STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265769	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit, The	3660 Summit Kansas City, MO 64111

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to provide the required annual 12 hours of in-service training and competencies skill check off for Certified Nursing Assistants (CNAs). This had the potential to affect all of the residents residing in the facility. The facility census was 56 residents. Review of the facility's Certified Nursing Assistant (CNA) Continuing Education Policy dated 5/25/23 showed:-All CNA's must complete a minimum of 12 hours of continuing education annually, in accordance with State and Federal regulations. -The Director of Nursing (DON) will create an annual training schedule and ensure relevant topics are covered. -CNAs must submit proof of completed training (e.g., certificates of completion) to the facility human resource department. -Supervisor will review training records quarterly to ensure compliance and document compliance. -Supervisor will track compliance and maintain records in personnel files. 1. Review of the undated Facility Assessment showed:-Administration did not have any information regarding how the facility would complete staff training. During an interview on 7/31/25 at 12:00 P.M., CNA C said:-The facility had recently offered in-services related to hand hygiene and perineal (peri the cleaning and maintenance of the perineum, the area between the anus and genitals) care. -Normally there were monthly in-services on pay days. -He/she was not aware if in-services were documented anywhere. Review of the facility CNA and nursing staff in-services and skills check offs showed:-The documents were requested on 8/1/25 and 8/4/25.-The Director of Nursing (DON) and the Administrator were not able to provide the current employee in-services and skills check offs.-There was no documentation provided to show current employees had the required amount of in-service training hours and competencies. During an interview on 8/1/25 at 8:40 A.M., Certified Medication Technician (CMT) A said:-He/she had recent in-services related to hand hygiene.-Normally there were monthly in-services on pay days.During an interview on 8/4/25 at 11:10 A.M. the DON said: -The facility provided in-services monthly but he/she was not able to provide written documentation of those trainings.-The facility had not completed nursing staff and CNA skills check off/staff competencies and did not have any documentation of any past skills check offs. -He/She was responsible for completing competency skills check offs for all nursing staff including CNAs. -He/She did not have any documentation to show the current employees had the required 12 hours annual training. During an interview on 8/4/25 at 2:10 P.M. the Administrator said:-He/she would expect the facility to have documentation to show in-services and skills check offs/competencies for the CNA's required 12-hour training were completed.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain the fan vent cover in the dining room that had heavy dust buildup; maintain the floor behind and under equipment where debris had built up; maintain the drains throughout the kitchen especially by the Victory refrigerator that had grime build up; maintain the cleanliness of the floor in the dry goods storage room; maintain the cleanliness of the ceiling above the wall mounted fan had food splashes present; maintain the fans inside the refrigerator that had debris on them that were blowing directly on drinks and the bottom shelf; maintain the cleanliness of the stove from dust and grime built up on the front, sides, the shelf, and behind on the hoses; maintain the cleanliness of the racks, floors, and walls in refrigerator #3 that had a white substance growing on it; failed to utilize sanitizer strips, and sanitizer not being used to wipe down surfaces, cloth being used to wipe down surfaces not being stored properly; there were no test strips available for the dishwasher; surfaces not maintained or cleaned, the plastic papers on the bottom shelf of the preparation table by the refrigerator had food residue spilled on it and had clean dishes sitting on the contaminated paper; items in the refrigerator were not labeled and dated; and staff members working in the kitchen failed to wash their hands. This practice potentially affected all 56 residents who ate the food from the kitchen. The facility census was 56 residents.1. Observation on 7/28/25 9:25 A.M. during the initial walk-through meal preparation showed:-There were opened and cut up food items with no dates in the refrigerator.-There was a plastic baggie with red sauce in it with no label to identify the food item and no date to show when the food item was placed in the refrigerator.-The refrigerator bottom shelf had debris on it.-The refrigerator fans were blowing debris on to uncovered drinks. -Freezer #1 had food that was not in a container and not covered. -The ceiling above the wall mounted fan had food splashes present.-The dish machine did not have any test strips available. Observation on 7/31/25 from 9:04 A.M. to 12:00 P.M. during the lunch meal preparation showed:-The fan vent cover in the dining room had heavy dust buildup. -The floors by the handwashing sink, stove, and refrigerator had debris and grime build up. -The stove had a red plastic funnel behind it along with dust build up on the hose. -There was grime built up on the side, front, top, and the shelf. -There were white tablets on the floor under the wire rack by the chest deep freezer.