A complete investigation would include witness statements from staff and other residents. -Statements from the residents involved in the incident should be included in an investigation. <p>During an interview on 12/17/24 at 2:18 P.M. Resident #9 said:</p> <ul style="list-style-type: none"> -Staff told him/her they were going to take his/her cigarettes away during a recent incident a week or so ago. -He/She pushed the staff with his/her belly. The staff and two residents were hitting him/her. <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>During an interview on 12/20/24 at 3:27 P.M., CNA J said:</p> <ul style="list-style-type: none"> -He/she heard Code Green. Staff were trying to calm Resident #9 down when Resident #9 started hitting CNA K. -Resident #89 came up behind Resident #9 and put him/her in a choke hold. -He/she and CNA L were able to remove Resident #89 and educated him/her about intervening in other resident behaviors. -He/She and CNA L put Resident #9 in a two person hold by holding his/her hand and arm. -He/she said the incident happened so fast he/she could not remember who was doing what, he/she was focused on holding onto Resident #9 arm and trying to calm Resident #9 down. <p>During an interview on 12/20/24 at 3:46 P.M., CMT E said:</p> <ul style="list-style-type: none"> -He/She normally works on the locked unit. -He/She was in the cafeteria area when he/she heard a commotion. -He/She saw Resident #9 and CNA K at the nurse's station. It looked like they were both hitting each other, but he/she was on sure who hit who, it looked like both were swinging from where he/she was at. -He/She called a Code [NAME] and was told to go find staff to assist. <p>During an interview on 12/23/24 at 11:52 A.M., CNA L said:</p> <ul style="list-style-type: none"> -He/She was doing rounds checking on residents getting ready for the next medication pass time. -He/She came out of a resident room and saw Resident #9 standing at the medication cart with the nurse. -The nurse handed the resident a couple of cigarettes. -He/She asked what was going on since the staff were not supposed to do that (hand out cigarettes when it was not smoke break time). -The nurse said he/she was giving out cigarettes. He/She told the nurse he/she was not supposed to do that. The nurse said he/she had been doing that all day. -He/She took the cigarettes from the resident and walked with him/her to the smoke room. -He/She spoke to CNA K and CNA J about the resident getting extra cigarettes from the nurse. -As they were discussing it, Resident #9 came into the smoke room and started screaming at the staff. <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>-They walked to the front of the unit by the nurse's station. Resident #9 continued to scream at the staff and an altercation broke out.</p> <p>-He/She went to call a Code Green, and that was when the altercation happened. It happened so fast, he/she did not see anyone other than Resident #89 hit Resident #9.</p> <p>During an interview on 12/23/24 at 12:05 P.M., the Administrator said:</p> <p>-He/She did not feel as though what was on the video was abuse.</p> <p>-The staff were not interacting with the resident appropriately. It appeared both side were agitated and not talking calmly.</p> <p>-There was no audio to the video, so he/she could not tell what was actually being said.</p> <p>-He/She could not tell if CNA K was kicking at the resident but was giving him/her the benefit of the doubt that perhaps he/she could have been kicking to get the smoke box out of the way.</p> <p>-Hitting or kicking a resident would be considered abuse.</p> <p>--NOTE: The smoke box was not in view of the camera and was not in between the resident and CNA K at the time CNA K kicked at the resident.</p> <p>During an interview on 12/23/24 at 4:02 P.M., the DON said:</p> <p>-Abuse investigations were completed by him/her and the Administrator.</p> <p>-He/She had seen the video of the altercation between Resident #9, Resident #89 and CNA K.</p> <p>-Staff should not have been yelling or pointing at the residents.</p> <p>-CNA K was being held back by the nursing staff.</p> <p>-CNA K did kick at Resident #9. It was not clear if contact was made.</p> <p>-This incident should have been considered potential abuse by CNA K.</p> <p>MO00246305</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720</p> <p>Based on observation, interview and record review ,the facility failed to complete a thorough investigation for an allegation of employee to resident abuse and resident to resident abuse on 12/8/24 for two sampled residents (Resident #9 and #89) out of 23 sampled resident. The facility census was 111 residents.</p> <p>Review of the facility's Abuse and Neglect policy dated 1/3/23 showed:</p> <ul style="list-style-type: none"> -Employees are trained through orientation and ongoing training on issues related to abuse prohibition practices such as dealing with aggressive residents, and recognizing signs of burnout, frustrations, or stress that may lead to abuse. -On a regular basis, supervisors will monitor the ability of staff to meet the needs of residents and staffs understanding of individual resident care needs. Situations such as inappropriate language, insensitive handling, and impersonal care will be corrected as they occur. -An investigation will include assessment of all residents involved and interventions to ensure protective oversight of all residents and involved residents in the facility. <p>Review of the facility's Incident and Accident Reporting policy dated 5/18/24 showed:</p> <ul style="list-style-type: none"> -Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. -If an incident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing (DON) and/or Administrator. <p>1. Review of Resident #9's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Impulse disorder (a psychiatric condition that makes it difficult to control actions or reactions). -Borderline intellectual functioning (below average cognitive functioning). -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). -Bipolar (mood disorders characterized usually by alternating episodes of depression and mania). -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). -Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a shocking, scary, or dangerous event). <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #9's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/26/24 showed the resident was cognitively intact with no behaviors.</p> <p>Review of Resident #89's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems). -Intellectual disabilities. -Schizophrenia. -Bipolar. -Asperger's syndrome (a developmental disorder that makes it difficult to interact with others and understand social cues). <p>Observation of the facility video of the incident on 12/8/24 showed:</p> <ul style="list-style-type: none"> -The video was undated and not timestamped. -A resident was standing at the nurse's station with his/her back to the camera using the telephone. The charge nurse was in the nurse's station behind the clear partition and CNA K and CNA L were standing at the nurse's station next to the resident on the telephone with their backs to the camera leaning on the medication cart. -CNA L and CNA K appeared to be talking to the nurse behind the partition while the one resident was on the telephone and other residents were walking up and down the hall. -Resident #9 walked up behind CNA K, CNA K turned to face the resident. The resident began pointing to a box (later identified as the cigarette box for the unit) and down the hall. CNA L then turned around to face the resident. -Resident #9 and CNA K's facial expressions and body language demonstrated both were talking in heated, elevated, agitated tones. CNA K was forcefully pointing his/her finger towards the resident. CNA L also began talking in a heated, elevated tone. The nurse remained behind the clear partition in the nurse's station. -Resident #89 is seen walking into frame behind Resident #9, then walks off. -Resident #9 is still talking in an agitated state when the nurse comes out from behind the nurse's station and gets between Resident #9 and CNA K. CNA L walks out of the camera frame. -The resident that was on phone then walked out of camera frame and Resident #89 walks up behind Resident #9. <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #9 and CNA K are still talking to each other in elevated agitated tones with the charge nurse standing between them.</p> <p>-Resident #9 rips off his/her jacket and lunges towards CNA K attempting to throw punches at CNA K.</p> <p>-Resident #89 comes up behind Resident #9 and attempts to put his/her forearm around the resident's neck as if to place in a choke hold.</p> <p>-Unidentified staff come into frame to pull Resident #89 off of Resident #9. The nurse was still between Resident #9 and CNA K.</p> <p>-CNA K begins lunging at Resident #9 with the charge nurse between the two, holding onto CNA K.</p> <p>-The charge nurse is then seen physically restraining CNA K to keep him/her from Resident #9 as two unidentified staff are each holding an arm on Resident #9.</p> <p>-CNA K is then seen kicking at Resident #9.</p> <p>Review of the facility investigation dated 12/12/24 showed:</p> <p>-An undated screen shot of a text message at 9:11 P.M. from Licensed Practical Nurse (LPN) C indicating Resident #9 took a cigarette from him/her then went to the CNA L to get a cigarette. LPN C told Resident #9 he/she already had a cigarette from him/her. The CNA L and Resident #9 went to the smoke area. When they came back to the nurse's station with other aides, they were talking back and forth and the resident and staff were loud. The resident became aggressive and tried to attack. Two CNAs held the resident's hands while he/she moved the other CNA from the situation.</p> <p>-Resident #9 and Resident #89 were not interviewed.</p> <p>-CNA L and CMT E were not interviewed</p> <p>**NOTE**There was no Registered Nurse Incident (RNI) report in the packet.</p> <p>During an interview on 12/17/24 at 2:18 P.M., Resident #9 said:</p> <p>-Staff told him/her they were going to take his/her cigarettes away during a recent incident a week or so ago.</p> <p>-He/She pushed the staff with his/her belly. The staff and two residents were hitting him/her.</p> <p>During an interview on 12/19/24 at 10:59 A.M., Resident #89 said:</p> <p>-Resident #9 was talking and suddenly got mad and attacked a staff member.</p> <p>-The staff member and Resident #9 were both hitting each other.</p> <p>-He/She hit Resident #9 to get the resident off of CNA K.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/23/24 at 12:05 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -He/She did not feel as though what was on the video was abuse. -The staff were not interacting with the resident appropriately. It appeared both side were agitated and not talking calmly. -There was no audio to the video, so he/she could not tell what was actually being said. -He/She could not tell if CNA K was kicking at the resident but was giving him/her the benefit of the doubt that perhaps he/she could have been kicking to get the smoke box out of the way. <p>--NOTE: The smoke box was not in view of the camera and was not in between the resident and CNA K at the time CNA K kicked at the resident.</p> <ul style="list-style-type: none"> -The investigation provided was the complete investigation. -The investigation provided was the complete investigation. -No witness statements or interviews were included in the investigation for Resident #9, Resident #89, CNA L and CMT E. -Statements from the residents and staff involved in the incident should be included in an investigation. <p>During an interview on 12/23/24 at 4:02 P.M., the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> -Abuse investigations were completed by the DON and the Administrator. -He/She had seen the video of the altercation between Resident #9 and Resident #89 and CNA K. -The investigation provided was the complete investigation. -Investigations should include interviews with all witnesses, including any staff and residents identified or involved in the incident. -Resident to resident altercations should be thoroughly investigated. -A complete investigation would include witness statements from staff and other residents. -Statements from the residents involved in the incident should be included in an investigation. <p>MO00246305</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 51150</p> <p>Based on interview and record review, the facility failed to notify the resident and/or the resident's representative(s) of a transfer to a nursing facility, including the reasons for the transfer in writing for two sampled residents (Residents #116 and #115) and failed to notify the Ombudsman (a resident advocate who provides support and assistance with problems and/or complaints regarding the facility) of the discharge for one sampled resident, (Resident #115), out of two closed record sampled residents. The facility census was 111 residents.</p> <p>Review of the policy Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave revised date of 5/14/24 showed:</p> <ul style="list-style-type: none"> -The transfer referred to the movement of a resident from a bed in one certified facility to a bed in another certified facility when resident expects to return to the original facility. -Notice of Discharge or Transfer: <ul style="list-style-type: none"> --Who must receive notice. ---Notify the resident and the resident representative the reason for the transfer or discharge in writing in a manner they understand. ---Notify a representative of the Office of the State Long-Term Care Ombudsman. --The Notice shall include the following information: <ul style="list-style-type: none"> ---Reason for the transfer or discharge. ---Effective date of the transfer or discharge. ---Location to which the resident is being transferred or discharged , including the specific address. ---The name, address, email, and telephone number of the designated regional long-term care ombudsman office. 1. Review of Resident #116's Admission record showed: <ul style="list-style-type: none"> -The resident was admitted to the facility on [DATE]. -The resident was discharged /transferred to another facility on 9/17/24. -The resident was his/her own responsible party. <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 - Few</p>	<p>Review of the resident's electronic medical record on 12/22/24 at 4:00 P.M., showed no notice of discharge in the resident's electronic medical record.</p> <p>During an interview on 12/23/24 at 8:54 A.M., Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> -The charge nurse was responsible for completing the notice of discharge. -The notice of discharge was documented in the resident's electronic medical record when completed. <p>During an interview on 12/23/24 at 2:33 P.M., Social Services Director (SSD) said:</p> <ul style="list-style-type: none"> -He/she and the Director of Nursing (DON) were responsible for ensuring that the notice of discharge was completed. -Notice of discharges should be uploaded in a resident's medical record when they discharge. <p>During an interview on 12/23/24 at 2:40 P.M., Administrator said the facility policy was not followed on this resident and the notice of discharge was not completed.</p> <p>51303</p> <p>2. Review of Resident #115's Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <p>Review of the resident's Nursing Progress Note on 10/29/24 at 6:58 P.M. showed:</p> <ul style="list-style-type: none"> -The resident was having severe pain on his/her left side. -He/She was transferred to the hospital for evaluation. <p>Review of the resident's electronic medical record on 12/20/24 at 3:00 P.M. showed:</p> <ul style="list-style-type: none"> -There was no transfer notice of discharge. -There was no documentation that showed the Ombudsman had been notified of the discharge. <p>A copy of the Transfer/Discharge Written Notification was requested on 12/20/24 at 3:12 P.M. and not provided.</p> <p>During an interview on 12/23/24 at 9:09 A.M. the Administrator said the Notice of Transfer had not been initiated.</p> <p>During an interview on 12/23/24 at 11:58 A.M. LPN B said:</p> <ul style="list-style-type: none"> -Nursing would give the notice of transfer to the hospital. <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 - Few</p>	<p>-Social Service Director (SSD) would follow up if nursing wasn't able to give the notice of transfer.</p> <p>-SSD would notify the Ombudsman for discharges.</p> <p>During an interview on 12/23/24 at 12:01 P.M. the SSD said:</p> <p>-If nursing did not provide a notice of transfer to the hospital, then he/she would follow up and give one.</p> <p>-He/she did not know that the resident did not have a notice of transfer.</p> <p>-He/she had not notified the Ombudsman of the transfer.</p> <p>During an interview on 12/23/24 at 4:02 P.M. the Director of Nursing (DON) said:</p> <p>-The Charge Nurse was responsible for sending the written notice of transfer.</p> <p>-The SSD would follow up and send if the Charge Nurse had not provided it.</p> <p>-He/She was not aware the resident was not given a Notice of Transfer.</p> <p>-He/She was not aware the Ombudsman was not notified.</p>

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150</p> <p>Based on observation, interview and record review, the facility failed to accurately assess the resident's dental status on the resident's Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) on one sampled resident (Resident #27) out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's policy titled MDS 3.0, Care Assessment Summary and Individualized Care Plans dated as revised on 11/6/23 showed:</p> <ul style="list-style-type: none"> -The purpose of the policy was to ensure that MDS 3.0 sections were completed accurately and in a timely manner by the assigned responsible parties. -The MDS addressed the holistic person, including functional status, quality of life and individual plan of care to address and meet the needs of the individual resident. -The MDS must be kept current and up to date. <p>1. Review of the Resident #27's admission MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -The resident was cognitively intact. -The resident had no missing teeth or issues with his/her teeth. <p>During an interview on 12/18/24 at 9:34 A.M., the resident said:</p> <ul style="list-style-type: none"> -He/she did not have any natural teeth upon admission to the facility. -He/she did not have any dentures upon admission to the facility. <p>Observation on 12/18/24 at 9:40 A.M. showed:</p> <ul style="list-style-type: none"> -The resident had no natural teeth. -The resident had no dentures. <p>During an interview on 12/20/24 at 12:56 P.M., Social Services Director (SSD) said:</p> <ul style="list-style-type: none"> -The MDS Coordinator was responsible for ensuring the accuracy of a resident's MDS assessment. -A resident's MDS should have reflected a resident who had no teeth/dentures upon admission. -He/she was unaware of why the resident's MDS did not accurately reflect the resident having no natural teeth or dentures. <p>During an interview on 12/23/24 at 8:54 A.M., Licensed Practical Nurse (LPN) B said:</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The MDS Coordinator was responsible for ensuring that a resident's MDS was accurate.</p> <p>-When a resident was admitted to the facility without any natural teeth and no dentures, this should have been reflected on the resident's MDS.</p> <p>-If the resident's MDS does not reflect the accuracy of a resident's dental assessment, he/she would consider the MDS inaccurate.</p> <p>During an interview on 12/23/24 at 9:26 A.M., MDS Coordinator said:</p> <p>-He/she was responsible for accuracy of the admission MDS assessments.</p> <p>-If a resident did not have natural teeth or dentures upon admission to the facility, it should have been reflected on the resident's MDS.</p> <p>During an interview on 12/23/24 at 4:03 P.M., Director of Nursing (DON) said:</p> <p>-The MDS Coordinator was responsible for the accuracy of the admission MDS assessment.</p> <p>-If a resident did not have teeth or dentures upon admission, it should have been reflected on a resident's MDS assessment.</p> <p>-If a resident's MDS did not reflect the accuracy of a resident's dental assessment, he/she would consider the MDS inaccurate.</p> <p>-He/she expected a resident's MDS to be accurate.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 51150</p> <p>Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for two sampled residents (Residents #27 and #72) out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's policy titled Comprehensive Care Plans dated as revised on 10/31/24 showed:</p> <ul style="list-style-type: none"> -The facility staff would develop and implement a comprehensive, person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. -The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by the facility for care planning) assessment. <p>1. Review of Resident #72's admission MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -The resident was admitted to the facility on [DATE]. -The resident was cognitively intact. -The resident had no history of falls upon admission to the facility. <p>Review of the resident's care plan revised 7/25/24, showed:</p> <ul style="list-style-type: none"> -The resident had a diagnosis of difficulty in walking. -The resident had a diagnosis of Unsteadiness on feet. -The resident had a diagnosis of history of falls. -Note: Falls were not care planned on the resident's care plan. <p>Review of the resident's incident progress note dated 10/27/24 at 6:41 P.M., showed:</p> <ul style="list-style-type: none"> -The resident fell to the floor in his/her room. -The resident was sent to the hospital for evaluation and treatment. <p>During an interview on 12/23/24 at 8:54 A.M., Licensed Practical Nurse (LPN) B said:</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 - Few</p>	<p>-The Director of Nursing (DON) was responsible for updating a resident's care plan after the resident fell .</p> <p>-He/she believed that a resident's care plan was supposed to be updated within 24 hours after a resident fell .</p> <p>-After a resident had a fall, new interventions should be placed on a resident's care plan to prevent future falls.</p> <p>During an interview on 12/23/24 at 9:26 A.M., MDS Coordinator said:</p> <p>-He/she was responsible for updating a resident's care plan after a resident fell .</p> <p>-A fall was considered a change in condition and a care plan should have been updated after a resident fell with new goals and interventions.</p> <p>During an interview on 12/23/24 at 2:33 P.M., Social Services Director (SSD) said:</p> <p>-The MDS coordinator was responsible for updating a resident's care plan after a resident fell .</p> <p>-He/she would expect a resident care plan to be updated after a resident fell .</p> <p>During an interview on 12/23/24 at 4:03 P.M., Interim DON said:</p> <p>-The MDS Coordinator was responsible for updating a resident's care plan after they fell .</p> <p>-He/she was unaware of when a resident's care plan should be updated.</p> <p>-He/she would expect a resident's care plan to be updated after they fell .</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469</p> <p>Based on interview and record review the facility failed to ensure medications that were prescribed by the physician were administered within the time frame the physician had ordered for one sampled resident (Resident #12) out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's policy, Medication Administration Policy, dated 6/26/24 showed:</p> <ul style="list-style-type: none"> -Medications were to have been administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. -Ensure that the six rights of medication administration were followed: <ul style="list-style-type: none"> -Right resident. -Right drug. -Right dosage. -Right route. -Right time. -Right documentation. -Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. <p>1. Review of Resident # 12's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Paranoid Schizophrenia (a mental disorder characterized by hallucinations- hearing voices, delusion, and disorganized thinking and behavior). -Bipolar Disease (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs (an abnormally high level of activity or energy)). -Insomnia (a persistent problem falling and staying asleep). -Chronic pain. -High risk sexual behaviors. <p>Review of the resident's care plan dated 9/6/24 showed:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff needed to be consistent. Keep routine as much as possible.</p> <p>-Staff was to administer antidepressant medications as ordered by the physician.</p> <p>-He/She used psychotropic medications related to diagnosis of Paranoid Schizophrenia and Bipolar disease, administer medications as order by the physician. put in chronological order</p> <p>Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated 11/26/24 showed:</p> <p>-He/She had a guardian.</p> <p>-He/She was cognitively intact.</p> <p>-He/She was Bipolar.</p> <p>-He/She was Schizophrenic.</p> <p>Review of the resident's Medication Administration Record (MAR) dated 12/1/24-12/17/24 showed the resident had the following physician's ordered which were given outside the one hour before or one hour after the time prescribed for administration:</p> <p>-Buspirone Hydrochloride (HCL) oral tablet 15 milligram (mg) by mouth three times a day for Paranoid Schizophrenia was given late nine times.</p> <p>-Chlorpromazine HCL tablet 100 mg by mouth three times a day for Paranoid Schizophrenia was given late three times.</p> <p>-Sodium Chloride one Gram (GM) by mouth once daily for hyponatremia (the level of sodium in the body was too low) was given late six times.</p> <p>-Hyponatremia was not on the face sheet as a diagnosis.</p> <p>-Atorvastatin Calcium tablet 10 mg one tablet by mouth at bedtime for Hyperlipidemia (high levels of fat particles in the blood) was given late (six hours) once.</p> <p>-Hyperlipidemia was not on the face sheet as a diagnosis.</p> <p>-Baclofen tablet 10 mg on tablet by mouth every morning and at bedtime related to chronic pain was not given at bedtime on 12/10/24.</p> <p>-Baclofen was given three times on 12/11/24 at 5:57 A.M., 9:37 A.M., and at 7:42 P.M.</p> <p>-Hydroxyzine HCL tablet 50 mg one tablet by mouth at bedtime for Paranoid Schizophrenia the regular bedtime dose was given and a second dose was given at 5:57 A.M. on 12/11/24.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Lorazepam tablet one mg by mouth two times a day related to Paranoid Schizophrenia was given three times on 12/11/24 at 5:57 A.M. (Bedtime dose on 12/10/24 was missed at 11 P.M.) 9:37 A.M. and 7:42 P.M.</p> <p>-Trazodone HCL tablet 150 mg give 1.5 tablet by mouth at bedtime for sleep for a total of 200 mg at bedtime was not given on 12/10/24. It was given at 5:57 A.M. on 12/11/24.</p> <p>-Trazodone was not given at bedtime on 12/11/24.</p> <p>-1.5 tablet Trazadone, of a 150 mg tablet would have equaled 225 mg not 200 mg.</p> <p>-Loratadine table 10 mg on tablet by mouth one time a day for diverticulosis of colon (inflammation or infection in one or more small pouches in the digestive tract) did not have a diagnosis listed on the face sheet.</p> <p>-MedroxyProgesterone Acetate 10 mg tablet two times a day related to Paranoid Schizophrenia (used for a hormone imbalance in women). Should have said to decrease sexual desires.</p> <p>During an interview on 12/16/24 at 1:26 P.M. the resident said:</p> <p>-He/She frequently received medications late, sometimes hours later.</p> <p>-He/She has a hard time sleeping and needs to receive medications on time.</p> <p>During an interview on 12/19/24 at 11:12 A.M. Certified Medication Technician (CMT) A said:</p> <p>-You have one hour before or after the time the physician prescribed to administer medications to the residents.</p> <p>-There have been times medications were not administered within the time frame.</p> <p>During an interview on 12/20/24 at 10:00 A.M. Director of Nursing (DON) and Registered Nurse (RN) A said:</p> <p>-Medications should have been administered one hour before or after the time they were scheduled.</p> <p>-The diagnosis should have matched the reason for the medication.</p> <p>-Medications were occasionally late.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the DON said:</p> <p>-Nursing has one hour before or one hour after the time the physician wrote the prescription for.</p> <p>-The staff should give what the physician ordered and at that time.</p> <p>-Each medication should have a correct diagnosis for it.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Pharmacy does a monthly check but they are not good about ensuring the diagnosis was correct for the medications.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150</p> <p>Based on interview and record review, the facility failed to complete a comprehensive discharge summary for one sampled resident (Resident #116) out of two sampled closed discharge record. The facility census was 111 residents.</p> <p>Review of the facility's policy, Resident Transfer/Discharge, Immediate Discharge and Therapeutic Leave Policy, dated 5/14/24 showed:</p> <ul style="list-style-type: none"> -The purpose of the policy was to establish policy and procedure regarding the transfer/discharge of residents. -When a resident is discharged or transferred the interdisciplinary discharge summary (recapitulation) must be completed in Point Click Care. -When a resident is transferred or discharged , the resident's attending physician must document in the medical record with the reason for the transfer/discharge. <p>1. Review of Resident #116's Admission Record showed:</p> <ul style="list-style-type: none"> -The resident was admitted to the facility on [DATE]. -The resident was discharged /transferred to another facility on 9/17/24. -The resident was his/her own responsible party. <p>Review of the resident's electronic medical record on 12/22/24 at 4:00 P.M., showed:</p> <ul style="list-style-type: none"> -No recapitulation of the resident's stay including diagnosis, course of illness/treatment, therapy, pertinent labs, radiology, and consultation results. -No reconciliation of all pre discharge medications with the resident's post discharge medications. -No post discharge plan of care developed to assist the resident to adjust to his/her living environment. <p>During an interview on 12/23/24 at 8:54 A.M., Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> -The charge nurse was responsible for completing the discharge summaries when a resident discharges from the facility. -The discharge summaries were documented in the resident's electronic medical record when completed. -He/she would consider an incomplete discharge summary with blanks not completed. <p>(continued on next page)</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>During an interview on 12/23/24 at 2:33 P.M., Social Services Director (SSD) said:</p> <ul style="list-style-type: none"> -He/she and the Director of Nursing (DON) were responsible for ensuring that the discharge summaries were completed. -When a resident discharged from the facility, the charge nurse placed a discharge order in the resident's medical record. -Discharge summaries should be uploaded in a resident's medical record when they discharge. <p>During an interview on 12/23/24 at 2:40 P.M., Administrator said the facility policy was not followed on this resident and the discharge summary was not completed correctly.</p> <p>During an interview on 12/23/24 at 4:03 P.M., Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> -All department were responsible for ensuring that discharge summaries were completed. -A resident's discharge summary should have been uploaded in a resident's electronic medical record once completed. -If a resident's discharge summary was not completed/partially completed, he/she would consider it to not have been done.

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51303</p> <p>Based on observation, interview and record review, the facility failed to establish a communication device for one sampled resident, (Resident #66) to improve the ability to carry out activities of daily living related to communication out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's Activities of Daily Living (ADL) policy revised 5/18/24 showed:</p> <ul style="list-style-type: none"> -The facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. --Care and services would be provided for the following activities of daily living: <ul style="list-style-type: none"> ---Using speech, language, or other functional communication systems. -Tips for improving or maintaining ADL skills. -Evaluating reason for decline in ADL skills. <p>1. Review of resident #66's Admission Record showed he/she was admitted [DATE] with the diagnoses to include:</p> <ul style="list-style-type: none"> -Malignant neoplasm of the laryngeal cartilage (a cancerous tumor that develops in the cartilage (a strong, flexible connective tissue) of the larynx or voice box. -Aphasia (loss of ability to produce or comprehend language due to brain injury). <p>Review of the resident's care plan revised 5/11/22 showed:</p> <ul style="list-style-type: none"> -The problem was he/she had a communication problem related to non-verbal and exhibits high impaired hearing pattern. He/she would look at you when spoken too but nods head yes to questions asked and doesn't follow questions. -The goal was he/she would maintain current level of communication function through the review date of 1/19/25. -The interventions included: <ul style="list-style-type: none"> --Allow adequate time to respond, repeat as necessary, do not rush. --Request clarification from the resident to ensure understanding. <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>--Face when speaking, make eye contact, turn off television and/or radio to reduce environmental noise.</p> <p>--Ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed.</p> <p>--Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed.</p> <p>--Monitor/document frustration level. Wait 30 seconds before providing resident with words.</p> <p>-The care plan did not show the SLP recommendation for a non-speech generating device.</p> <p>Review of Speech Language Pathology (SLP) Evaluation and Plan of Treatment start of care dated 7/29/24 showed:</p> <p>-The reason for referral was secondary to decline in expressive and receptive language and cognitive communication skills.</p> <p>-Prior medical history of malignant neoplasm of laryngeal cartilage and aphasia.</p> <p>Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 9/27/24 showed:</p> <p>-He/She was moderately cognitively intact.</p> <p>-He/She was rarely understood.</p> <p>Review of the SLP Discharge Summary dated 11/6/24 showed:</p> <p>-To facilitate optimal cognitive-communicative performance, the following strategies are recommended: measure to remove obstacles in the environment to increase safety, touch to achieve and maintain attention to tasks and visual aids to increase orientation/decrease wandering.</p> <p>-Additional mode of communication of non-verbal recommended primary mode of communication of a non-speech generating device.</p> <p>Observation on 12/17/24 at 2:22 P.M. the resident had difficulty with speech and would answer yes or no or nod to yes and shake head for no to answer questions.</p> <p>During an interview on 12/17/24 at 2:26 P.M. Certified Medication Technician (CMT) C said there was a poster the facility made that he/she could point at.</p> <p>During an interview on 12/19/24 at 10:47 A.M. CMT C said:</p> <p>-He/She believed the resident had a communication device.</p> <p>-He/She went to the resident's room and could not locate a communication device.</p> <p>(continued on next page)</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/24 at 10:47 A.M. the resident said no, he/she was not provided a communication device.</p> <p>During an interview on 12/19/24 at 1:00 P.M. the Administrator said:</p> <ul style="list-style-type: none"> -The resident had received SLP therapy. -He/She could not locate a communication poster and/or book. <p>During an interview on 12/20/24 at 8:54 A.M. CMT B said:</p> <ul style="list-style-type: none"> -He/She communicated with the resident and would watch his/her gestures. -He/She would attempt to give the resident medication and if he/she would pat the stomach, he/she interpreted the gesture as refusing medications. <p>During an interview on 12/20/24 at 9:01 A.M. the resident said:</p> <ul style="list-style-type: none"> -He/She remembered he/she had SLP therapy. -He/She did not have a communication board. -He/She would like a communication board to be able to get wants/needs across better. <p>During an interview on 12/23/24 at 9:49 A.M. Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> -He/She would observe and evaluate residents for communication needs. -Staff knew how to communicate with the residents because they spoke with them daily. -He/she was not aware the SLP recommended a non-speech generating device for the resident. <p>During an interview on 12/23/24 4:02 P.M. the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> -He/She would expect therapy recommendations to be implemented. -He/She would expect residents with unclear or no speech to have picture charts or a communication device. -He/She was not aware the resident did not have a communication device.

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469</p> <p>Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #51) was seen by a Dermatologist out of 23 sampled residents. The facility census was 111 residents.</p> <p>Policy requested from the facility and was not provided.</p> <p>1. Review of Resident #51's Admission Record showed:</p> <p>-He/She was admitted to the facility on [DATE].</p> <p>-He/She had a guardian.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) dated [DATE] showed:</p> <p>-He/She was moderately cognitively impaired.</p> <p>-Other skin problems was not checked.</p> <p>Observation and interview of the resident on 12/17/24 at 10:25 A.M. showed:</p> <p>-He/She had a golfball sized cyst on the left side of his/her face.</p> <p>-The cyst bothers him/her and should have been taken care of months ago.</p> <p>-He/She said that there was a physician's appointment this fall but there was a problem with the transportation to the appointment and he/she did not go to the appointment.</p> <p>-Nursing staff said someone should have rescheduled the appointment but was unable to tell him/her when the appointment was.</p> <p>Review of the Social Service Progress Notes, dated 9/27/24 showed:</p> <p>-The resident had an appointment with Dermatology (skin specialist) on 9/27/24, which was canceled due to transportation.</p> <p>-The progress note did not show the resident's guardian had been notified of the canceled appointment.</p> <p>Review of the Social Service Progress Notes, dated 12/20/24 showed the make up appointment for 3/11/25 was not made until 12/20/24.</p> <p>During an interview on 12/20/24 at 10:00 A.M. the Social Services Director (SSD) said:</p> <p>-He/She was in charge of making the physician's appointments for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had missed this one.</p> <p>-The appointment for the resident was not made until 12/20/24.</p> <p>-The makeup Dermatology appointment was now scheduled in March 2025.</p> <p>-The appointment should have been made the same week as the original appointment.</p> <p>-The guardian should have been notified of the missed appointment.</p> <p>-He/She had just notified the guardian of the new appointment date.</p> <p>-This was his/her responsibility and it was missed.</p> <p>During an interview on 12/20/24 at 12:00 P.M. Registered Nurse (RN) A and the Director of Nursing (DON) said:</p> <p>-If a resident had an appointment that was canceled for any reason the SSD should have rescheduled it that day or as soon as possible.</p> <p>-That appointment must have been missed.</p> <p>-The SSD was in charge of making physician appointments and ensuring the resident had transportation to the appointment.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the DON said:</p> <p>-If a resident missed a physician's appointment a rescheduled appointment should have been made that day.</p> <p>-The SSD was responsible for scheduling physician appointment and ensuring the resident had transportation to the appointment.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720</p> <p>Based on interview and record review, the facility failed to ensure weekly skin and/or wound assessments were completed each week for one sampled resident (Resident #21) out of 23 sampled residents. The facility census was 111 residents.</p> <p>A policy for skin and wound assessments was requested but not received at the time of exit.</p> <p>1. Review of Resident #21's Face Sheet showed he/she had a diagnosis of a left heel Stage III wound (a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) with a diagnosis onset date of 9/30/24. The resident also had a diagnosis of diabetes.</p> <p>Review of the resident's Braden Risk Assessment (a tool used to predict the likelihood of developing a pressure ulcer) dated 6/11/24 score was 21 indicating the resident was not at risk for developing pressure ulcers.</p> <p>Review of the resident's Clinical Admission note dated 9/19/24 showed the resident arrived at the facility with blisters noted on his/her right and left lower extremities. The note did not include detailed descriptions of the wounds or measurements.</p> <p>Review of the resident's readmission Braden Risk assessment dated [DATE] score was 15 indicating he/she was at mild risk for developing pressure ulcers.</p> <p>Review of the resident's readmission progress note dated 9/19/24 showed he/she was readmitted to the facility from the hospital with a left heel pressure ulcer. The documentaion did not include a detailed assessment with description and/or measurements.</p> <p>Review of the resident's Progress Note dated 9/29/24 showed:</p> <ul style="list-style-type: none"> -A Certified Nursing Assistant (CNA) reported the resident had blisters on both heels. -The heels were assessed, cleansed, and Skin Prep (a topical barrier between skin and adhesives) was applied. -He/She will notify the wound nurse. -No documentation of a detailed description or measurements. -No documented skin/wound assessments since the resident's readmission on 9/19/24. <p>Review of the resident's care plan updated on 9/30/24 showed:</p> <ul style="list-style-type: none"> -He/She had a Stage III pressure ulcer on his/her left heel. -Wound nurse was to follow. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Skin and Wound Total Body Skin assessment dated [DATE] showed the resident had three new wounds. The documentation did not include the location of the wounds, the type of wounds, a detailed description, or measurements.</p> <p>Review of the resident's Skin Check dated 10/3/24 showed the resident had a diabetic foot ulcer (an open wound or sore that develops on the foot of someone with diabetes), this was a new skin issue. Staff documented the wound as an in-house acquired Stage I pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence) on the resident's left heel. The wound was described as an intact blister measuring 5 centimeters (cm) in length by 5 cm in width.</p> <p>--NOTE: An intact blister would be considered a Suspected Deep Tissue Injury (sDTI - Deep tissue injury may be characterized by a purple or maroon localized area of discolored intact skin or a blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Presentation may be preceded by tissue that is painful, firm, mushy, boggy, and warmer or cooler as compared to adjacent tissue) and not a Stage I pressure ulcer. Staff also documented the wound as a diabetic ulcer.</p> <p>Review of the resident's Skin and Wound Evaluation dated 10/3/24 showed the resident had a wound on his/her left heel. The wound was not identified as being a pressure ulcer or non-pressure ulcer. The documentation did not indicate when the wound developed or if it was acquired at the facility or at the hospital. The wound was 3.6 cm by 3.4 cm. There was no further documentation to describe the wound.</p> <p>--NOTE: The resident's Skin Check also dated 10/3/24 showed the wound was 5 cm by 5 cm.</p> <p>Review of the resident's Health Status Note dated 10/3/24 showed:</p> <p>-He/She had pressure ulcers to his/her bilateral (both left and right) heels.</p> <p>-The pressure ulcers appeared to be Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister). The wounds were cleaned and treatment applied.</p> <p>-No detailed description or measurements were documented.</p> <p>Review of the Nurse Practitioner's (NP) note dated 10/8/24 for the date of service 10/3/24 showed an unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcer on the resident's left heel acquired on 9/30/24.</p> <p>Review of the resident's medical record showed the following skin/wound assessments in October 2024 showed no documentation a skin and/or wound assessment was completed on 10/10/24.</p> <p>Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/8/24 showed:</p> <p>-He/She was cognitively intact.</p> <p>-Had two or more unstageable pressure ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical record showed the following skin/wound assessments in November 2024:</p> <ul style="list-style-type: none"> -No documentation a skin and/or wound assessment for the left heel or for the right heel was completed on 11/28/24. <p>Review of the resident's medical record showed the following skin/wound assessments in December 2024:</p> <ul style="list-style-type: none"> -No documentation a skin and/or wound assessment for the left heel or for the right heel was completed on 12/5/24. <p>During an interview on 12/19/24 at 8:50 A.M., the resident said he/she had pressure ulcers on both of his/her heels but he/she thinks they have completely healed now.</p> <p>During an interview on 12/19/24 at 8:57 A.M. Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> -The facility has a wound nurse that does weekly skin/wound assessments. -The wound nurse was responsible for documenting the skin/wound assessments in the resident's medical record. -The resident's heels have healed and now they are just doing preventative treatments <p>During an interview on 12/23/24 at 4:02 P.M., the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> -He/She expected staff to complete weekly skin/wound assessments and document the assessments in the resident's medical record. -He/She did not audit at this time to ensure this was being done.