-The floor in the dry storage area had black sticky residue present. -Refrigerator #3 had liquid on the floor and white substance growing on the racks and walls. -The drains especially by the refrigerator had grime build up. -The wall mounted fan and the portable fan by the stove had a buildup of dust on them. -The peanut butter container that sat out in room temperature had jelly residue on it. -The bottom shelf of the preparation table had clean dishes sitting on a dirty cover. -The [NAME] used a towel to wipe off the preparation tables but did not store the towel in the sanitizer bucket when it was not in use. -Staff did not use sanitizer test strips to test the sanitizer solution.-The Dietary Aid asked the Dietary Manager (DM) for test strips the DM took out a rolled strip with no date or label on them as to what they were for and if they were still valid. -The kitchen staff did not wash their hands before putting on gloves to start working. -The [NAME] did not wash his/her had before putting on gloves before putting chicken strips in the pan to be baked. -The Dietary Aid did not wash his/her hands after he/she handled the trash, before handling juice.-The Cook/Aid came into the kitchen with gloves on, touched multiple items in the kitchen, left and returned to the kitchen with a box then proceeded to place small bowls of pudding on a tray while wearing the same gloves. During an interview on 7/31/25 at 12:00 P.M. the [NAME] said:-Test strips were available.-Only one bucket was used to wipe down the steam table. -He/She did not test the sanitizer solution to ensure it was appropriate.During interview on 7/31/25 at 1:33 P.M. the DM said:-Deep cleaning in the kitchen happened once a week on Thursday. -The refrigerators were cleaned on Thursday. -Staff should wash their hands every time they come into the kitchen, every time they have touched something different, and before putting on gloves.-Staff should check the sanitizer solution every two hours.-Staff should (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	check the temperatures of the dish machine after every meal and it should be drained and restarted. -The dish washer was a low temperature machine.-Test strips for the dish machine were discarded when cleaning and more needed to be ordered. -The white tablets on the floor were a new type of pest control the company put down. The staff would sweep them up when they cleaned.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review the facility failed to ensure Quality Assurance and Performance Improvement (QAPI-a structured approach to improving quality in healthcare settings) and QAPI activities (development of performance improvement action plans, monitoring, analysis and feedback) were documented to show how the facility was measuring the success of quality improvement actions and performance. This failure potentially affected 56 residents. The facility census was 56.1. Review of the facility Certification and Survey Provider Enhanced Reports (CASPER-reports generated from information submitted by the facility to assess their performance and identify areas for improvement. The report provides insights into various aspects of care, such as staffing levels, quality measures, and compliance with regulations) dated 7/21/25, showed repeat deficiencies were cited in prior survey processes (since July 2022) in the areas of resident rights, resident care, rehabilitation services, Staffing, Infection Control, Dietary Services, and Life Safety Code. Review of the facility's Payroll Based Journal Report showed:-The facility had low weekend staffing in two quarters: July 2024 to September 2024 and October 2024 to December 2024.-The facility had one star rating in one quarter: July 2024 to September 2024. Review of the undated Facility Assessment showed:-The facility would audit and review the demography, Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning) data information and current nursing assessments to obtain the data, current and average 12-month data.-The Quality Assurance and Performance Improvement (QAPI) team and the operational director are responsible to annually obtain, review and revise the information on the facility profile.-The QAPI team updated the information if needed or significant changes in the facility profile.-Revise and document the information accordingly.-Extract data from the MDS to obtain information for resident diseases and conditions, physical and mental disabilities, ethnic and cultural population, religion and religious practices.-Extract data on resident census and condition and the roster sample matrix.-Extract the CASPER report to review all quality measure reports to assess and correct information. Review of facility documentation provided showed the facility did not submit documentation of a completed QAPI plan since the last survey (June 2023) or within the last year (June 2024 to June 2025) as requested during the entrance conference for review. During an interview on 8/4/25 at 10:41 A.M., the Administrator said:-The Quality Assurance (QA) Committee included the Administrator, Corporate Manager, Medical Director, Social Services Director, Dietary Manager, Director of Nursing, Maintenance Director, and sometimes the Activity Director attends.-The QA Committee met at least quarterly and their last meeting was May 2025.-They determined areas of concern by reviewing prior citations, weekly reports they used that showed falls, wounds, weight loss, medications-antibiotic and antipsychotic medication use, infections, behavior incidents, and resident counsel reports to determine what areas they may need to develop an improvement plan for.-Once they determined what areas they were going to focus on-depending on what the concern area was - they would develop the plan of action and then they in-serviced the staff on the plan and how it was to be carried out.-He/She and whomever they determined would be responsible for monitoring the plan would meet weekly or as often as needed to determine the success of the plan and reviewed it as needed.-They have not been documenting any QAPI plan of action, performance improvement plan (PIP), monitoring of action plans and QA areas they have completed a QAPI for.-They reported the results of any QAPI, PIP/action plans in the QA Committee meeting verbally and did not have documentation of prior or current action plans, monitoring of their QAPI , or any action plans/PIP or QAPI that was resolved.-He/She did not know this information had to be documented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to ensure an on-going process for monitoring facility-wide Infection Prevention Control Program (IPCP) was established; failed to ensure surveillance logs were maintained with written documentation for 17 months out of 18 months (January 2024 to May 2025) of surveillance to include but not limited to: documentation of monitor, track, and identify trends of infections in the facility and outcome of findings; and failed to ensure infection control prevention practice of proper hand hygiene preformed during personal care for one sampled resident (Resident #2) out 24 residents. The facility census was 56 residents.Review of the facility General Infection Control Program dated 2023 showed:-A system for surveillance is designed to establish and maintain data base with describes endemic rates of nosocomial infections or facility-acquired infections. -A systematic observation on the occurrence and distribution of facility-acquired infections among the resident for the propose of prevention and control. Surveillance implies that the data has been complied to examined and reviewed in order to determine problems that may exist within the environment. -Infection Control Preventionist (ICP), a person designated to serve as coordinator of the facility's infection prevention and control program. -Surveillance including process and outcome surveillance, monitoring, data analysis, documentation and communicable disease reporting (as required by state and federal law and regulation). Review of the facility's Hand Washing policy dated 2020 showed:-All care staff must apply proper hand washing before, after and between care deliveries. -Perform hand washing after remove gloves. Review of the facility's Gloving policy and Procedure dated 2024 showed:-Changes gloves from a soiled body site to a clean one on the same resident. -Before exiting a resident room. Review of the facility's undated Facility Assessment showed: -General nursing related infections preventions: Identification, containment of infection and prevention of infections, 1. Review of the facility Infection Control Surveillance log on 8/4/25 at 10:38 A.M., showed: -The Director of Nursing (DON) did not have written infection surveillance tracking from January 2024 to May 2025.-The DON recently completed the June 2025 infection surveillance tracking and trending of residents with infections and had started entering data for July 2025.-The DON did not have written monthly infection control reports that were presented to the Quality Assurance (QA) Committee for review and follow-up on any resident infections with trending patterns. During an interview on 8/4/25 at 10:41 A.M. the Administrator said:-The QA Committee included Administration, Corporate, the Medical Director, Social Services, Dietary, the DON, the Maintenance Director, sometimes the Activities Director attended the meetings.-The Infection Control Surveillance was being completed by the DON currently, who was not ICP certified. -The facility was going to have a prior ICP come back to be the facility ICP again.-Licensed Practical Nurse (LPN) B was in training for ICP. He/She had started June 2025 and did not have his/her certification of completion because he/she took the classes but did not pass the final ICP exam. -The DON had not been tracking and trending infections until June 2025.-The DON was responsible for completing the facility's infection control surveillance to include tracking and trending of infections. -He/she was not aware the DON had not been completing the documentation for tracking and trending of infections nor antibiotic stewardship. During an interview on 8/4/25 at 11:10 A.M., the DON said: -He/she was responsible for completing the facility's infection control surveillance to include tracking and trending of infections. -Licensed Nursing staff were responsible for completing Appropriate Antibiotic Use Audit tool which would be placed in an antibiotic/infection binder/log book found at the nursing station. -He/She was responsible for completing the documentation for each month's infection surveillance. -He/she had not been documenting ongoing monthly infection surveillance tracking and trending since the last ICP left in June 2024. -During the QA meeting he/she would discuss residents with current infections and also discussed any infections during care plan meetings.