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 51150</p> <p>Based on observation, interview, and record review, the facility failed to ensure respiratory equipment such as oxygen tubing, Continuous Positive Airway Pressure (CPAP - a method of noninvasive ventilation assisted by a flow of air delivered at a constant pressure throughout the respiratory cycle) were cleaned and stored in a sanitary condition for two sampled residents, (Resident #72 and #27) out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's policy, Oxygen Administration, dated 5/18/24 showed:</p> <ul style="list-style-type: none"> -The facility was to follow the manufacturer recommendations for the frequency of cleaning oxygen equipment and filters. -Change oxygen tubing and mask, cannula (a medical device that provides supplemental oxygen to patients through two prongs that fit into the nostrils) weekly and as needed if it becomes soiled or contaminated. -Keep delivery devices covered in plastic when not in use. <p>1. Review of Resident #72's Admission Record showed:</p> <ul style="list-style-type: none"> -The resident was admitted to the facility on [DATE]. -The resident had a diagnosis of obstructive sleep apnea (a condition that occurs when the airway becomes narrow as the muscles relax during sleep which reduces oxygen in the blood and causes arousal from sleep). <p>Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated 9/4/24, showed:</p> <ul style="list-style-type: none"> -The resident was cognitively intact. -Note: The MDS did not show oxygen therapy and did not show CPAP therapy. <p>Review of the resident's care plan, dated 12/5/24 showed:</p> <ul style="list-style-type: none"> -The resident had obstructive sleep apnea. - Note: The care plan did not show oxygen therapy and did not show CPAP therapy. <p>Review of the resident's Physicians Order Sheet (POS) dated December 2024 showed:</p> <ul style="list-style-type: none"> -Oxygen at 2 liters per nasal cannula (a medical device that delivers oxygen to a person through their nose) as needed for shortness of breath. <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 - Few</p>	<p>-CPAP at bedtime, check and make sure distilled water was added. Clean every day after use at bedtime.</p> <p>-Note: The CPAP order was on hold and the oxygen order was active.</p> <p>Observation on 12/17/24 at 1:27 P.M. showed:</p> <p>-The nasal cannula tubing was not in a bag or dated.</p> <p>-The nasal cannula tubing was wrapped around a portable oxygen tank.</p> <p>-The CPAP mask was laying on the floor and not in a bag.</p> <p>During an interview on 12/17/24 at 1:27 P.M., the resident said:</p> <p>-He/she uses his/her oxygen as needed for shortness of breath.</p> <p>-The nasal cannula tubing was never covered when not in use.</p> <p>-He/she never recalled the nasal cannula tubing ever being changed and/or cleaned by the staff.</p> <p>-He/she had not used his/her CPAP machine in a while because he/she found it under his/her bed one day and covered in mice droppings.</p> <p>-Staff has never cleaned his/her CPAP mask and his/her mask was never covered when not in use.</p> <p>Observation on 12/19/24 at 8:40 A.M. showed:</p> <p>-The nasal cannula tubing was not in a bag or dated.</p> <p>-The nasal cannula tubing was wrapped around a portable oxygen tank.</p> <p>-The CPAP mask was laying on floor and not in a bag.</p> <p>Observation on 12/20/24 at 1:42 P.M. showed:</p> <p>-The nasal cannula tubing was not in a bag or dated.</p> <p>-The nasal cannula tubing was wrapped around a portable oxygen tank.</p> <p>-The CPAP mask was laying on the floor and not in a bag.</p> <p>2. Review of Resident #27's Admission Record showed:</p> <p>-The resident was admitted to the facility on [DATE].</p> <p>-Note: The admission record had no respiratory related diagnosis.</p> <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 - Few</p>	<p>Review of the resident's quarterly MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -The resident was cognitively intact. -Note: The MDS did not show oxygen therapy. <p>Review of the resident's care plan, dated 12/5/24 showed no oxygen therapy was listed.</p> <p>Review of the resident's POS dated December 2024 showed:</p> <ul style="list-style-type: none"> -Change and date oxygen tubing weekly on Sundays. every night shift. every Mon, Sun. -Oxygen at 2 liters per minute per nasal cannula as needed for shortness of breath. <p>Observation on 12/18/24 at 9:41 A.M. showed:</p> <ul style="list-style-type: none"> -The nasal cannula was placed in the resident's nose and running at 2 liters per minute. -The nasal cannula tubing was not dated. <p>During an interview on 12/18/24 at 9:41 A.M., the resident said:</p> <ul style="list-style-type: none"> -He/she has never seen a staff member clean and/or change out his/her nasal cannula tubing. -His/her nasal cannula tubing was never covered when not in use. <p>Observation on 12/19/24 at 12:06 P.M. showed:</p> <ul style="list-style-type: none"> -The resident's nasal cannula tubing was laying on his/her bed and not covered. -The nasal cannula tubing was not dated. -The oxygen tank was turned on and running and 2 liters per minute. <p>Observation on 12/20/24 at 12:25 P.M. showed:</p> <ul style="list-style-type: none"> -The resident's nasal cannula tubing was laying on his/her bed and not covered. -The nasal cannula tubing was not dated. <p>During an interview on 12/23/24 at 8:47 A.M., Certified Medication Technician (CMT) F said:</p> <ul style="list-style-type: none"> -He/she thought a resident's oxygen tubing would need to be changed weekly or monthly but he/she was unsure of exactly how often. -He/she would think that oxygen tubing and CPAP mask would be stored in a plastic bag when not in use by a resident. <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 - Few</p>	<p>During an interview on 12/23/24 at 8:54 A.M., Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> -Oxygen tubing should be changed every Sunday. -Oxygen tubing and CPAP mask should be stored in a plastic bag when not in use by a resident. -Oxygen tubing should be labeled with the date the tubing was last changed. <p>During an interview on 12/23/24 at 9:07 A.M., Certified Nurse Assistant (CNA) H said:</p> <ul style="list-style-type: none"> -The charge nurses were responsible for changing the resident's oxygen tubing. -The oxygen tubing should be changed out once weekly. -He/she was unsure of how the oxygen tubing was to be stored when not in use by a resident. <p>During an interview on 12/23/24 at 4:03 P.M., Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> -Oxygen tubing should be changed once per week. -When not in use, oxygen tubing and CPAP mask should be in a zip lock bag. -Oxygen tubing should be dated with the date that the tubing was last changed. 		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720</p> <p>Based on interview and record review, the facility failed to ensure residents were seen by a physician at least every 30 days for the first 90 days and then at least every 60 days thereafter for three sampled residents (Resident #9, #108, and #107) out of 23 sampled residents. The facility census was 111 residents.</p> <p>1. Review of Resident #9's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Impulse disorder (a psychiatric condition that makes it difficult to control actions or reactions). -Borderline intellectual functioning (below average cognitive functioning). -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). -Bipolar (mood disorders characterized usually by alternating episodes of depression and mania). -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). -Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a shocking, scary, or dangerous event). <p>Review of the resident's medical record showed the following physician visits:</p> <ul style="list-style-type: none"> -On 4/22/24 the medical Nurse Practitioner (NP) visited the resident and completed an admission History and Physical (H&P). -On 4/30/24 the resident's physician visited the resident. This was the first visit after admission from the medical physician. -On 5/6/24 the medical NP visited the resident. -On 5/20/24 the medical NP visited the resident. --No visits from the resident's physician in May 2024. -On 6/3/24 the medical NP visited the resident. -On 6/11/24 the resident's physician visited the resident. This was the second visit after admission from the medical physician. This was more than 30 days from the last physician's visit. -On 7/16/24 the medical NP visited the resident. <p>(continued on next page)</p>		

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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 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 7/23/24 the resident's physician visited the resident.</p> <p>-On 7/31/24 the medical NP visited the resident.</p> <p>-On 8/7/24 the resident's physician visited the resident.</p> <p>-On 8/13/24 the medical NP visited the resident.</p> <p>-On 9/2/24 the medical NP visited the resident.</p> <p>-On 9/26/24 a medical NP visited the resident noting the resident was new to this physician groups service.</p> <p>-On 9/30/24 the medical NP visited the resident.</p> <p>-On 11/14/24 the medical NP visited the resident.</p> <p>2. Review of Resident #108's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Bipolar disorder.</p> <p>-Schizophrenia.</p> <p>-PTSD.</p> <p>Review of the resident's medical record showed the following physician visits:</p> <p>-On 5/20/24 the medical NP visited the resident.</p> <p>-On 5/26/24 the resident's admission H&P was completed by the resident's physician.</p> <p>-On 6/11/24 the resident's physician visited the resident.</p> <p>-On 6/17/24 the medical NP visited the resident.</p> <p>-On 6/25/24 the resident's physician visited the resident.</p> <p>-On 7/2/24 the medical NP visited the resident.</p> <p>-On 7/16/24 the medical NP visited the resident for a readmission assessment.</p> <p>-On 7/23/24 the resident's physician visited the resident.</p> <p>-On 8/5/24 the medical NP visited the resident.</p> <p>-On 8/20/24 the resident's physician visited the resident.</p> <p>(continued on next page)</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 8/28/24 the medical NP visited the resident.</p> <p>-On 9/10/24 the medical NP visited the resident.</p> <p>-On 9/29/24 the medical NP visited the resident.</p> <p>-No documentation the medical NP or the resident's physician visited the resident between 9/29/24 - 12/23/24.</p> <p>3. Review of Resident #89's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems).</p> <p>-Intellectual disabilities.</p> <p>-Schizophrenia.</p> <p>-Bipolar.</p> <p>-Asperger's syndrome (a developmental disorder that makes it difficult to interact with others and understand social cues).</p> <p>Review of the resident's medical record showed the following physician visits from 12/26/23-12/23/24:</p> <p>-On 12/26/23 the psychiatric (psych) NP visited the resident.</p> <p>--No documentation the resident's physician visited from 12/23 - 2/7/24.</p> <p>-On 2/3/24 the psych NP visited the resident.</p> <p>-On 2/7/24 the medical physician visited the resident.</p> <p>-On 3/19/24 the medical physician visited the resident.</p> <p>-On 4/2/24 the medical physician visited the resident.</p> <p>--No documentation the resident's physician or NP visited in 5/24.</p> <p>-On 6/14/24 the psych NP visited the resident.</p> <p>-On 6/25/24 the medical physician visited the resident.</p> <p>-On 7/9/24 the medical physician visited the resident.</p> <p>-On 7/29/24 the psych NP visited the resident.</p> <p>(continued on next page)</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 8/21/24 the psych NP visited the resident.</p> <p>-On 8/22/24 the medical physician visited the resident.</p> <p>-On 8/29/24 the psych NP visited the resident.</p> <p>--No documentation the resident's physician or NP visited in 9/24.</p> <p>-On 10/18/24 the medical NP visited the resident.</p> <p>-On 10/27/24 the psych NP visited the resident.</p> <p>-On 11/22/24 the medical NP visited the resident.</p> <p>-On 11/23/24 the psych NP visited the resident.</p> <p>--No documentation the resident's psych physician visited from 12/23 - 12/23/24.</p> <p>4. Review of Resident #107's Face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Schizoaffective disorder.</p> <p>-Borderline intellectual functioning.</p> <p>-Anxiety.</p> <p>-PTSD.</p> <p>Review of the resident's medical record showed the following physician visits:</p> <p>-On 7/31/24 an admission H&P visit by the medical NP.</p> <p>--No documentation the resident's physician visited the resident upon admission.</p> <p>-On 8/28/24 the medical NP visited the resident.</p> <p>-On 9/4/24 the resident's medical physician visited the resident. This is the first documented physician's visit for the resident since admission.</p> <p>-No documentation the resident has been seen by the physician or NP since 9/4/24.</p> <p>5. During an interview on 12/23/24 at 4:02 P.M., the Director of Nursing (DON) said:</p> <p>-He/She had been in this position for about two weeks.</p> <p>-He/she was responsible to ensure the resident's physician visited the resident every 30 days for the first 90 days after admission.</p> <p>(continued on next page)</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The NP can see the resident in between physician visits.</p> <p>-The physician should visit the resident every 60 days.</p> <p>-The facility changed physician services a couple of months ago, probably in September 2024.</p> <p>-Physician's should document their visit in the resident's medical record.</p> <p>MO00246720</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>42955</p> <p>Based on interview and record review, the facility failed to ensure staff, residents and visitors had access to daily staffing by not posting staffing data in a prominent and readily accessible area for all residents to have access. The facility census was 111 residents.</p> <p>Review of the facility's Nurse Staffing Posting Information Policy, dated 6/26/24, showed:</p> <ul style="list-style-type: none"> -The purpose of the policy was to make sure nurse staffing information was readily available in a readable format to resident's and visitors at any given time. -The nurse staffing sheet was posted daily and contained: <ul style="list-style-type: none"> --The facility name. --Current date. --Current resident census. --Total number and actual hours worked by Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNA). -The facility posted the Nurse Staffing sheet at the beginning of each shift. -It was in a prominent place readily accessible to residents and visitors. <p>Observation on 12/16/24 at 12:05 P.M. showed a wipe board hanging in the lobby of the facility which displayed the date, and number of people working by title CNA, LPN, RN.</p> <p>Observation on 12/16/24 at 12:56 P.M., showed no staffing was posted on the medical unit, men's unit, or the women's unit.</p> <p>During an interview on 12/18/24 at 9:36 A.M., CNA A said:</p> <ul style="list-style-type: none"> -The staffing was posted at the nurse's station in the front of the building. -He/She was unsure if it was posted on the other units. <p>During an interview on 12/18/24 at 10:14 A.M., CNA B said:</p> <ul style="list-style-type: none"> -Staffing sheets were posted on a wipe board when you first came in the building in the lobby. -He/She thought I was also posted behind the nurse's station on the main floor. -He/She was unaware of staffing being posted elsewhere. <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/18/24 at 10:37 A.M., the Staffing Coordinator said:</p> <ul style="list-style-type: none"> -Staffing was posted by the nurse's station on the first floor. -Staffing was not noted to be staff on the other units. <p>During an interview on 12/18/24 at 12:33 P.M., LPN B said:</p> <ul style="list-style-type: none"> -Staffing was posted on the wipe board in the lobby. -It was also by the nurse's station on the main level. <p>During an interview on 12/19/24 at 10:00 A.M., CNA D said:</p> <ul style="list-style-type: none"> -Staffing should be posted in the Certified Medication Technician (CMT) room (a glass room on the unit). -Sometimes they wrote it on the wipe board in the CMT room. <p>Observation on 12/19/24 at 10:00 A.M., showed:</p> <ul style="list-style-type: none"> -No staffing written on the wipe board. -No other staffing noted to be posted. <p>During an interview on 12/19/24 at 10:11 A.M., LPN A said:</p> <ul style="list-style-type: none"> -Staffing was not posted on the women's unit. -It was posted upstairs by the nurse's station. <p>During an interview on 12/20/24 at 9:53 A.M., the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> -Normally staffing was posted in the front lobby. -All staff, residents and visitors should have had access to the staffing. -Not all residents had access to the front lobby. -There were two locked units in the facility and those residents could not access the lobby without assistance. -It should have been posted on all units. <p>During an interview on 12/20/24 at 9:53 A.M., the Administrator said:</p> <ul style="list-style-type: none"> -The Staffing Coordinator and the receptionist in the front were responsible for changing and updating the staffing. <p>(continued on next page)</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-It should be posted where staff, visitors and all residents could see it.</p> <p>-Residents on the locked units could not see the staffing in the lobby unless they had to go out of the facility.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39469</p> <p>Based on interview and record review, the facility failed to ensure the Narcotic (a substance used to treat moderate to severe pain) medication count was correct, and failed to ensure that two nursing staff were counting the narcotics at the beginning and end of each shift. The facility census was 111 residents.</p> <p>Review of the facility's Administration and Accountability Policy, dated 5/14/24 showed:</p> <ul style="list-style-type: none"> -All controlled substances were accounted for in the following ways: -All controlled substances obtained were recorded on the designated usage form. -Written documentation must be clearly legible with all applicable information provided. -The controlled Drug Record serves the dual purpose of recording both narcotic disposition and patient administration. -The Charge nurse or other designee should have conducted a daily visual audit of the required documentaion of controlled substances. -For patient care areas which do not utilize an automated dispensing systems the amount on hand was to have been checked against the amount used daily from the documented records. -Two licensed nurses account for all controlled substances at the end of each shift. -Any discrepancy in the count of controlled substances should have been resolved by the end of the shift during which it was discovered. -Any discrepancies which were not able to have been resolved must have been reported immediately to the DON, Charge Nurse, and the Pharmacy. <p>1. Review of the Controlled Drugs - Count Record (Men's Locked Unit) dated 12/1/24 through 12/19/24 showed:</p> <ul style="list-style-type: none"> -There were two shifts 8:00 A.M. to 8:00 P.M. and 8:00 P.M. to 8:00 A.M. -On the day shift out of 38 opportunities, four were blank. 30 shifts were signed by the same person on-coming and off going without a second signature. -On the night shift out of 36 opportunities, 35 were blank. -The count of controlled substances cards started at 24 cards, 14 were added, 10 were subtracted the correct count should have been 28, 4 cards were unaccounted for. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of supplemental Resident #16's Individual Patient Narcotic Record on 12/19/24 at 10:00 A.M. showed the following Physician's order:</p> <ul style="list-style-type: none"> -Pregabalin (medication used to treat pain) 50 milligrams (mg) capsule one capsule by mouth three times a day. -On 12/7/24 the resident had 60 capsules. -29 capsules were signed out as given. -The count should have been 31 capsules left. -The documented count was 30. -On 12/17/24 the count showed he/she had 30 capsules left. <p>3. Review of Resident #51's Individual Patient Narcotic Record on 12/19/24 at 10:00 A.M. showed the following Physician's order:</p> <ul style="list-style-type: none"> -Lorazepam (anxiety medication) 0.5 MG one tablet by mouth three times a day. -On 11/29/24 the resident had 90 tablets. -On 12/4/24 two doses were given. -On 12/4/24 an addition four doses were signed out as given for a total of 6 tablets given. -On 12/19/24 the count was correct. <p>4. Review of supplemental Resident #52's Individual Patient Narcotic Record on 12/19/24 at 10:00 A.M. showed the following Physician's order:</p> <ul style="list-style-type: none"> -Hydrocodone/Tylenol (combination pain medication) 5/325 MG tablets one tablet by mouth every six hours as needed. -On 11/25/24 the resident had 60 tablets. -On 11/21/24 the resident had 45 tablets. -On 11/25/24 the resident had 44 tablets. -There was no signature, date, or time the medication was given between 11/21/24 and 11/25/24. <p>During an interview on 12/19/24 at 11:12 A.M. Certified Medication Technician (CMT) A said:</p> <ul style="list-style-type: none"> -The Controlled Drugs - Count Record was not signed or counted by a second nursing staff member. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She counted when he/she came on shift and when he/she left the shift so he/she was signing twice. No one counted as the oncoming night shift.</p> <p>-That was how he/she always did the narcotic count.</p> <p>-Maybe the nurse on the first floor should have come to his/her unit to count with him/her.</p> <p>-He/She had not told anyone that a second person was not counting.</p> <p>-The Director of Nursing (DON) was ultimately responsible for the narcotics' count.</p> <p>During an interview on 12/20/24 at 2:00 P.M. Registered Nurse (RN) A said:</p> <p>-Two nursing staff should have counted together one on-coming and one off going then signed the Narcotic Count Sheet.</p> <p>-The staff should have given the medication according to the physician's order and the correct amount given.</p> <p>-If the count was not correct the Director of Nursing (DON) should have been notified and an investigation completed.</p> <p>During an interview on 12/ 23/24 at 4:10 P.M. the DON said:</p> <p>-An on-coming and off-going nursing staff were responsible to count the narcotics and sign the sheet at the same time ensuring the count was correct.</p> <p>-He/She has been doing spot checks and had not found any issues.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from unnecessary medications and recommendations were addressed by the physician in a timely manner for four sampled residents (Residents #9, #108 and #19 and failed to ensure a medication that was prescribed had an associated diagnosis for one sampled resident (Resident #25) out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's Medication Regimen Review (MRR) policy dated 6/24/24 showed:</p> <ul style="list-style-type: none"> -The drug regimen review should be completed by the pharmacist at least monthly. -Facility staff shall act upon the recommendations. <p>1. Review of Resident #9's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Impulse disorder (a psychiatric condition that makes it difficult to control actions or reactions). -Borderline intellectual functioning (below average cognitive functioning). -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). -Bipolar (mood disorders characterized usually by alternating episodes of depression and mania). -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). -Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a shocking, scary, or dangerous event). <p>Review of the resident's September 2024 Physician Order Sheet (POS) and Medication Administration Record (MAR) showed:</p> <ul style="list-style-type: none"> -Ibuprofen (an over the counter pain medication) 400 milligrams (mg) by mouth every 6 hours as needed for pain. -Levothyroxine (a medication used to treat thyroid conditions) - 75 micrograms (mcg) every morning for hypothyroidism (low thyroid). <p>Review of the resident's monthly pharmacy DRR dated 9/22/24 showed:</p> <ul style="list-style-type: none"> -Ibuprofen - add give food or snack. -Levothyroxine - add give whole tablet with plenty of water on an empty stomach, do not crush. <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's October 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Ibuprofen 400 mg by mouth every 6 hours as needed for pain. --The order did not contain the pharmacy recommendation to add give with food or snack. -Levothyroxine - 75 mcg every morning for hypothyroidism. --The order did not contain the pharmacy recommendation to give whole tablet with plenty of water on an empty stomach, do not crush. <p>Review of the resident's monthly pharmacy DRR dated 10/28/24 showed to please follow up on 9/22/24 nursing recommendations and add responses in progress notes under pharmacy review,</p> <p>Review of the resident's November 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Ibuprofen 400 mg by mouth every 6 hours as needed for pain. --The order did not contain the pharmacy recommendation to add give with food or snack. -Levothyroxine - 75 mcg every morning for hypothyroidism. --The order did not contain the pharmacy recommendation to give whole tablet with plenty of water on an empty stomach, do not crush. <p>Review of the resident's monthly pharmacy DRR dated 11/24/24 showed:</p> <ul style="list-style-type: none"> -Ibuprofen - add give food or snack. -Levothyroxine - add give whole tablet with plenty of water on an empty stomach, do not crush. <p>2. Review of Resident #108's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Bipolar disorder. -Schizophrenia. -PTSD. <p>Review of the resident's May 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Famotidine 20 mg twice daily for gastroesophageal reflux disease (GERD - back-up of stomach acid/heartburn). -Omeprazole 40 mg daily for GERD. -Pulmicort inhaler 90 micrograms per activation (mcg/act) one puff twice daily for asthma. <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 12/23/2024
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's monthly pharmacy DRR dated 5/15/24 showed:</p> <ul style="list-style-type: none"> -Add to Pulmicort Inhaler instructions rinse mouth after use. -Resident currently received Famotidine (a histamine H2 blocker - an acid reducer) 20 mg twice daily and Omeprazole (a proton-pump inhibitor (PPI) to reduce stomach acid) 40 mg daily for GERD. Please assess the medical risk versus benefit and if your patient would benefit from use of a single entity acid reduction therapy agent or state below that a change in the current therapy regimen is clinically contraindicated. --Agree (write new orders). --Disagree (please state in your progress note if therapy change is not indicated). <p>Review of the resident's June 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Famotidine 20 mg twice daily for GERD. -Omeprazole 40 mg daily for GERD. -Pulmicort inhaler 90 mcg/act one puff twice daily for asthma. --The order did not contain the recommendation rinse mouth after use. <p>Review of the resident's monthly pharmacy DRR dated 6/20/24 showed:</p> <ul style="list-style-type: none"> -Please follow up on 5/15/24 physician recommendations regarding PPI/H2 use and link physician response in progress notes under pharmacy review note section for tracking. -Add to Pulmicort Inhaler instructions rinse mouth after use. <p>Review of the resident's July 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Omeprazole 40 mg daily for GERD discontinued on 7/2/24. -Famotidine 20 mg twice daily for GERD discontinued on 7/2/24. -Famotidine 20 mg twice daily for GERD dated 7/12/24. -Pulmicort inhaler 90 mcg/act one puff twice daily for asthma discontinued on 7/2/24. --The order did not contain the recommendation rinse mouth after use. -Pulmicort inhaler 90 mcg/act one puff twice daily for asthma dated 7/12/24. --The order did not contain the recommendation rinse mouth after use. <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's monthly pharmacy DRR dated 7/18/24 showed to please follow up on 6/20/24 physician recommendations regarding PPI/H2 use and link physician response in progress notes under pharmacy review note section for tracking.</p> <p>Review of the resident's August 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Famotidine 20 mg twice daily for GERD dated 7/12/24. -Pulmicort inhaler 90 mcg/act one puff twice daily for asthma dated 7/12/24. --The order did not contain the recommendation rinse mouth after use. <p>Review of the resident's monthly pharmacy DRR dated 8/18/24 showed to please follow up on 6/20/24 physician recommendations regarding PPI/H2 use and link physician response in progress notes under pharmacy review note section for tracking.</p> <p>Review of the resident's September 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Famotidine 20 mg twice daily for GERD dated 7/12/24. -Pulmicort inhaler 90 mcg/act one puff twice daily for asthma dated 7/12/24. --The order did not contain the recommendation rinse mouth after use. -Levothyroxine 150 mcg once a day (scheduled for morning pass at 8:00 A.M.) for hypothyroidism. <p>Review of the resident's monthly pharmacy DRR dated 9/22/24 showed:</p> <ul style="list-style-type: none"> -Add to Pulmicort Inhaler instructions rinse mouth after use. -Move Levothyroxine to 7:00 A.M. on POS. <p>Review of the resident's October 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Famotidine 20 mg twice daily for GERD dated 7/12/24. -Pulmicort inhaler 90 mcg/act one puff twice daily for asthma dated 7/12/24. --The order did not contain the recommendation rinse mouth after use. -Levothyroxine 150 mcg once a day (scheduled for morning pass at 8:00 A.M.) for hypothyroidism. --The order did not contain the recommendation to move the administration time to 7:00 A.M. <p>Review of the resident's monthly pharmacy DRR dated 10/28/24 showed:</p> <ul style="list-style-type: none"> -Noted H2 is the only acid reducer currently active. Disregard physician follow-up. <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Add to Pulmicort Inhaler instructions rinse mouth after use on POS/MAR.</p> <p>-Move Levothyroxine to 7:00 A.M. on POS/MAR.</p> <p>Review of the resident's November 2024 POS and MAR showed:</p> <p>-Pulmicort inhaler 90 mcg/act one puff twice daily for asthma dated 7/12/24.</p> <p>--The order did not contain the recommendation rinse mouth after use.</p> <p>-Levothyroxine 150 mcg once a day (scheduled for morning pass at 8:00 A.M.) for hypothyroidism.</p> <p>--The order did not contain the recommendation to move the administration time to 7:00 A.M.</p> <p>Review of the resident's monthly pharmacy DRR dated 11/24/24 showed no new suggestions this month.</p> <p>Review of the resident's December 2024 POS and MAR showed:</p> <p>-Pulmicort inhaler 90 mcg/act one puff twice daily for asthma dated 7/12/24.</p> <p>--The order did not contain the recommendation rinse mouth after use.</p> <p>-Levothyroxine 150 mcg once a day (scheduled for morning pass at 8:00 A.M.) for hypothyroidism.</p> <p>--The order did not contain the recommendation to move the administration time to 7:00 A.M.</p> <p>Review of the resident's monthly pharmacy DRR dated 12/12/24 showed:</p> <p>-Add to Pulmicort Inhaler instructions rinse mouth after use on POS/MAR.</p> <p>-Move Levothyroxine to 7:00 A.M. on POS/MAR.</p> <p>39469</p> <p>3. Review of Resident #19's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of Hypothyroidism (a condition in which the thyroid gland doesn't produce enough of the thyroid hormone).</p> <p>Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 12/9/24 showed:</p> <p>-He/She was cognitively intact.</p> <p>-He/She had a thyroid disorder (hypothyroidism).</p> <p>Review of the resident's pharmacy notes to Nursing showed:</p> <p>-Please add instruction for levothyroxine Do Not Crush on the POS and MAR.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The note to nursing was dated 11/23/24 and again on 12/13/24.</p> <p>Review of the resident's December 2024 POS on 12/20/24 showed:</p> <p>-Levothyroxine 125 microgram (mcg) tablet orally one time a day related to Hypothyroidism.</p> <p>-Take this medication on an empty stomach.</p> <p>-Do not take this medication with other medications.</p> <p>-It did not say not to crush the medication.</p> <p>4 Review of Resident #25's face sheet showed:</p> <p>-He/she was admitted to the facility on [DATE].</p> <p>-His/Her diagnoses did not show he/she had seizures (an uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by an abnormal electrical activity in the brain), was bipolar (episodes of mood swings ranging from depression to highs (manic periods of high activity), or had migraines (a headache accompanied by nausea and sensitivity to light or sound).</p> <p>Review of the resident's Quarterly MDS dated [DATE] showed he/she was cognitively intact.</p> <p>Review of the residents December 2024 POS showed the following order:</p> <p>-Valproic Acid (medication used for seizures, bipolar, or migraines) oral capsule 250 mg give two capsules by mouth in the morning, dated 9/27/24.</p> <p>-Did not have a reason or diagnosis as to why the resident was on Valproic acid.</p> <p>5. During an interview on 12/19/24 at 8:33 A.M. Certified Medication Technician (CMT) A said:</p> <p>-Before giving a medication you have to check the medication to ensure it was the correct medication to give to the resident.</p> <p>-The physician would have wrote what reason the medication was given to the resident.</p> <p>-He/She did not know who would have been responsible to ensure each medication had a corresponding diagnosis.</p> <p>-The reason the medication was given to the resident should have been on the POS and on the MAR.</p> <p>During an interview on 12/19/24 at 9:30 A.M. the resident said:</p> <p>-He/She did not know what medications he/she took.</p> <p>-He/She had not had any seizures.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/19/24 Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> -You have to check the medication before administering it. -The physician should have had a reason the resident received the medication and would have been documented on the POS and the MAR. -The Pharmacist checks the POS every month to ensure they were correct. -If there was an issue the Director of Nursing (DON) should have fixed it. -There should have been a diagnosis and the diagnosis should have been on the POS and MAR. <p>During an interview on 12/23/24 at 8:47 A.M., CMT F said he/she thought the DON or possibly the Administrator were responsible for monitoring the monthly drug regimen reviews from the pharmacist.</p> <p>During an interview on 12/23/24 at 8:57 A.M., LPN B said:</p> <ul style="list-style-type: none"> -The DON was responsible for monitoring the monthly drug regimen reviews from the pharmacist. -He/She was not sure how the process worked for communicating with the physician if a recommendation was made since it all went through the DON. <p>During an interview on 12/23/24 at 4:10 P.M. the DON said:</p> <ul style="list-style-type: none"> -He/She received the notes from the pharmacy. -He/She would have notified the physician of the issue the pharmacy had seen. -The physician should have addressed any issue. -If they disagreed there would have been a note why. -The issues that the pharmacy saw should have been addressed within 72 hours. -There should have been a diagnoses for each medication and the diagnosis should have been correct. -He/She had recently taken over ensuring the pharmacy notes had been addressed and that the medications had the correct corresponding diagnosis as this had not been done. -He/She had been in the position for only a week or two. -He/She was responsible for communicating with the physician if a pharmacy recommendation was made. -Recommendations should be addressed within 72 hours. 		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from unnecessary psychotropic medications for five sampled residents (Residents #9, #108, #66 #102, and #7) out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's Gradual Dose Reduction of Psychotropic Drugs updated 5/14/24, showed:</p> <ul style="list-style-type: none"> -Residents who use psychotropic drugs received gradual dose reductions and behavioral interventions, unless clinically contraindicated, to discontinue those drugs. -Psychotropic drugs were defined as any drug that affects the brain activities associated with mental processes and behaviors. -Psychotropic drugs included but were not limited to the following categories: antipsychotics, antidepressants, antianxiety, and hypnotics. -Rationale for clinical contraindications may be documented in the electronic health record. -A GDR will be attempted annually unless clinically contraindicated. <p>1. Review of Resident #9's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Impulse disorder (a psychiatric condition that makes it difficult to control actions or reactions). -Borderline intellectual functioning (below average cognitive functioning). -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). -Bipolar (mood disorders characterized usually by alternating episodes of depression and mania). -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). -Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a shocking, scary, or dangerous event). <p>Review of the resident's May 2024 Physician's Order Sheet (POS) and Medication Administration Record (MAR) showed Divalproex (an antiseizure medication used to treat bipolar) 250 milligrams (mg) two times daily for bipolar.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's monthly pharmacy Drug Regimen Review (DRR) dated 5/13/24 showed Divalproex - add do not crush.</p> <p>Review of the resident's June 2024 POS and MAR showed:</p> <p>-Divalproex 250 mg two times daily for bipolar.</p> <p>--The order did not contain the pharmacy recommendations to add do not crush.</p> <p>Review of the resident's monthly pharmacy DRR dated 6/23/24 showed Divalproex - add do not crush.</p> <p>Review of the resident's July 2024 POS and MAR showed:</p> <p>-Divalproex 250 mg two times daily for bipolar.</p> <p>--The order did not contain the pharmacy recommendations to add do not crush.</p> <p>Review of the resident's monthly pharmacy DRR dated 7/16/24 showed:</p> <p>-Divalproex - add do not crush.</p> <p>-Review psychotropic medications indication against listed diagnosis for appropriateness and accuracy for therapy.</p> <p>Review of the resident's medical record from 7/16/24 - 9/22/24 showed no documentation the resident's physician addressed the pharmacy's recommendation to review the resident's psychotropic medications for appropriateness and accuracy for therapy.</p> <p>Review of the resident's August 2024 POS and MAR showed:</p> <p>-Divalproex 250 mg two times daily for bipolar. The order was discontinued on 8/31/24.</p> <p>--The order did not contain the pharmacy recommendations to add do not crush.</p> <p>Review of the resident's monthly pharmacy DRR dated 8/18/24 showed to please follow up on 7/16/24 nursing recommendations and add responses in progress notes under pharmacy review.</p> <p>Review of the resident's September 2024 POS and MAR showed no current order for Divalproex.</p> <p>Review of the resident's monthly pharmacy DRR dated 9/22/24 showed Divalproex - add do not crush.</p> <p>Review of the resident's October 2024 POS and MAR showed no current order for Divalproex.</p> <p>Review of the resident's monthly pharmacy DRR dated 10/28/24 showed to please follow up on 9/22/24 nursing recommendations and add responses in progress notes under pharmacy review,</p> <p>Review of the resident's November 2024 POS and MAR showed no current order for Divalproex.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's monthly pharmacy DRR dated 11/24/24 showed Divalproex - add do not crush.</p> <p>2. Review of Resident #108's Face Sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Bipolar disorder. -Schizophrenia. -PTSD. <p>Review of the resident's May 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Divalproex DR administer 1250 mg at bedtime for major depression. -Divalproex DR administer 250 mg one time daily for major depression. <p>Review of the resident's monthly pharmacy DRR dated 5/15/24 showed add to Divalproex DR instructions do not crush.</p> <p>Review of the resident's June 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Divalproex DR administer 1250 mg at bedtime for major depression. -Divalproex DR administer 250 mg one time daily for major depression. <p>Review of the resident's monthly pharmacy DRR dated 6/20/24 showed add to Divalproex DR instructions do not crush.</p> <p>Review of the resident's July 2024 POS and MAR showed:</p> <ul style="list-style-type: none"> -Divalproex DR administer 1250 mg at bedtime for major depression discontinued on 7/2/24. -Divalproex DR administer 750 mg at bedtime for schizophrenia dated 7/12/24. -Divalproex DR administer 250 mg one time daily for major depression discontinued on 7/2/24. <p>Review of the resident's monthly pharmacy DRR dated 7/18/24 showed to please follow up on 6/20/24 physician recommendations regarding PPI/H2 (acid reducers)- use and link physician response in progress notes under pharmacy review note section for tracking.</p> <p>Review of the resident's August 2024 POS and MAR showed Divalproex DR administer 750 mg at bedtime for schizophrenia dated 7/12/24.</p> <p>Review of the resident's monthly pharmacy DRR dated 8/18/24 showed to please follow up on 6/20/24 physician recommendations regarding PPI/H2 use and link physician response in progress notes under pharmacy review note section for tracking.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's September 2024 POS and MAR showed Divalproex DR administer 750 mg at bedtime for schizophrenia dated 7/12/24.