-He/she did not document infection prevention interventions and did not document any education provided due to any infection trends found. -The facility administration and the DON did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	document outcome from infection control review by the QA team. 2. Review of Resident #2 admission Face sheet showed the resident admitted with the following diagnoses:-Cerebral palsy (a group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth).-Dementia (is the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's day to day activities).Review of the resident's Activities of Daily Living (ADL's) Care Plan dated 3/21/24 showed:-The resident was dependent on 1-2 staff for bathing and personal care. -The resident could be resistant to laying down and incontinence care during the day shift. Review of the resident's Quarterly Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning) dated 7/15/25 showed the resident: -Was cognitively intact able to make his/her needs known. -Required assistance with personal care and was incontinent of bowel and bladder. Review of the resident's Physician Order Sheet (POS) dated July 2025 showed:-Calmoseptine (skin protective barrier cream) cream apply topically to buttock (either of the two round fleshy parts that form the lower rear area of a human trunk) twice daily as needed for wound healing. Observation on 7/29/25 at 2:46 P.M. of the resident's incontinence care showed:-The resident was in bed.-There was a lingering smell of urine.-The resident required total staff assistance with bed mobility/turning and personal care. -Certified Nursing Assistant (CNA) C entered the resident room and washed his/her hands prior to putting on gloves, while CNA A entered the room.--CNA A did not sanitize or wash his/her hands prior to placing gloves on hands. -The resident's brief was wet, which had leak through to the bed sheet and his/her hospital gown was wet. -CNA C provided perineal care, (peri care the cleaning of the genital and anal areas) for the resident. -CNA C used one wipe at a time to clean the front area and changed gloves from the front to back care process. -CNA C removed the gloves and placed clean gloves on hands without sanitize hands to finish resident incontinence care. -CNA C with gloved hands placed small amount of cream on top of his/her right-hand glove, then with his/her left gloved hand, placed the cream onto the resident's open reddened areas on his/her lower buttocks. -CNA C then placed new clean brief on the resident with same soiled gloves. -CNA A put new sheets and bed chucks on the resident's bed and changed the resident's gown. -CNA C did not wash or sanitize his/her hands between each glove changes or from the dirty to clean process. -CNA C removed gloves and washed hands prior to leaving the resident room. -CNA A did not wash or sanitize his/her hands before putting on gloves. During an interview on 7/31/25 at 12:00 P.M., CNA C said:-He/she should have washed or sanitized his/her hands between each glove change and from a dirty to clean process. -He/she recently had peri care training to include hand hygiene. During an interview 8/1/25 12:06 P.M., CNA B said:-He/she would sanitize or wash his/her hands when going from clean to dirty process and between each glove change. During an interview on 8/4/25 at 9:59 A.M., Licensed Practical Nurse (LPN) A said:-He/she would expect staff to perform hand hygiene by either sanitizing or washing their hands with soap and water prior to resident care, when going from a dirty to clean process and between each glove change. During an interview on 8/4/25 at 11:10 A.M., DON said: -He/She would expect staff to perform hand hygiene before and after any resident care, when going from a dirty and clean processes, and between each glove change. -He/She had provided recent in--services on hand hygiene and peri care to all staff.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on observation, interview, and record review, the facility failed to employ a certified Infection Control Preventionist at least part time to coordinate the surveillance of the facility's Infection Control and Prevention Program. The facility census was 56 residents. Review of the facility General Infection Control Program Policy dated 2023 showed:-Infection Control Preventionist (ICP), a person designated to serve as coordinator of the facility's infection prevention and control program. -Surveillance including process and outcome surveillance, monitoring, data analysis, documentation and communicable disease reporting (as required by state and federal law and regulation. 1. Review of the requested copy of the facility ICP's certification on 8/4/25 at 10:30 A.M. showed:-The facility did not have a current employee with a certificate of completion as an ICP.-The Director of Nursing (DON) and Licensed Practical Nurse (LPN) B, who was in training for the ICP position, did not have an active ICP certification. During an interview on 8/4/25 at 10:41 A.M. in the Quality Assurance (QA) interview the Administrator said:-The QA Committee included Administration, Corporate, Medical Director, Social Services, Dietary, DON, Maintenance Director, and sometimes the Activities Director attended the meetings.-The Infection Control Surveillance was being completed by the DON currently, who was not ICP certified. -The facility was going to have a prior IC Preventionist come back to be the facility IC Preventionist again.-LPN B was in training for the IC Preventionist, he/she had just started last month (June 2025) and he/she did not have his/her certification of completion because he/she took the classes but did not pass the final ICP exam. -The DON had not been tracking and trending infections until last month (June 2025).