</p> <p>Review of the resident's monthly pharmacy DRR dated 9/22/24 showed add to Divalproex DR instructions do not crush.</p> <p>Review of the resident's October 2024 POS and MAR showed Divalproex DR administer 750 mg at bedtime for schizophrenia dated 7/12/24.</p> <p>Review of the resident's monthly pharmacy DRR dated 10/28/24 showed add to Divalproex DR instructions do not crush on POS/MAR.</p> <p>Review of the resident's November 2024 POS and MAR showed Divalproex DR administer 750 mg at bedtime for schizophrenia dated 7/12/24.</p> <p>Review of the resident's monthly pharmacy DRR dated 11/24/24 showed no new suggestions this month.</p> <p>Review of the resident's December 2024 POS and MAR showed Divalproex DR administer 750 mg at bedtime for schizophrenia dated 7/12/24.</p> <p>Review of the resident's monthly pharmacy DRR dated 12/12/24 showed add to Divalproex DR instructions do not crush on POS/MAR.</p> <p>51150</p> <p>3. Review of the Resident #102's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by the facility for care planning) dated 8/29/24, showed:</p> <ul style="list-style-type: none"> -The resident was admitted to the facility on [DATE]. -The resident was cognitively intact. <p>Review of the resident's pharmacy's MRR dated 9/21/24 showed:</p> <ul style="list-style-type: none"> -The resident was receiving olanzapine (Antipsychotic) 5 mg by mouth every morning. -The resident was receiving quetiapine (Antipsychotic) 50 mg by mouth at bedtime. -The resident was receiving trazadone (Antidepressant) 150 mg by mouth at bedtime. -The resident was receiving buspirone (Antianxiety) 5 mg by mouth three times per day. -The pharmacist recommended a GDR of one or more of the medications. -The physician did not respond to the pharmacist recommendation. <p>Review of the resident's Order Summary Report dated 12/24 showed:</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident was receiving olanzapine 5 mg by mouth every morning.</p> <p>-The resident was receiving quetiapine 50 mg by mouth at bedtime.</p> <p>-The resident was receiving trazadone 150 mg by mouth at bedtime.</p> <p>-The resident was receiving buspirone 5 mg by mouth three times per day.</p> <p>-Note: The medications had not been reduced.</p> <p>Review of the resident's electronic medical record on 12/18/24 showed no documentation that a GDR had been attempted on the resident's psychotropic medication.</p> <p>4. Review of the Resident #7's quarterly MDS dated [DATE], showed the resident was cognitively intact.</p> <p>Review of the resident's MRR dated 12/16/23 showed:</p> <p>-The resident was receiving quetiapine 25 mg by mouth with meals.</p> <p>-The resident was receiving quetiapine 50 mg by mouth at bedtime.</p> <p>-The resident was receiving risperidone 1 mg by mouth twice per day.</p> <p>-The resident was receiving lamotrigine (mood stabilizer) 350 mg by mouth every 12 hours.</p> <p>-The resident was receiving lorazepam (Antianxiety) 1 mg by mouth twice per day.</p> <p>-The pharmacist recommended a gradual dose reduction of one or more of the medications.</p> <p>-The physician did not respond to the pharmacist recommendation.</p> <p>Review of the resident's MAR dated 11/1/24-11/30/24, showed:</p> <p>-The resident was receiving quetiapine 50 mg by mouth at bedtime.</p> <p>-The resident was receiving Seroquel 100 mg by mouth at bedtime.</p> <p>-The resident was receiving lamotrigine 350 mg by mouth every 12 hours.</p> <p>-The resident was receiving lorazepam 1 mg by mouth twice per day.</p> <p>-The resident was receiving risperidone 1 mg by mouth twice per day.</p> <p>-The resident was receiving Seroquel 50 mg by mouth three times per day.</p> <p>Review of the resident's electronic medical record on 12/18/24 at 1:39 P.M., showed:</p> <p>(continued on next page)</p>

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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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-No GDR attempt on resident's psychotropic medications within the last 12 months.</p> <p>-No rationale as to why a GDR was not attempted on the resident's psychotropic medication within the past 12 months.</p> <p>51303</p> <p>5. Review of Resident #66's Admission Record showed he/she was admitted [DATE] with the diagnoses to include:</p> <p>-Psychosis (a mental state involving loss of contact with reality and causing deterioration of normal social functioning) NOS (Not otherwise specified).</p> <p>-Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety).</p> <p>-Major depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living) recurrent severe without psychotic features.</p> <p>Review of the resident's care plan revised on 7/15/22 showed he/she was at risk for adverse reaction related to polypharmacy receiving Haloperidol and Divalproex for psychosis and Hydroxyzine for anxiety.</p> <p>Review of a Pharmacy Communication to the psychiatrist on 4/16/24 showed:</p> <p>-The pharmacist was questioning a GDR on psychotropic medications.</p> <p>-The resident was on the following medications:</p> <p>--Haloperidol 1 mg tablet by mouth twice daily due to unspecified psychosis not due to a substance or known physiological condition effective 7/27/21.</p> <p>--Hydroxyzine 50 mg capsule by mouth three times daily related to anxiety disorder effective 9/25/21.</p> <p>--Divalproex Sodium delayed release 250 mg tablet by mouth twice daily related to unspecified psychosis not due to a substance or known physiological condition effective 10/30/21.</p> <p>-The pharmacist asked the physician to assess risk versus benefit and if resident would benefit from a GDR of one or more therapy agents; or state below if a change in the current therapy regimen is clinically contraindicated.</p> <p>-The resident's psychiatrist and/or physician did not respond to the GDR request or complete a rationale showing why the medications were not reduced.</p> <p>Review of the resident's Order Summary Report (OSR) for 12/2024 showed:</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Haloperidol 1 mg tablet by mouth twice daily due to unspecified psychosis not due to a substance or known physiological condition.</p> <p>-Hydroxyzine 50 mg capsule by mouth three times daily related to anxiety disorder.</p> <p>-Divalproex Sodium delayed release 250 mg tablet by mouth twice daily related to unspecified psychosis not due to a substance or known physiological condition.</p> <p>-Note: There were no reductions to the resident's medications.</p> <p>During an interview on 12/23/24 at 8:47 A.M., Certified Medication Technician (CMT) F said he/she thought the Director of Nursing (DON) or possibly the Administrator were responsible for monitoring the monthly drug regimen reviews from the pharmacist.</p> <p>During an interview on 12/23/24 at 8:57 A.M., Licensed Practical Nurse (LPN) B said:</p> <p>-The DON was responsible for monitoring the monthly drug regimen reviews from the pharmacist.</p> <p>-He/She was not sure how the process worked for communicating with the physician if a recommendation was made since it all went through the DON.</p> <p>During an interview on 12/23/24 at 9:49 A.M. LPN B said:</p> <p>-The DON processed the medication regimen reviews (MRRs).</p> <p>-The DON was responsible to track that MMR/GDRs were completed.</p> <p>-He/She was unaware of how pharmacy concerns were addressed/processed.</p> <p>-DON would notify the charge nurse if an order needed to be updated/changed.</p> <p>During an interview on 12/23/24 at 4:02 P.M. the DON said:</p> <p>-The pharmacy recommendations were sent to him/her.</p> <p>-Pharmacy reviews and/or recommendations were completed monthly.</p> <p>-Pharmacy recommendations should be processed within 72 hours of receipt.</p> <p>-He/She compared recommendations with the orders and then would notify the provider, attending physician or psychiatric provider, if there was something to address.</p> <p>-He/She expected the documented rationale if the provider didn't agree with the pharmacy recommendation to be in the resident's electronic medical record.</p> <p>-Recommendations should be addressed within 72 hours.</p> <p>During an interview on 12/23/24 at 8:47 A.M., CMT F said:</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The DON and possibly the Administrator were responsible for ensuring that MRR's and GDR's were completed.</p> <p>-He/she did not know how the MRR and GDR process worked.</p> <p>-He/she believed that the charge nurse, DON, and administrator were responsible for notifying the physician when the pharmacist made a recommendation about a resident's psychotropic medications.</p> <p>During an interview on 12/23/24 at 8:54 A.M., LPN B said:</p> <p>-The DON was responsible for the MRR's and GDR's.</p> <p>-He/she was unaware of how the MRR and GDR process.</p> <p>During an interview on 12/23/24 at 4:03 P.M., DON said:</p> <p>-He/she was responsible for ensuring that the MRR's and GDR's were completed.</p> <p>-He/she recently took this responsibility over from the previous DON.</p> <p>-He/she compared the MRR with the resident's orders in their charts and notified the physician if anything was supposed to be addressed.</p> <p>-The physician was responsible for documenting a rationale to any GDR recommendations from the pharmacist within 72 hours of the pharmacist recommendation.</p> <p>-The physician's rationale would be documented in the resident's electronic medical record if completed.</p> <p>-If there was no documented rationale from the physician for a resident's GDR recommendation in a resident's electronic medical record, it was not completed.</p> <p>-A GDR must be attempted at least once per year on psychotropic medications.</p> <p>-A MRR must be completed monthly.</p>

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified of abnormal laboratory values for one sampled resident, (Resident #19) out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's policy, Diagnostic Testing Services Policy, dated 6/26/24 showed:</p> <ul style="list-style-type: none"> -The facility would provide the appropriate diagnostic tests in accordance with the physician's orders. -Qualified nursing personnel would have received and reviewed the diagnostic test reports and communicated the results to the ordering physician within 24 hours of receipt unless the report results fall outside of clinical reference ranges and required immediate attention at which time the physician would have been notified upon receipt. <p>39469</p> <p>1. Review of Resident #19's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of bipolar disorder (a mental disorder characterized by manic highs (highly excited, over active and distracted), and lows (feelings of depression).</p> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 12/9/24 showed he/she was cognitively intact.</p> <p>Review of the resident's care plan dated 7/3/24 showed:</p> <ul style="list-style-type: none"> -He/She was at risk for the following signs and symptoms related to a diagnosis of bipolar disorder. -Changing clothes multiple times a day. -Displaying high emotions and low emotions. -Signs of depression. <p>Review of the resident's December 2024 Physician's Order Sheet (POS) showed an order for Lithium Carbonate Extended Release (ER) give 450 milligrams (mg) by mouth two times a day related to Bipolar disorder, dated 9/15/24.</p> <p>Review of the resident's laboratory results on 12/18/24 showed:</p> <ul style="list-style-type: none"> -A lithium level laboratory test was completed on on 11/1/24. -The result was 0.4 which was low (0.6 to 1.3) was normal. <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There was no documentation the physician was notified of the low lithium level.</p> <p>During an interview on 12/19/24 at 1:00 P.M. the Nurse Practitioner (NP) said:</p> <p>-The nursing staff should have called them if the level was low.</p> <p>-If the difference was within 0.1 they would have watched it and rechecked it the next month.</p> <p>-If the difference was more than 0.1 then they should have notified their office and rechecked the lab within the week.</p> <p>-He/She could not find documentation they had been notified by the staff.</p> <p>-He/She would have to reorder the lithium level as it was too low.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the Director of Nursing (DON) said:</p> <p>-A low Lithium level was something that the Nursing staff should have reported to the physician that day.</p> <p>-The Lithium level should have been redrawn by the laboratory.</p> <p>-Nurses should have ensured the laboratory values were within range.</p> <p>-Currently they do not have an audit system in place to ensure the physician was notified of laboratory values that were out of range.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51303</p> <p>Based on observation, interview, and record review, the facility failed to ensure routine and/or emergency dental services to meet the needs of residents were offered to two sampled residents, (Residents #26 and #98), out of 23 sampled residents. The facility census was 111 residents.</p> <p>Review of the facility's policy Dental Services dated 6/26/24 showed:</p> <ul style="list-style-type: none"> -It is the policy of the facility to assist residents in obtaining routine and emergency dental care. -Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, minor partial or full denture adjustments, and limited prosthodontic procedures such as taking impressions for dentures and fitting dentures. -Oral care and denture care shall be provided in accordance with identified needs and as specified in the plan of care. -The Social Services Director (SSD) would maintain contact information for providers of dental services that are available to facility residents. <p>1. Review of Resident #26's Admission Record showed he/she was admitted to the facility on [DATE].</p> <p>Review of the resident's Order Summary Report (OSR) showed a physician's order dated 6/17/21 may see dentist.</p> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 5/16/24 showed:</p> <ul style="list-style-type: none"> -He/She was cognitively intact. -No dental issues. <p>Review of the resident's Clinical Admission assessment dated [DATE] showed the resident did not have any teeth.</p> <p>Review of the resident's care plan revised on 8/27/24 showed the resident was independent with self-care.</p> <p>Review of the resident's Quarterly MDS dated [DATE] showed no dental issues.</p> <p>During an interview on 12/18/24 at 9:24 A.M. the resident said:</p> <ul style="list-style-type: none"> -He/She had dentures, but couldn't keep them in his/her mouth as they were too loose. -He/She had not been on the list to be seen by a dentist. <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had not seen a dentist.</p> <p>Observation on 12/18/24 at 9:24 A.M. of the resident's mouth showed the resident did not have any teeth.</p> <p>During an interview on 12/18/24 at 9:24 A.M. the resident said he/she did not wear dentures because they were too loose.</p> <p>2. Review of Resident #98's Admission Record showed he/she was admitted to the facility on [DATE].</p> <p>Review of the resident's Order Summary Report (OSR) showed a physician's order may see dentist dated 9/26/23.</p> <p>Review of the resident's Clinical Admission assessment dated [DATE] showed:</p> <p>-He/She had his/her own teeth.</p> <p>-The resident had broken or loose fitting full or partial dentures.</p> <p>-The resident had cavities and/or broken teeth.</p> <p>Review of the resident's Annual MDS dated [DATE] showed:</p> <p>-He/She was cognitively intact.</p> <p>-The resident had no issues with his/her teeth.</p> <p>Review of the resident's Monthly Summary assessment dated [DATE] noted resident had his/her own teeth but did not identify missing tooth on lower partial denture.</p> <p>Review of the resident's care plan initiated 10/29/24 showed:</p> <p>-He/She had upper/lower partial dentures.</p> <p>-Interventions included:</p> <p>--Coordinate arrangements for dental care, transportation as needed/as ordered.</p> <p>-- Monitor/document/report as needed any signs or symptom of oral/dental problems needing attention: Pain (gums, toothache, palate), abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in mouth, or lesions.</p> <p>--Please assist with denture care.</p> <p>During an interview on 12/17/24 at 2:00 P.M. the resident said:</p> <p>(continued on next page)</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-His/Her teeth were starting to fall out.</p> <p>-He/She had not seen a dentist in quite a while.</p> <p>-He/She would like to see dentist.</p> <p>-He/she had told the staff but couldn't remember who.</p> <p>Observation on 12/18/24 at 1:03 P.M. of the resident's mouth showed:</p> <p>-He/She had multiple missing teeth.</p> <p>-He/She had yellow and discolored teeth in poor repair.</p> <p>-He/She had the lower partial plate (partial denture) in but was missing a tooth on the bottom right side of the lower partial plate.</p> <p>During an interview on 12/19/24 at 8:39 A.M. Certified Medication Technician (CMT) C said:</p> <p>-He/She would notify the nurse of dental concerns.</p> <p>-The nurse would then notify the Social Service Director (SSD).</p> <p>-The dentist would see residents at the facility.</p> <p>-He/She was not aware of any residents with dental concerns.</p> <p>During an interview on 12/19/24 at 8:44 A.M. Licensed Practical Nurse (LPN) B said:</p> <p>-The SSD handled dental appointments.</p> <p>-Nursing would be given a list when the dentist was at the facility.</p> <p>-He/She was not aware of Resident #28 or Resident #98 needing to see the dentist.</p> <p>During an interview on 12/19/24 8:52 A.M. the SSD said:</p> <p>-The facility had a provider for dental care.</p> <p>-He/She scheduled residents for dental care.</p> <p>-The dental provider was due to come in December 2024 but he/she did not have a date yet.</p> <p>-Newly admitted residents go on the list to see the dentist.</p> <p>-Routine dental visits are every six months.</p> <p>-The dental provider would see all residents on the list if guardians approved them to be seen.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She would receive a list from the dental provider with the residents' names for the next visit.</p> <p>-He/She was not aware Resident #26 had not seen a dentist.</p> <p>-He/She was not aware Resident #98 having loose teeth or missing a tooth on his/her partial plates.</p> <p>51150</p> <p>3. Review of the Resident #27's admission MDS dated [DATE], showed:</p> <p>-The resident was admitted to the facility on [DATE].</p> <p>-The resident was cognitively intact.</p> <p>-The resident had no missing teeth.</p> <p>Review of the resident's care plan revised 10/16/24, showed:</p> <p>-No mention of the resident's missing teeth.</p> <p>-Note: The resident has no natural teeth, and the resident does not have any dentures.</p> <p>During an interview on 12/18/24 at 9:34 A.M., the resident said:</p> <p>-He/she did not have any natural teeth upon admission to the facility.</p> <p>-He/she did not have any dentures upon admission to the facility.</p> <p>-He/she did have a hard time chewing foods with no teeth.</p> <p>-He/she was on a regular diet at the facility.</p> <p>-He/she had not been offered dental services since admission into the facility.</p> <p>-He/she would like to see a dentist.</p> <p>-He/she would like to get dentures.</p> <p>Observation on 12/18/24 at 9:40 A.M. showed:</p> <p>-The resident had no natural teeth.</p> <p>-The resident had no dentures.</p> <p>Review of the resident's electronic medical record on 12/18/24 at 10:00 A.M. showed the resident did not have any documentation related to having dental services or appointments for dental services.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/20/24 at 12:56 P.M., Social Services Director (SSD) said:</p> <ul style="list-style-type: none"> -He/she was unsure why the resident had not yet seen a dental provider. -He/she was responsible for placing residents on the dental provider schedule. -He/she did not know the resident was edentulous (no teeth) so he/she had not set up an appointment prior to the survey. <p>4. During an interview on 12/23/24 at 9:26 AM MDS Coordinator said:</p> <ul style="list-style-type: none"> -The SSD handled dental visits for residents. -He/She gathered information for the MDS on interview of resident, observation, and the clinical record. -He/She was not aware of resident #26's dentures did not fit. -He/She was not aware Resident #98's had concerns with his/her teeth and missing tooth on the lower partial. - <p>During an interview on 12/23/24 at 4:02 P.M. the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> -The facility had a dental provider. -The SSD scheduled residents to be seen by the dentist. -He/She expected residents would be screened for dental concerns monthly with monthly summaries. -He/She was not aware resident #26's dentures were loose and not worn. -He/She was not aware of resident #98's had concerns with his/her teeth and missing a tooth on his/her lower partial. -He/She expected a resident with dental concerns would be seen by the dentist.

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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>22727</p> <p>Based on observation, interview and record review, the facility failed to store food in a manner that protected it from mice, failed to date items with the date opened, failed to perform hand hygiene, failed to store kitchen items on surfaces that were easily cleanable, failed to use clean gloves, and failed to maintain the sheet pan rack in a clean manner. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility census was 111 residents.</p> <p>Review of the facility's policy titled Dietary-Equipment Operations, Infection Control, and Sanitation Policy dated as last reviewed on 2/2/24 showed:</p> <ul style="list-style-type: none"> -Tray carts should be washed and sanitized after each meal. -The policy did not address handwashing, glove use, food storage, and storage of items on surfaces that were not easily cleanable. <p>1. Observation on the initial kitchen tour on 12/16/24 at 12:19 P.M. showed:</p> <ul style="list-style-type: none"> -Large, opened bags of rice and brown sugar were under the main storage prep table, were not closed or in containers, and they were not dated with the date they were opened. -Two shelf racks in a closet that had pans stored on them were rusty and not easily cleanable. <p>Observation and interview on 12/16/24 at 2:27 P.M. showed:</p> <ul style="list-style-type: none"> -Two shelf racks in a closet that had pans stored on them were rusty and not easily cleanable. -Four uncovered Styrofoam cups were stored on the bottom shelf under blender which had a surface that was chipped and peeling so that it was not easily cleanable. -Two uncovered Styrofoam cups were stored on the bottom shelf across from the refrigerators which had a surface that was chipped and peeling so that it was not easily cleanable. -A large section of the corner of a bag of au gratin mix that was stored on the spice rack near the coffee station was chewed off. -The bag of au gratin mix had mouse droppings and yellow stains on it. -Large, opened bags of rice and brown sugar were under the main storage prep table, were not closed or in containers, and they were not dated with the date they were opened. -Cook B dropped one of his/her gloves on the floor, picked it up and put it on and returned to handling food. <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 sheet pan rack had built-up white food debris.</p> <p>-A bag of breadcrumbs on the bottom shelf of the spice rack was open, not sealed and dated.</p> <p>-The bag of breadcrumbs had three gnats on it and there were black discolored areas on the bag.</p> <p>-Two large paper bags that had brown lunch bags in them had an unknown powder on them and dark stained areas that looked like dried liquid.</p> <p>-Cook B said the breadcrumbs were from Thanksgiving and both the bag (of au gratin mix) and the bag of breadcrumbs should have been in a storage container and dated.</p> <p>Continuous observation on 12/17/24 at 9:58 A.M. showed:</p> <p>-Dietary Aide (DA) B was handling biscuits with gloves on.</p> <p>-DA B removed his/her gloves, drank from a personal soda bottle, sat the soda bottle on the prep table, did not wash his/her hands, put on new gloves, and returned to handling the biscuits.</p> <p>-The Dietary Manager picked up the soda and put it in his/her office.</p> <p>-DA B had on gloves and was spooning chicken and vegetables for the chicken pot pie into pans.</p> <p>-DA B removed his/her gloves, went into the Dietary Manager's office, took a drink of his/her soda.</p> <p>-DA B did not wash his/her hands, put on new gloves, stirred the pot pie filling, put filling on the bottom half of the biscuits, and placed the top half of the biscuits over the pot pie filling.</p> <p>-DA B wiped down the prep table down.</p> <p>-DA B wiped down the outside of the warmer.</p> <p>-DA did not wash his/her hands.</p> <p>-DA got some supplies of a drawer, filled the coffee pots up with water, and blended the mechanical soft chicken pot pie.</p> <p>During an interview on 12/18/24 at 1:03 P.M., DA A and [NAME] B said:</p> <p>-They were supposed to get new prep tables.</p> <p>-They should wash hands and change gloves when going from dirty to clean and when going from drinking to returning to food prep.</p> <p>-They should not use any gloves that fell on the floor, and they should throw them away.</p> <p>-The sugar and rice should have been in a sealed container.</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>	<ul style="list-style-type: none"> -They shouldn't use anything stored on shelves that were not easily cleanable. -They have a mouse issue, but exterminator comes weekly. -They should wash hands and change gloves in the above situations. <p>During an interview on 12/18/24 at 1:19 P.M., the Dietary Manager said:</p> <ul style="list-style-type: none"> -They normally had big containers for things like rice, sugar, and brown sugar, but he/she didn't know where they were. -Items like rice, sugar, breadcrumbs should have been stored in a sealed container and dated when opened. -They should have everything stored in containers in the kitchen to prevent exposure to mice. -Handwashing should have been performed when going from dirty to clean activities. -Handwashing should have been performed after drinking. -Gloves dropped on the floor should not have been used. -They were supposed to be approved to get new prep tables. <p>During an interview on 12/18/24 at 2:37 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -He/She expected employees to wash their hands when going from dirty to clean. -He/She expected employees to throw away and not use a glove dropped on the floor. -He/She expected food to be stored to protect it from pests including mice. -He/She expected food packaging that was opened to be closed and dated the date it was opened. -Shelving should be replaced if they were not easily cleanable.

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>22727</p> <p>Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly by having a roll-off dumpster and the surrounding area over-flowing of trash, equipment, and furniture. The facility census was 111 residents.</p> <p>The facility did not have a policy related to this deficiency.</p> <p>1. Observation on 12/16/24 at 8:30 A.M., 12/17/24 at 8:30 A.M., 12/18/24 at 10:00 A.M., 12/18/24 at 11:06 A.M., 12/18/24 at 1:08 P.M., and 12/19/24 at 9:55 A.M., showed:</p> <ul style="list-style-type: none"> -One dumpster with two closing lids in the facility's south-east parking lot. -A roll-off dumpster north of the other dumpster in the facility's south-east parking lot. -The roll-off dumpster: <ul style="list-style-type: none"> --Was 23 feet in length, 7 feet in width, and 4 feet in height. --Was completely full of about two layers of trash bags visible over the top of the dumpster. --There were two bags of trash in front of the dumpster on the ground and a bag of trash on the ground on the north-east side of the dumpster. --There were two toilets, two mattresses, an office chair, multiple wood boards from broken furniture, four wood pallets and trash strewn all around on the parking lot and in the field by the dumpster. <p>During an interview on 12/18/24 at 10:00 A.M., the Dietary Manager said:</p> <ul style="list-style-type: none"> -The small dumpster was the dumpster for dietary. -The other dumpster was for everyone else. -The dietary dumpster was emptied about every two or three days. -The other dumpster required a flatbed truck. -He/She was told there was a shortage of flat-bed drivers, so the other dumpster didn't get emptied. <p>During an interview on 12/18/24 at 11:06 A.M., the Maintenance Director said:</p> <ul style="list-style-type: none"> -Everybody used the roll-off dumpster, including people who did not work at the facility. <p>(continued on next page)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She instructed the staff to stop putting trash in the roll-off dumpster, but they kept doing it.</p> <p>-He/She contacted the dumpster rental service company last week about getting it removed from the property and they said they would send someone out.</p> <p>-There were no lids on the roll-off dumpster.</p> <p>-There should not be trash over the top of the roll-off dumpster.</p> <p>-It looked terrible.</p> <p>-One of the regional employees said they needed to get another dumpster so they could transfer some of the overflowing trash to a different dumpster.</p> <p>During an interview on 12/18/24 at 12:20 P.M., the Administrator said:</p> <p>-He/She ordered the dumpster because they were focusing on the building environment and were getting rid of old equipment and furnishings and replacing it.</p> <p>-He/She ordered the wrong size dumpster.</p> <p>-The dumpster rental service company won't empty the dumpster.</p> <p>-He/She was ordering a new dumpster so they could move the overflow into it.</p> <p>-He/She would provide documentation regarding contact with the dumpster rental service company.</p> <p>As of exit, no documentation was provided by the facility.</p> <p>MO00246556</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff were using appropriate infection control practices during wound care for three sampled residents, (Resident #19, #1 and #14), failed to ensure Enhanced Barrier Precautions (EBP-strategy to decrease transmission of infections and/or cross-contamination during high-contact care activities for residents in nursing homes that include wearing gowns, gloves and at times a face mask) were used for one sampled resident with open wounds (Resident #19), failed to have appropriate EBP signage on the doors and Personal Protective Equipment (PPE) available near the rooms for three sampled residents (Resident #19, #1 and #14), failed to ensure the medication room on the Men's Locked Unit was kept clean and hand hygiene products were available for staff, and failed to ensure staff preformed hand hygiene during medication pass, out of 23 sampled residents, and failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases when the facility failed to provide Tuberculosis (TB-a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) testing for five sampled resident (Resident #1, #23, #72, #98 and #108) out of five sampled residents. The facility census was 111 residents.</p> <p>Review of the facility Standard Precautions-Infection Control policy dated 5/14/2024 showed:</p> <p>-Standard Precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status.</p> <p>--This includes hand hygiene, selection and use of Personal Protective Equipment (PPE-e.g., gloves, gowns, face masks, respirators, eye protection). Respiratory hygiene and cough etiquette, safe injection practices, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment.</p> <p>-Hand Hygiene is a general term for cleaning hands by handwashing with soap and water or the use of an antiseptic hand rub, also known alcohol-based hand rub (ABHR).</p> <p>--During the delivery of resident care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces.</p> <p>-Personal Protective Equipment refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission.</p> <p>Review of the facility Hand Hygiene policy dated 6/26/2024 showed:</p> <p>-All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, resident, and visitors.</p> <p>-Alcohol-based hand rub with 60-95% alcohol is the preferred method of cleaning hands in most clinical situations.</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>-Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.</p> <p>-The use of gloves does not replace hand hygiene.</p> <p>-If the task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves.</p> <p>-Use ABHR includes but not limited to:</p> <p>--Between resident contacts.</p> <p>--After handling contaminated objects.</p> <p>--Before applying and after removing PPE, including gloves.</p> <p>--Before and after handling clean or soiled dressings, linens, etc.</p> <p>--Before performing resident care procedures.</p> <p>--After handling items potentially contaminated with blood, body fluids, secretions, or excretions.</p> <p>--When, during resident care, moving from a contaminated body site to a clean body site.</p> <p>Review of the facility Clean Wound Dressing Change policy dated 5/18/2024 showed:</p> <p>-Provide wound care in a manner to decrease potential for infection and/or cross-contamination.</p> <p>-Each wound will be treated individually.</p> <p>-When multiple wounds are being dressed, the dressings will be changed in order of least contaminated to most contaminated (i.e. change extremity wounds before wounds contaminated with stool).</p> <p>-Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application:</p> <p>--If the table is soiled, wipe clean.</p> <p>--Place a disposable cloth or linen saver on the overbed table.</p> <p>-Place only supplies to be used per wound on the clean field at one time (include wound cleanser, gauze for cleansing, disposable measuring guide and pen/pencil, skin protectant products as indicated, dressings, tape).</p> <p>--Use no-touch techniques to remove ointments and creams from their containers (i.e. use tongue blade or applicator). Liquid solutions should be poured directly onto gauze sponges.</p> <p>-Establish area for soiled products to be placed.</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>Wash hands and put on clean gloves.</p> <p>Place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites.</p> <ul style="list-style-type: none"> -Loosen the tape and remove the existing dressing. -Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. -Wash hands and put on clean gloves. -Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e. clean outward from the center of the wound). Pat dry with gauze. -Measure wound using disposable measuring guide. - Wash hands and put on clean gloves. -Apply topical ointments or creams and dress the wound as ordered. Protect surrounding skin as indicated with skin protectant. -Secure dressing. [NAME] with initials and date. -Discard disposable items and gloves into appropriate trash receptacle and wash hands. <p>Review of the facility Enhanced Barrier Precautions dated 5/18/2024 showed:</p> <ul style="list-style-type: none"> -EBP (gown and gloves) must be used for wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a Multidrug-resistant Organism (MDRO). -Any wound care requiring a dressing including chronic wounds, but not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. -Make gowns and gloves available immediately near or outside of the resident's room. -Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). -Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. -EBP are intended to be placed for the resident's entire stay in the facility or until resolution of the wound or discontinuation of the indwelling device that placed them at higher risk. <p>1. Review of Resident #1's Admission Record showed he/she initially admitted on [DATE] and readmitted [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Paraplegia (loss of movement of both legs and generally the lower trunk). <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>-Pressure ulcer (PU-localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) left buttock, stage III (full-thickness skin loss extending into the tissue beneath the skin, forming a small crater).</p> <p>-PU Right heel stage III.</p> <p>-PU Left heel stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling).</p> <p>-Unspecified open wound right foot, subsequent encounter (any encounter after the active phase of treatment).</p> <p>-PU Right buttock stage IV.</p> <p>-Type II Diabetes Mellitus (DM-condition that affects the way the body processes blood sugar (glucose)).</p> <p>-Acute Lymphoblastic Leukemia (a type of cancer of the blood and bone marrow that affects white blood cells) not having achieved remission.</p> <p>-Neuromuscular dysfunction of bladder (a disorder of urinary bladder control due to damage to the spinal cord or to the nerves supplying the bladder).</p> <p>Review of the resident's care plan dated 11/25/24 showed:</p> <p>-Limited physical mobility related to diagnosis of Paraplegia.</p> <p>-Area of trauma to the right buttock with potential to get worse due to non-compliance.</p> <p>-Pressure ulcer to left and right buttocks, and accidental puncture & laceration of skin, subcutaneously (the layer of tissue that underlies the skin) during other procedure.</p> <p>-Suprapubic indwelling catheter (a hollow flexible tube that is used to drain urine from the bladder and inserted through the abdominal wall into the bladder) with drainage bag (bag that collects urine) related to a Neurogenic bladder.</p> <p>Observation on 12/16/24, 12/17/24 and 12/18/24 throughout each day showed no EBP signage on the resident's door nor a cart for EBP supplies outside his/her room.</p> <p>During an interview on 12/18/24 at 1:53 P.M., Licensed Practical Nurse (LPN) B said there should be a sign on the resident's door for EBP due to the indwelling catheters and open wounds.</p> <p>Observation on 12/18/24 at 1:56 P.M., of the resident's wound care and dressing changes showed LPN B:</p> <p>-Used EBP of gown and 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>	<p>-Opened wound supply cart in resident's room and removed items and placed on the bedside dresser without cleaning it or placing a clean barrier surface down.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Cut old dressing off the resident's left foot and touched other objects in room without changing gloves or washing/sanitizing hands.</p> <p>-Another staff brought his/her name badge in and he/she put it in pocket under gown without changing gloves or washing/sanitizing hands.</p> <p>-Placed chux pad (a disposable, absorbent pad used to protect surfaces from incontinence) under the resident's feet and removed old dressing on right foot.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Cleaned wounds on both resident's feet with wound cleanser and gauze.</p> <p>-Turned resident to right side to clean the left lateral foot better, with same gloves.</p> <p>-Change gloves sanitized hands and re-gloved.</p> <p>-Cut Xeroform (medicated Vaseline gauze) dressing to fit wound area and covered with an abdominal pad (ABD an extra thick primary or secondary dressing used for wounds) dressing on left foot.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Looked through the wound supply cart for another ABD pad.