-The DON was responsible for completing the facility's infection control surveillance to include tracking and trending of infections. -He/she was not aware that the DON had not been completing the documentation for tracking and trending of infections nor antibiotic stewardship. During an interview 8/4/25 at 11:10 A.M., the DON said: -The facility did not employee a certified Infection Control Preventionist at that time.-The last ICP employee had left the facility in June 2024. -The DON had not completed the ICP program and was not ICP certified. -The facility hired a nurse in June 2025, who was working on getting the ICP certification.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and interview, the facility failed to repair a drainpipe that was coming off the Victory Refrigerator and dripping water on to the floor next to a bolt which was causing it to rust instead of draining directly into the nearby drain. The facility census was 56 residents.1. Observation on 7/31/25 from 9:04 A.M. to 1:33 P.M. showed:-The drainpipe leading from the Victory Refrigerator was not draining into the adjacent drain.-It was draining on the floor next to a bolt which was causing it to rust and then the rust and water would run on to the floor into the drain. During an interview on 7/31/25 at 1:33 P.M. Dietary Manager said:-The drainpipe had not reached the drain for about a month. -He/She did not know what happened to it.-He/She thought it was on the schedule to be fixed but wasn't sure.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure the fan in the laundry area was free from a heavy buildup of dust. This practice potentially affected an unknown number of residents because the fan was directed towards the clean clothing on a hanger. The facility census was 56 residents.1. Observation on 7/28/25 at 1:41 P.M., showed one fan with heavy buildup of dust on the blades and the grate (the plastic/metal covering over the exposed parts of machinery) which was directed towards the clean clothes on a hanger behind Laundry Aide (LA) A.During an interview on 7/28/25 at 1:42 P.M., LA A said he/she did not know the last time the fan was cleaned.During an interview on 7/28/25 at 1:49 P.M., the Housekeeping/Laundry Supervisor said he/she brought the fan out of a closet somewhere and did not know the last time the fan was cleaned.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure there was negative air flow (a ventilation system that continually attempts to move air out of the room) in required areas such as the soiled utility/biohazard rooms, shower rooms and the restrooms of resident rooms. This practice affected all residents, because none of the resident room restrooms had negative air flow. The facility census was 56 residents.1. Observation on 7/29/25 with Maintenance Person A showed the following:-At 10:04 A.M., there was the absence of negative air flow in the biohazard room located behind the first floor nurse's station.-At 10:10 A.M., there was the absence of negative air flow in the restroom of resident room [ROOM NUMBER]. -At 10:37 A.M., there was the absence of negative air flow in the restroom of resident room [ROOM NUMBER].-At 1:32 P.M., there was the absence of negative air flow in the second floor biohazard room. 2. During an interview on 7/29/25 at 10:05 A.M., Maintenance Person A said he/she did not know how long there had not been any negative air flow.During an interview on 7/29/25 at 10:06 A.M., the Corporate Maintenance Person said the motor which operated the negative airflow in the first floor biohazard room, and rooms throughout the facility, was broken.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a closed record was complete by showing a recapitulation of stay for one sampled closed record resident (Resident #62) out of 24 sampled residents. The facility census was 56 residents. 1. Review of Resident #62's admission sheet showed the resident was admitted to the facility on [DATE], with diagnoses of Congenital Dyserythropoietic Anemia (rare blood disorder resulting from a decrease number of red blood cells), Post Traumatic Stress Disorder (PTSD), Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety), Essential Hypertension (High Blood Pressure), Alcohol Dependence, absence of right leg above knee, Anemia (a decrease in hemoglobin in the blood to levels below the normal range), absence of left leg below knee, homelessness, Type 2Diabetes Mellitus (a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin), low back pain, other chronic pain, sleep disorder, and dependence on wheelchair. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 5/9/25, showed the resident:-Was cognitively intact.-Had medically complex conditions. Review of resident's nursing notes dated 6/2/25 showed the resident was discharged by facility van to his/her siblings house. Review of resident's discharge instructions dated 6/2/25 showed a list of medications. Review of the resident's medical record showed on 6/2/25 there was no recapitulation of stay.During an interview on 8/4/25 at 11:03 A.M., Social Services Designee said:-He/She did not know what a recapitulation was. -He/She did not have a list of items that the resident brought with them to the facility. During an interview on 8/4/25 at 12:36 P.M., the Director of Nursing (DON) said:-There should have been a recapitulation. -The charge nurse was responsible for the recapitulation.

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	265769	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit, The	3660 Summit Kansas City, MO 64111

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure perineal (peri) care was provided as needed for one sampled resident (Resident #3) out of 24 sampled residents. The facility census was 56 residents. Review of the facility's policy titled Policy for Daily Activities of Daily Living (ADL) dated 2024 showed bed mobility care is performed daily every 2 hours for limited mobility residents and every 4-6 hours depending on tissue tolerance and whenever needed. 1. Review of Resident #3 admission Record showed he/she was admitted on [DATE], with the following diagnoses:-Unspecified 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, judgment, and impulses).-Type 2 Diabetes Mellitus (a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).-Essential Hypertension (HTN chronic condition of high blood pressure).-Hyperlipidemia (high level of lipids in the blood). Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 3/12/25 showed the resident:-Was cognitively impaired.-Always incontinent. -Dependent on staff. Review of the resident's Care Plan dated 3/12/25, showed:-The resident had comfort measures related to terminal illness.-The resident was on hospice (end of life care).-The resident had an Activities of Daily Living (ADL) self-care performance deficit related to weakness from Dementia. -The resident was totally dependent on staff. -The resident required the use of a Hoyer lift for transfer.-The resident had cognitive impaired function/Dementia or impaired thought process related to severe Dementia. -The resident had a communication problem related to mental status Dementia with confusion. Review of the resident's nursing care sheet dated July 2025 showed:-Peri care was done for the day.-It did not list out the time of day that the care was provided. Review of the resident's Hospice notes dated 7/15/25, showed:-The resident had bowel incontinence.-The resident had inability to change position.-The resident had urine incontinence. -Incontinence was being managed by briefs and proper skin care. During an interview on 7/29/2025 at 2:00 P.M. Certified Nursing Assistant (CNA) B said staff would check the resident every two hours.Observation on 7/30/25 from 10:26 A.M. to 12:20 P.M. showed:-Staff did not perform any peri care checks on the resident.-Staff did not reposition the resident. -The resident was served lunch at 12:20 P.M.Observation on 7/30/25 at 1:22 P.M. showed the resident was seen in the same position.Observation on 8/1/25 from 9:14 A.M. to 12:34 P.M., showed:-Staff did not perform any peri care checks on the resident.-Staff did not reposition the resident. -Resident was served lunch at 12:34 P.M. During an interview on 8/1/25 at 11:23 A.M., Licensed Practical Nurse (LPN) A said staff would check the resident every two hours. During an interview on 8/1/25 at 2:40 P.M., CNA A said:-He/She checked the resident every two hours or whenever he/she would get assistance. -He/She checked the resident in the morning and had LPN A assist him/her. -He/She did not know what time he/she checked the resident on 8/1/25.-The nursing cares sheet did not break the day up into hours, so he/she wasn't sure what time he/she checked the resident. During an interview on 8/1/25 at 3:07 P.M., LPN A said:-He/She thought he/she checked the resident on 8/1/25 at 10:00 A.M. and at 12:00 P.M.-He/She would check him/her discretely and sometimes take him/her to the bath house to check. During an interview on 8/4/25 at 12:30 P.M., the Director of Nursing (DON) said:-A resident that was unable to perform his/her own ADLs should be checked by a staff member every two hours.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an individualized activity plan was goal directed and incorporated the interest and ability of one sampled resident (Resident #20) out of 24 sampled residents. The facility census was 56 residents. Review of the facility Activity policy dated 2022, showed:-The purpose to ensure residents receive meaningful activities. To ensure assessments for activities preferences are completed on admission. To ensure progress documentation of activity assessment. -Provide a plan of activities appropriate to the needs of the residents. -Assess resident needs and develop resident activities goals for the written care plan. -Encourage resident participation in activities and document outcomes. -Review goals and progress notes. -Properly document Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning) reports and progress notes. Develop a plan of care addressing activity preferences and services. -Obtain necessary equipment and supplies and provide for their accessibility through organized storage.-Quarterly documentation on activity progress note and whenever needed, changes in conditions or preferences. -The Activity director is to ensure communication with all departments via morning meetings and Quality Assurance (QA) meetings regarding activity assessments or changes in level of activities. -The Activity director conducts resident council meeting and reports to the QA team for interventions and follow-up. 1. Review of Resident #20's admission sheet showed the resident was admitted to the facility on [DATE], with the following diagnoses:-Unspecified Dementia (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, judgment, and impulses).-Anxiety disorder (a common mental health condition characterized by excessive and persistent worry, fear, and nervousness).-Muscle weakness.-Rheumatoid Arthritis (an inflammatory disease that may lead to serious joint damage and disability).-Urinary incontinence.