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Placed another ABD over top of foot for protection and wrapped with Kerlix wrap (a name brand of gauze wrap).</p> <p>-Changed gloves but did not wash/sanitize hands.</p> <p>-Removed dressing on right lateral foot near heel, two small areas and cleaned with wound cleanser and gauze.</p> <p>-Rubbed lower left leg, dry skin, and bottom of foot with A&D ointment (a Vaseline ointment with vitamins A and D added).</p> <p>-Removed gloves and put on new gloves without washing or sanitizing hands and went through cart again to find items.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Placed Xeroform dressing on each area.</p> <p>(continued on next page)</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Did not change gloves or wash/sanitize hands.</p> <p>-Placed ABD pad over buttocks.</p> <p>-Placed clean brief under resident.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Cleaned peri area with wet wipes.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Readjusted resident's catheter tubing's (resident had a Foley catheter [a tube with retaining balloon passed through the urethra into the bladder to drain urine] and a Suprapubic catheter) and cleaned both catheter tubing's.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Fastened the resident's brief pulled up the resident's pants.</p> <p>-Removed gloves, took scissors to the medication room and cleaned scissors with bleach wipes and washed hands.</p> <p>During an interview on 12/19/24 at 10:49 A.M., the wound company Nurse Practitioner said the resident:</p> <p>-Had a history of leukemia and Osteomyelitis (bone infection usually caused by bacteria).</p> <p>-Had gone through multiple rounds of IV antibiotics that had not helped in the wound healing process.</p> <p>-Refused to be admitted to a hospice (end of life) program.</p> <p>-Refused Nephrostomy (a passage way maintained by a thin tube placed through the back into the kidney to temporarily drain urine that is blocked) tubes to help with healing.</p> <p>-Wounds were healing and doing much better then when he/she first started seeing this resident.</p> <p>During an interview on 12/20/24 at 9:57 A.M., Certified Nursing Assistant (CNA) M said when doing catheter care:</p> <p>-Washed his/her hands and gown and glove up.</p> <p>-Clean the catheter tubing with a wet wipe starting at the top insertion area and wipe down several inches.</p> <p>-When finished remove gloves and wash hands.</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>-Change gloves and wash/sanitize hands when going from a dirty area to a clean area.</p> <p>-The nurse usually did the resident's catheter care when doing his/her dressing changes.</p> <p>During an interview on 12/23/24 at 11:13 A.M., CNA N said when doing catheter care:</p> <p>-Washed hands and put on PPE, gown and gloves due to the EBP requirements.</p> <p>-Held the tubing in one hand and wiped down the tubing from the top about 2 inches with the wet wipes.</p> <p>-Changed gloves when going from dirty area to a clean area and sanitized or washed hands and put on new gloves to finish cares.</p> <p>-Don't touch other items in the room during cares.</p> <p>-If did touch something change gloves wash/sanitize hands and re-glove.</p> <p>2. Review of Resident #14's Admission Record showed he/she admitted on [DATE] and readmitted on [DATE] with the following diagnoses:</p> <p>-Osteoarthritis (inflammation of the of the bone with progressive cartilage deterioration).</p> <p>-Paranoid Schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, feeling distrustful, suspicious, and fearful of others unable to distinguish reality from fantasy having delusions and hallucinations, to manage emotions, make decisions, and relate to others).</p> <p>-Anxiety disorder (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus).</p> <p>-Major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>-Acquired Absence Right leg above knee.</p> <p>Review of the resident's Significant Change Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility staff for care planning) dated 9/20/24 showed:</p> <p>-Re-entry 8/31/24.</p> <p>-Entered from an acute hospital.</p> <p>-Major orthopedic surgery.</p> <p>Review of the resident's care plan dated reviewed on 12/18/24 showed:</p> <p>-Had limited physical mobility related to bilateral amputee utilized a wheelchair for mobility.</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>-Would remove his/her dressing multiple times throughout a 24-hour period.</p> <p>Review of the resident's Treatment Administration Record (TAR) dated December 2024 showed:</p> <p>-Xeroform Oil Emulsion Gauze External Pad (Bismuth Tribromophenate Petrolatum an antimicrobial compound that was the active ingredient in Xeroform).</p> <p>-Apply to Left Above the Knee Amputation (AKA).</p> <p>-Cover with ABD pad topically every day shift for wound care.</p> <p>-Dressings were changed daily.</p> <p>Observations on 12/16/24, 12/17/24, and 12/18/24 throughout each day showed no EBP signage on the resident's door nor a cart for EBP supplies outside his/her room.</p> <p>During an interview on 12/19/24 at 12:00 P.M., the resident said:</p> <p>-He/She did not know what the EBP sign was for on the door.</p> <p>-It was put up last night he/she didn't ask any staff what it was for.</p> <p>-Did not think any nurse put a gown on to change the dressing on his/her knee.</p> <p>Observation on 12/20/24 at 11:36 A.M., of the resident's left knee dressing change showed LPN D:</p> <p>-Knew what EBP was.</p> <p>-Put gown, gloves and mask on.</p> <p>-Did not clean the bedside table or place a clean barrier on the bedside table.</p> <p>-Placed several dressing packages on the resident's bedside table.</p> <p>-Removed gloves.</p> <p>-Sanitized hands and gloved up told res what doing.</p> <p>-Resident was sitting next to bed near the opened door.</p> <p>-Did not close the door.</p> <p>-Removed old dressing from the surgical wound on left knee.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Cleaned the incision with wound cleanser.</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>-Opened Xeroform package with gloves on.</p> <p>-Did not change gloves or wash/sanitize hands.</p> <p>-Placed Xeroform dressing over surgical site and covered with an ABD dressing.</p> <p>-Placed a bordered gauze over the ABD to secure.</p> <p>-The bordered gauze was too small to cover all edges.</p> <p>-With the same gloves on moved packages of dressings around on bedside table looking for tape. Could not find tape.</p> <p>-Removed gown and gloves without washing/sanitizing hands and left room to get tape.</p> <p>-Returned gowned up did not wash or sanitize hands and put on gloves and taped all edges of the dressing.</p> <p>3. During an interview on 12/23/24 at 12:07 P.M., LPN B said:</p> <p>-When doing dressing changes supplies should be ready before starting.</p> <p>-Provide privacy for the resident.</p> <p>-Supplies should be on a cleaned surface or clean barrier.</p> <p>-Wash hands, glove up and gown up.</p> <p>-Should change gloves and wash/sanitize hands and re-glove between each wound area.</p> <p>-If need to touch other items in room should change gloves and wash/sanitize hands and re-glove.</p> <p>-When finished remove gown, gloves and place in an EBP red trash bag and wash hands.</p> <p>During an interview on 12/23/24 at 4:02 P.M., the Director of Nursing (DON) said:</p> <p>-The nurse should have all supplies ready before starting dressing changes.</p> <p>-The room door and curtains should be closed for privacy when doing dressing changes.</p> <p>-The nurse should not touch other items during the procedure without changing gloves and washing/sanitizing hands and re-gloving.</p> <p>-Gloves should be changed and hands washed/sanitized between one wound and another.</p> <p>-During catheter care gloves should be changed and hands washed/sanitized if going from a dirty area to a clean area.</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>-Residents with wounds or catheters should have EBP.</p> <p>-There should be an EBP sign on the resident's door.</p> <p>-There should be a cart outside the resident's room with EBP supplies.</p> <p>-There should be a red trash receptacle in the resident's room for soiled wound dressings.</p> <p>39469</p> <p>4. Review of the facility's policy, General Medication Administration Process, dated 6/26/24 showed:</p> <p>-Staff was to wash hands prior to administering medication per facility protocol and product.</p> <p>-Staff was to perform hand hygiene and before preparing medication and before and after direct contact with the resident.</p> <p>Observation on 12/19/22 at 8:33 A.M. of medication pass on the Men's locked unit with Certified Medication Technician (CMT) D showed:</p> <p>-CMT D did not perform hand hygiene before starting the medication pass.</p> <p>-He/She did not have hand sanitizer on the medication cart.</p> <p>-He/She went into room [ROOM NUMBER] and administered medication to the resident.</p> <p>-He/She did not perform hand hygiene after administering the medication to the resident.</p> <p>Observation on 12/19/22 at 11:22 A.M. of medication pass on the Men's locked unit with CMT D showed:</p> <p>-He/She did not perform hand hygiene before starting the medication pass.</p> <p>-He/She did not have hand sanitizer on the medication cart.</p> <p>-He/She administered medications to the residents in room [ROOM NUMBER] and 210.</p> <p>-He/She did not perform hand hygiene after administering the medication to the residents.</p> <p>-He/She locked the medication cart to wake a resident up to take their medication.</p> <p>-He/She did not perform hand hygiene after nudging the resident.</p> <p>-He/She did not perform hand hygiene after unlocking the medication cart.</p> <p>-He/She administered medication with a glass of water he/she had poured to the resident in room [ROOM NUMBER].</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>-If they pulled something out of their pocket they also should have done hand hygiene.</p> <p>-He/She was ultimately responsible to ensure staff was performing hand hygiene according to protocol.</p> <p>5. Review of Resident #19's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Non pressure chronic ulcer of the back.</p> <p>-Open wound right upper arm.</p> <p>-He/She had a guardian.</p> <p>Review of the resident's care plan dated 8/11/24 showed:</p> <p>-He/She had actual impairment to skin integrity to right axilla area (armpit).</p> <p>-He/She was to avoid scratching.</p> <p>Review of the resident's annual MDS dated [DATE] showed:</p> <p>-He/She was cognitively intact.</p> <p>-Had unhealed pressure ulcers.</p> <p>-Had an infection of the foot.</p> <p>-Was getting dressings to the foot.</p> <p>Review of the resident's Physician's Order Sheet (POS) dated December 2024 showed the following order:</p> <p>-Cleanse open areas to lower right leg with wound cleanser, pat dry, apply silver alginate (medication used for treatment of infected chronic wounds) and cover with bordered gauze dressing (an absorptive dressing that consists of three layers), every day shift for wounds.</p> <p>Observation on 12/20/24 at 2:55 P.M. of wound care showed:</p> <p>-The resident had 5 wounds on his/her lower right leg.</p> <p>-LPN A used a gauze soaked in normal saline to cleanse the resident's leg.</p> <p>-LPN A swiped down the right side of the resident's leg using one gauze to wipe the three wounds.</p> <p>-LPN A swiped down the left side of the resident's leg using one gauze to wipe the two wounds.</p> <p>-LPN A cleansed his/her hands and changed 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>	<p>-LPN A reached into his/her pocket to pull out a pen.</p> <p>-LPN A pulled the resident's curtain tighter closed with the same gloves on.</p> <p>-He/She applied medication to the residents wounds without changing gloves first.</p> <p>During an interview on 12/20/24 at 2:55 P.M. LPN A said:</p> <p>-He/she should have changed gloves after wiping each wound.</p> <p>-He/She forgot to change gloves and cleanse hands after putting his/her hand in his/her pocket and pulling the curtain shut.</p> <p>During an interview on 12/20/24 at 10:00 A.M. the DON and RN A said:</p> <p>-Staff should wash their hands every time they changed gloves.</p> <p>-Staff should use different gauze for each wound that was cleaned.</p> <p>-If staff touched anything they needed to change gloves and wash their hands.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the DON said:</p> <p>-If the nurse was doing wound care and reached into his/her pocket or pulled the curtain shut they should have changed gloves and cleansed their hands.</p> <p>-When cleansing a wound staff should use new gauze for each wound.</p> <p>-The staff had a lot of education on hand washing.</p> <p>-He/She was ultimately responsible for ensuring staff was doing wound care appropriately.</p> <p>6. Observation on 12/16/24 at 1:00 P.M. did not show anyone on the Men's locked unit was on EBP.</p> <p>-There were no signs on any of the resident's doors.</p> <p>-There was no isolation cart near any of the resident's rooms.</p> <p>Observation on 12/17/24 at 9:00 A.M. did not show anyone on the Men's locked unit was on EBP.</p> <p>-There were no signs on any of the resident's doors.</p> <p>-There was no isolation cart near any of the resident's rooms.</p> <p>Observation on 12/17/24 at 3:15 P.M. did not show anyone on the Men's locked unit was on EBP.</p> <p>-There were no signs on any of the resident's doors.</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>-There was no isolation cart near any of the resident's rooms.</p> <p>During an interview on 12/19/24 at 8:33 A.M. CMT D said:</p> <p>-He/She had education about EBP provided by the former DON maybe a month ago.</p> <p>-If a resident was on EBP it would have been documented on the Medication Administration Record (MAR).</p> <p>-There would have been a sign on the resident's door stating he/she was on EBP.</p> <p>-There would have been an isolation cart outside the resident's room.</p> <p>-He/She had not seen a sign or isolation cart outside anyone's room this week.</p> <p>-No one at this time on the Men's locked unit was on EBP.</p> <p>-Resident #19 had a wound on his/her leg that nursing had been treating.</p> <p>-The charge nurse was responsible for alerting the staff if someone was on EBP.</p> <p>-If a resident was on EBP staff should have worn gloves, face mask, gown and booties.</p> <p>-There was no physician's order for Resident #19 to have been on EBP.</p> <p>-He/She was not aware that any of the residents were currently on EBP.</p> <p>During an interview on 12/20/24 at 10:00 A.M. the DON and RN A said:</p> <p>-Before this week they had not been using EBP.</p> <p>-Anyone who had an open wound should have been on EBP.</p> <p>-There should have been a sign on the resident's door indicating he/she was to have been on EBP.</p> <p>-There should have been an isolation cart with PPE in it at the resident's door.</p> <p>-The physician should have written an order for EBP.</p> <p>-Staff had education about EBP.</p> <p>-The DON was responsible for ensuring the residents who had open wounds or any kind of tubing were on EBP.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the DON said:</p> <p>-Resident #19 had an open wound and should have been on EBP.</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>-Any resident that had an open wound or any kind of tubing coming out of their body should have been on EBP.</p> <p>-There should have been a sign on the resident's door indicating he/she was on EBP and what kind of PPE staff was expected to wear while caring for that resident.</p> <p>-There should have been an isolation cart outside the resident's room with PPE for the staff to wear while caring for the resident.</p> <p>-There should have been a physician's order stating the resident was on EBP.</p> <p>-It should have been documented in the care plan the resident was on EBP.</p> <p>-It should have been passed on it the shift report the resident was on EBP.</p> <p>-He/She was ultimately responsible to ensure residents were on EBP and that staff was aware of it.</p> <p>-Staff had education from him/her and previously from the form DON about EBP.</p> <p>7. Observation on 12/17/24 at 9:47 A.M. and on 12/19/24 at 8:33 A.M. of the medication room on 200 locked unit (men's) unit showed:</p> <p>-The only sink in the medication room was dirty with rust.</p> <p>-There were no paper towels in the medication room.</p> <p>-There was no hand soap in the dispenser.</p> <p>-The floor was dirty and sticky.</p> <p>During an interview on 12/19/24 at 8:33 A.M. CMT A said:</p> <p>-He/She did not know who was responsible for cleaning the medication room.</p> <p>-He/She did not clean it.</p> <p>-The medication room should have been cleaned daily.</p> <p>-The floor should have been cleaned daily.</p> <p>-There should have been soap and paper towels in the medication room for staff to wash their hands.</p> <p>-He/She had never seen anyone clean the medication room.</p> <p>-Housekeeping should have cleaned it.</p> <p>Observation on 12/19/24 at 11:00 A.M. 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>-The only sink in the medication room was dirty with rust.</p> <p>-There were no paper towels in the medication room.</p> <p>-There was no hand soap in the dispenser.</p> <p>-The floor was dirty and sticky.</p> <p>During an interview on 12/19/24 at 11:00 A.M. LPN A said:</p> <p>-When they were done with the medication carts they pushed them into the locked nurse's station.</p> <p>-He/She did not know who was responsible for cleaning the medication room, maybe housekeeping.</p> <p>-The medication room should have been cleaned daily.</p> <p>-The floor should have been cleaned daily.</p> <p>-There should have been soap and paper towels in the medication room for staff to cleanse their hands.</p> <p>-He/She had never seen anyone clean the medication room.</p> <p>-Housekeeping should have cleaned it.</p> <p>-The nurse would have to unlock the door as housekeeping didn't have a key to the medication room.</p> <p>During an interview 12/23/24 at 9:50 A.M. Floor Technician A said:</p> <p>-He/She had worked at the facility for several years and had not cleaned the medication rooms.</p> <p>-Cleaning the medication rooms was up to the Nursing staff.