-Other malaise (is a non-specific symptom that general feeling of discomfort, illness, or lack of well-being). Review of the resident's quarterly MDS dated [DATE], showed the resident: -Needed modified independence-some difficulty in new situations only.-Needed setup or clean-up assistance with eating and dental care. -Needed partial/moderate assistance with transferring, dressing, and toileting. -Needed substantial/maximal assistance with bathing. -Was dependent on a wheelchair. -Note: His/Her activity preferences were not identified on this assessment.Review of the resident's Care Plan dated 7/15/25, showed:-On 5/30/24 the resident had limited to no activity involvement. Currently, one to one activities to help with engagement.-On 8/21/24 the resident had limited involvement in group activities and continued one to one.-The goal showed the resident would participate in activities of choice times per week by review date. --The goal did not indicate how many times per week the resident would participate in activities. -Interventions showed one to one activities and the resident preferred socializing, nail care, and enjoyed the television (tv) channels 4, 41, 9, and 5.-Staff was to explain to the resident the importance of social interaction, and leisure activity time. -Encourage the resident's participation by notifying in advance of activities, announce activities on intercom, and personally invite. Review of the resident's Special Programming One to One Log showed:-One to one activities only occurred one time per week.-7/7/25-nail care; 7/14/25-nail care; 7/21/25-nail care; 7/28/25-nail care.-There was no other documentation showing the resident was offered any other one on one activities.-There was no other documentation of the resident participating in scheduled activities. Observation on 7/29/25 from 11:30 A.M. to 12:20 P.M. showed: -The resident was sitting in a wheelchair in the tv community area and kept repeating to staff that they needed to close the cupboard doors until the staff closed the doors.-The resident then would say it was time to eat and to go get another resident. -Staff would tell him/her that the resident was sleeping. Resident would keep saying they needed to go get the other resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/30/25 showed:-At 2:13 P.M. the resident was in bed with his/her eyes closed and the bed was low to the floor with fall mats next to it. -At 3:03 P.M. the resident was awake and said he/she was tired and was going to get up at 4:00 P.M. for dinner. -The activity calendar showed on Tuesdays at 2:00 P.M. was residents' choice. -There were no scheduled activities after 2:00 P.M. Monday to Friday. Observation on 8/1/25 at 9:17 A.M., showed:-The resident was sitting in the community tv area eating his/her breakfast. -He/She ate all his/her breakfast. -There were no activities going on.-There was nothing available for the resident's to do before scheduled activities began.During an interview on 8/1/25 at 9:17 A.M. the resident said:-He/She was feeling better today.-He/She was getting a bath later. Review of the posted activity calendar dated August 2025 showed:-Scheduled activities did not start until 10:00 A.M. Monday to Friday. During an interview on 8/1/25 at 10:06 A.M., Certified Medication Technician (CMT) A said:-He/She believed the resident used to be a Registered Nurse and liked to direct the staff.-He/She had seen the resident be constant and repetitive verbally.During an interview on 8/1/25 at 10:30 A.M., Certified Nursing Assistant (CNA) C said:-The resident would be demanding and authoritative. -The resident used to be a nurse.-He/She could redirect the resident by using the residents nursing background. -He/She would also use positive enforcement and previous examples of the resident doing similar things to get them to do it today. -In the beginning they tried to redirect the resident with activities like puzzles, but it didn't work. -Redirecting the resident to church or reasoning with him/her like a nurse and having the resident refer to his/her nursing training worked. During an interview on 8/1/25 at 11:23 A.M., Licensed Practical Nurse (LPN) A said:-He/she would redirect the resident by going over and talking with him/her.-The resident liked to go to church on Mondays, going to parties, and bingo. During an interview on 8/4/25 at 11:15 A.M., the Activity Director said:-He/She would do the resident's nails.-He/She would trim his/her hair occasionally when the resident wanted it. -The resident would go to the community activities.-The resident liked to have his/her mail read to them. -The resident used to be a CNA. -The resident was able to participate in nursing home week.-He/She had one on one activities with the resident every Monday when doing his/her nails. -He/She said they had heard of measuring goals for the residents but had not started with this resident.-He/She did not know why the resident needed one on ones was just told it was because the resident didn't do a lot of other activities. During an interview on 8/4/25 at 12:36 P.M., the Director of Nursing (DON) said:-If a resident was not involved in group activities and if their level of participation or function was lower then what they could comprehend then the resident should be on one on ones. -There should be documentation as to why the person should have one on ones. -There should be documentation as to how many times a week they were getting one on ones. -There should be documentation what the resident's goals were and how those goals were to be measured. -The resident liked to be involved in one on ones with snacks.-The resident also liked to be involved with what's going on.