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the DON said:</p> <p>-The sink and floor in the medication room should have been cleaned.</p> <p>-There should have paper towels and soap in the medication room for hand hygiene.</p> <p>-Housekeeping should have cleaned and ensured there were supplies in the medication room daily.</p> <p>42955</p> <p>8. Review of the facility's Tuberculosis Testing policy, dated 6/29/23, showed:</p> <p>-The purpose of the policy was to ensure each resident of the facility was tested for TB.</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>-Upon admission and readmission each resident received a two-step purified protein derivative (PPD) tuberculin skin test (TST-a test to detect TB completed by injecting a small amount of TB protein under the top layer</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727</p> <p>Based on observation, interview and record review, the facility failed to maintain an effective pest control program for four sampled residents (Resident #108, #43, #23 #35) out of 23 sampled residents, so that the facility remained free of pests and rodents. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who reside in or visit the facility. The facility census was 111 residents.</p> <p>Review of the facility's policy titled Pest Control Program Policy dated 5/14/24 showed:</p> <p>-It was the policy of the facility to maintain an effective pest control program that eradicates and contains common household pests and rodents.</p> <p>-Effective pest control program was defined as measures to eradicate and contain common household pests including mice.</p> <p>1. Review of the facility pest control invoices showed:</p> <p>-On 9/24/24 - one mouse caught on a trap.</p> <p>-On 10/1/24 - discovered rodent activity at bait stations.</p> <p>-On 11/5/24 - found rodent activity around back side of building.</p> <p>-On 11/19/24 - found rodent activity near dumpsters.</p> <p>-On 12/3/24 - found evidence of rodent activity around north and south side of building.</p> <p>2. Observation on 12/16/24 at 1:57 P.M. showed a large amount of mouse droppings in the front conference room, in the corner behind the door that covered two square feet.</p> <p>Observation of the kitchen on 12/16/24 at 2:27 P.M. showed:</p> <p>-A large section of the corner of a bag of au gratin mix that was stored on the spice rack near the coffee station was chewed off.</p> <p>-The bag had mouse droppings and yellow stains on it.</p> <p>-Large, opened bags of rice and brown sugar were under the main storage prep table and were not closed or in containers.</p> <p>During an interview on 12/16/24 at 2:27 P.M., [NAME] B said the bag (of au gratin mix) should have been in a container but now it should have been thrown away.</p> <p>During an interview on 12/18/24 at 1:03 P.M., Dietary Aide (DA) A and [NAME] B said:</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-They have a mouse problem.</p> <p>-An exterminator came every week.</p> <p>During an interview on 12/18/24 at 12:55 P.M., the Administrator said:</p> <p>-They've attempted to clean up the mice situation.</p> <p>-There was a field behind the facility.</p> <p>-Residents took food to their rooms.</p> <p>-They encouraged residents not to keep food in their room.</p> <p>-They had a pest control company come once a week.</p> <p>-The mice had been an ongoing issue for at least the past year.</p> <p>-He's/She's had several complaints regarding the mice.</p> <p>-They were doing their best with cleaning the facility.</p> <p>-They did environmental rounds related to the presence of mice.</p> <p>-He's/She's thinking about getting a cat.</p> <p>During an interview on 12/18/24 at 1:14 P.M., the Maintenance Director said:</p> <p>-Pest control comes weekly, and they put out sticky traps and snap traps as well as small pellets in non-resident areas.</p> <p>-There was a field behind the facility and it's cold.</p> <p>-He/She changed pest control companies to try to improve the situation.</p> <p>During an interview on 12/18/24 at 1:19 P.M., the Dietary Manager said they should have everything stored in containers in the kitchen to prevent exposure to mice.</p> <p>During an interview on 12/18/24 at 2:37 P.M., the Administrator said they should have the food in the kitchen stored to protect it from mice.</p> <p>32720</p> <p>3. Review of Resident #108's Face Sheet showed he/she was admitted to the facility on [DATE].</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/20/24 showed he/she was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 12/18/24 at 9:40 A.M., 12/18/24 at 2:54 P.M., 12/19/24 at 1:20 P.M., 12/20/24 at 3:03 P.M., and 12/23/24 at 11:15 A.M. showed:</p> <p>-The baseboard next to the head of the resident's mattress had a thick line of mouse droppings. The floor was also discolored yellow area near the head of the mattress next to the baseboard leading from the bathroom door to the bed.</p> <p>-The baseboards along the wall near the exit door to the room was lined with mouse droppings, a smashed sticky mouse trap behind the room door, the flooring along the baseboards appeared to have a floor wax covering and trapping insects and smashed mouse droppings.</p> <p>During an interview on 12/18/24 at 9:40 A.M., the resident said:</p> <p>-He/She had seen mice in his/her room.</p> <p>-Mice ran around everywhere on the unit.</p> <p>-His/Her mattress was on the floor and mice would get into his/her bed.</p> <p>4. Review of Supplemental Resident #43's quarterly MDS dated [DATE] showed the resident was cognitively intact.</p> <p>Observation on 12/20/24 at 11:00 A.M. showed mouse droppings were on the floor along the baseboards with a torn, smashed sticky mouse trap on the floor in the corner of the room.</p> <p>During an interview on 12/20/24 at 11:04 A.M. the resident said:</p> <p>-There were always mice droppings on the floor.</p> <p>-He/She did not know the last time anyone changed out the torn, crumpled sticky mouse trap, it has been over a month.</p> <p>During an interview on 12/20/24 at 11:20 A.M., Registered Nurse (RN) A said:</p> <p>-He/She was aware of the mice issues.</p> <p>-He/She thought the pest control company came often, maybe weekly.</p> <p>During an interview on 12/20/24 at 3:03 P.M., the Activities Director said:</p> <p>-He/She had seen mice on the unit.</p> <p>-The mouse situation was bad.</p> <p>-An exterminator was there weekly and put out traps, but it did not help.</p> <p>Observation on 12/23/24 at 11:14 A.M. showed:</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The sticky mouse trap was in the same location, torn and crumpled.</p> <p>-Mouse droppings were on the floor along the baseboards.</p> <p>39469</p> <p>5. Review of Resident #25's quarterly MDS dated [DATE] showed:</p> <p>-He/She had been admitted to the facility on [DATE].</p> <p>-He/She was cognitively intact.</p> <p>Observation on 12/16/24 at 1:30 P.M. showed there was mice droppings on the floor along the wall in the area of the resident's bed.</p> <p>During an interview on 12/16/24 at 1:30 P.M. the resident said:</p> <p>-He/She had seen three mice in his/her room two weeks ago.</p> <p>-He/She believed the mice came into the room through a hole under the heating unit.</p> <p>-He/She had talked to the maintenance man about the mice issue.</p> <p>-The maintenance man put sticky traps out to catch the mice in the room.</p> <p>-Housekeeping cleaned the room daily.</p> <p>-There was still mouse droppings on the floor daily.</p> <p>6. Review of Resident #23's quarterly MDS dated [DATE] showed:</p> <p>-He/She was admitted to the facility on [DATE].</p> <p>-He/She was cognitively intact.</p> <p>Observation on 12/16/24 at 1:42 P.M. showed:</p> <p>-There was mouse droppings and yellow substance on the floor in the corner by the resident's bed.</p> <p>-There was a small hole in the baseboard in the corner where he/she believed mice came into the room.</p> <p>-There was a small hole under the heating unit where the resident believed the mice came into the room.</p> <p>During an interview on 12/16/24 at 1:42 P.M. the resident said:</p> <p>-Housekeeping cleaned the room daily.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She had talked to maintenance but they did not fix the holes in the corner or under the heating unit.</p> <p>During an interview on 12/17/24 at 10:00 A.M. the resident said:</p> <p>-He/She had seen a couple of mice in his/her room within the last week.</p> <p>-He/She had notified maintenance of the problem.</p> <p>7. During an interview on 12/23/24 at 10:00 A.M. the Business Office Manager said:</p> <p>-He/She had seen two mice in his/her office last week.</p> <p>-One of the mice ran over his/her foot.</p> <p>-The facility had recently changed pest control companies.</p> <p>-The pest control company had been coming out weekly.</p> <p>-The pest control company had put out sticky traps.</p> <p>-The traps have not worked.</p> <p>8. Observation on 12/23/24 at 10:15 A.M. showed:</p> <p>-A mouse ran down the hallway and into room [ROOM NUMBER] under the resident's bed.</p> <p>-The resident was not in the room at the time.</p> <p>During an interview on 12/23/24 at 10:30 A.M. Floor Technician A said:</p> <p>-He/She went into room [ROOM NUMBER] to get the mouse out.</p> <p>-There were actually two mice in the room.</p> <p>-They had a lot of issues with the mice everywhere in the building.</p> <p>-They did not have enough staff at this time to strip and wax the floors as they should have been.</p> <p>9. During an interview on 12/23/24 at 10:45 A.M. the Maintenance Director said:</p> <p>-They have enough staff.</p> <p>-They had an issue with mice, as the weather turned cold they came into the building from the field behind the building.</p> <p>-When he/she had seen holes in the wall he/she would stuff steel wool into the hole.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-They had recently changed pest control companies.</p> <p>-In the last month the pest control company had come out to put out sticky traps in each room.</p> <p>-They still had mice.</p> <p>-Housekeeping cleaned the floors daily but there was still mice excrement on the floors.</p> <p>During an interview on 12/23/24 at 4:10 P.M. the Director of Nursing (DON) said:</p> <p>-The pest control company was coming into the facility weekly to set out sticky traps.</p> <p>-There was still a mouse problem throughout the building.</p> <p>-A couple of the residents had received education about not feeding the mice.</p> <p>-Housekeeping cleaned the rooms daily and the mouse excrement should have been cleaned up.</p> <p>37576</p> <p>10. During an interview on 12/19/24 at 1:27 P.M., CNA P said:</p> <p>-He/She worked the night shift and there were mice running all around the facility.</p> <p>-The mice had been worse in the last month.</p> <p>-During the night you could see the mice come in and out of the MDS office.</p> <p>-The mice run through the Dining Room and down the halls and in and out of resident rooms and everywhere.</p> <p>-At the Nurses Station on the main unit there were two small holes one at the far end and one in the middle that the mice run in and out of.</p> <p>-He/She didn't think the facility was doing enough about it.</p> <p>-He/She didn't think the residents should have to live in this type of an environment.</p> <p>-He/She didn't think the staff should have to work in this type of an environment.</p> <p>-There were mice droppings along the edges of the floors everywhere.</p> <p>- Residents and staff were told by Administration and maintenance that pest control comes in weekly and put new mouse sticky traps in all the rooms.</p> <p>-He/She had never seen a mouse caught in one of the traps.</p> <p>11. Observation on 12/23/24 at 10:13 A.M., showed:</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-A mouse running back and forth in room [ROOM NUMBER] between the beds and the bathroom for several minutes before it disappeared out of site under bed two.</p> <p>-No residents were in the room at the time.</p> <p>MO00246556</p> <p>MO00246720</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>42955</p> <p>Based on interview and record review, the facility failed to provide the required 12 hours of nurse aide in-service training that included the topics of dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses), and Abuse, Neglect and Exploitation (ANE) for four out of five sampled Certified Nursing Assistants (CNA) (CNA A, CNA B, CNA E and CNA G) for January 2024 through December 2024. The facility census was 111 residents.</p> <p>Review of the facility's Nurse Aide (NA) Training Program Policy, dated 5/18/24, showed:</p> <ul style="list-style-type: none"> -The purpose of the policy was to maintain appropriate and effective NA in-service training, ensuring the continue competence of nurse aides. -The facility and the Director of Nursing (DON) were responsible for the coordination and/or provision of NA education. -Each NA was provided at least 12 hours of in-service training annually. -The facility maintained documentation of training. -Training records were forwarded to the Human Resources (HR) Director. -The employee was responsible for attending and completing mandatory in-service trainings to maintain employment with the facility. -A review of the employee's attendance and completion records was performed at least annually. <p>-Minimum training included:</p> <ul style="list-style-type: none"> --Effective Communication. --Dementia management. --ANE. --Elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program. --Resident Rights. --Behavioral Health. <p>1. Review of the facility's Active Employee List, undated, showed:</p> <p>(continued on next page)</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>-CNA A was hired on 3/14/22.</p> <p>-CNA B was hired on 3/30/22.</p> <p>-CNA E was hired on 9/11/24.</p> <p>-CNA G was hired on 7/18/23.</p> <p>Review of CNA A's Training Record, dated 1/1/24 to 12/18/24, showed there was no documentation showing CNA A had dementia training.</p> <p>Review of CNA B's Training Record, dated 1/1/24 to 12/18/24, showed there was no documentation showing CNA B had ANE training.</p> <p>Review of CNA E's Training Record, dated 1/1/24 to 12/18/24, showed:</p> <p>-There was no documentation showing CNA E had dementia training.</p> <p>-There was no documentation showing CNA E had any training hours.</p> <p>Review of CNA G's Training Record, dated 1/1/24 to 12/18/24, showed:</p> <p>-There was no documentation showing CNA G had dementia training.</p> <p>-CNA G received three hours of documented training.</p> <p>During an interview on 12/18/24 at 9:36 A.M., CNA A said:</p> <p>-He/She received training through in-services and on the computer-based training program.</p> <p>-Topics included Resident Rights, ANE, communication, dementia.</p> <p>-He/She had dementia training at some time during an in-service.</p> <p>-He/She received notifications through email when a training was due.</p> <p>During an interview on 12/18/24 at 10:14 A.M., CNA B said:</p> <p>-He/She received training on peri-care (cleaning the private areas of a resident), how to defuse a situation, personal interactions with residents, how to handle behaviors.</p> <p>-He/She had ANE during multiple in-services.</p> <p>-There was a sign-in sheet at in-services and a computer-based program as well.</p> <p>-There is a certain amount that had to be done each year but was unsure of the number.</p> <p>-If we do not have enough hours the administrator came and tell us to get it done.</p> <p>(continued on next page)</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>-The computer-based program tracked training hours and topics.</p> <p>-The program emailed when a training was due.</p> <p>During an interview on 12/18/24 at 10:37 A.M., the Staffing Coordinator said:</p> <p>-The Administrator reviewed all the training to make sure training was getting done.</p> <p>-Each CNA needed 12 hours of training each year.</p> <p>-Human Resources (HR) staff were responsible for tracking the training hours and worked with the administrator to ensure it was getting done.</p> <p>During an interview on 12/20/24 at 9:53 A.M., the Director of Nursing (DON) said:</p> <p>-Training was offered to staff on a regular basis through In-services and through the computer training program.</p> <p>-It included hand washing, ANE, peri care, transfers, infection control.</p> <p>-Each CNA was required to have 12 hours of mandated training a year.</p> <p>-The DON and HR staff were responsible for ensuring staff receive the required training.</p> <p>-Documentation was kept on the computer program and in-service sign-in sheets.</p> <p>During an interview on 12/20/24 at 9:53 A.M., the Administrator said:</p> <p>-The computer program tracked the training topics and hours each CNA completed.</p> <p>-Any in-services provide required employees to sign the sign-in sheets.</p> <p>-Sign-in sheets showed the date, topics, who attended, and who the presenter was.</p> <p>-The sign-in sheet did not reflect the length of time the presentations were.</p> <p>-Each in-service was approximately 15-30 minutes depending on the number participants, their questions and the information provided.</p> <p>-There were also bi-weekly in-services for about an hour.</p> <p>-This was documented on in-service sign-in sheets kept in the DON office.</p> <p>-The DON and HR Director were responsible for ensuring staff receive the required training.</p> <p>-Staff sign by their name on the pre-printed staff list.</p> <p>(continued on next page)</p>

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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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-If a staff person did not sign by their name on the in-services sign-in sheet then they may have signed the bottom, or attended a different session offered later.</p> <p>During an interview on 12/20/24 at 9:53 A.M., the Regional Director of Operations (RDO) said:</p> <ul style="list-style-type: none"> -The computer program triggered when training was due. -It triggered each employee individually as well as the HR Director. -New hires triggered all the basic training and had to be completed during orientation. -Each CNA was required to have 12 hours a year. -It had to include dementia and ANE. -The DON and HR Director were responsible for ensuring all staff received the required training. -Training was documented on the computer training program and in-service sign-in sheets as well as corporate office.