-The resident was not big on tv, music or puzzle books.-Personal care was very important to the resident. -The staff would redirect him/her with what was in front of them, for example if there was food staff would have the resident take a bite. -If there was nothing to use then they would redirect the resident to go wash his/her hands or with some other grooming tasks. -The resident enjoyed personal care.-The resident was a retired nurse.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician orders were followed regarding a medical device being placed by proper personnel and administered as ordered for one sampled resident (Resident #1) that was not supposed to be self-administered out of 24 sampled residents. The facility census was 56 residents.Review of the facility's Medication Administration policy and procedure dated 2024, showed there was no policy or procedure for administering treatments or medical equipment or devices. Review of the facility's Self Administration policy and procedure dated 2018, showed there was no policy or procedure for self-administering medical equipment or devices.1. Review of Resident #1's Face Sheet showed the resident was admitted on [DATE], with diagnoses including end stage renal disease (ESRD a condition where the kidneys are damaged and cannot filter blood effectively), left leg fracture, depression, anxiety disorder, high cholesterol, low iron, and dependence on dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 3/24/25, showed the resident:-Was alert and oriented with no cognitive incapacity.-Was independent or needed supervision with bathing, dressing hygiene, eating and toileting.-Had lower extremity impairment and used a wheelchair for mobility. Review of the resident's Care Plan updated 3/28/25, showed the resident had modified independence for meeting physical, social, emotional and intellectual needs. It showed the resident was a fall risk related to weakness at times. The care plan:-Did not show the resident's current ambulatory status, and did not show that the resident had any health concerns with his/her legs.-Did not show that the resident needed or used a bone stimulator, did not show what it was used for, how it was to be administered, who was to administer it and how staff was monitoring its use. -It did not show the resident was able to self-administer the stimulator. Review of the resident's Physician's Order Sheet (POS) dated July 2025, showed physician's orders for:-A bone stimulator to the resident's left lower extremity for 20 minutes daily (ordered 3/14/25).-Check the resident's lower left extremity for integrity every shift (ordered 12/19/24).-The physician's orders did not show orders that the resident was to self-administer the bone stimulator. Review of the resident's Treatment Administration Record (TAR) dated July 2025, showed physician's orders to check the resident's left lower extremity every shift for integrity and to (apply) the bone stimulator to the left lower extremity for 20 minutes daily. The TAR showed:-Nursing staff initialed that they administered the bone stimulator as ordered daily except on 7/10/25, 7/11/25, 7/20/25 and 7/29/25, where there was no documentation or rationale for why it was not documented. Review of the resident's Medical Record did not show any documentation showing the facility assessed the resident for his/her ability to apply and administer bone stimulator device. Observation and interview on 7/29/25 at 2:21 P.M., showed the resident was in his/her room sitting up on his/her bed. There was a black, round device strapped on his/her lower leg that was connected to a machine that showed a timer. The machine was on and running. When the timer was completed, the resident removed the device from his/her leg and began placing it back in the container that was sitting beside him/her on the bed. The resident said:-The device was a bone stimulator that he/she wore for 20 minutes daily.-The bone stimulator helped his/her leg bone to heal because after he/she fractured his/her leg, it was not healing properly.-He/She used the bone stimulator independently and staff did not assess or monitor him/her while he/she used it.-He/She received the bone stimulator at the orthopedic clinic and had been using it since February/March 2025.-When he/she finished using the bone stimulator, he/she put it away (in the case) and let the nurse know he/she was finished.-He/she learned how to use the bone stimulator at the orthopedic clinic. During an interview on 8/1/25 at 1:59 P.M., Certified Nursing Assistant (CNA) B said:-He/She had seen the resident use the bone stimulator on his/her leg and saw him/her use it yesterday, but (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she did not know what it was for or what it did for the resident.-He/She had not ever administered it on the resident and had never been told to administer it on the resident.-When he/she asked the nurse, the nurse said the resident used the bone stimulator to heal his/her leg bone. During an interview on 8/1/25 at 2:28 P.M., Licensed Practical Nurse (LPN) A said:-The resident used the bone stimulator for bone healing-it was like an ultra sound for his/her leg.-The resident used the device because his bone was not healing due to his/her smoking.-The orthopedic clinic just checked the healing of the resident's bone again recently and it was still not completely healed so they would continue to have them use the bone stimulator.-The device cost $5000.00 and the orthopedic clinic brought it to the facility and trained him/her on its use.-He/She usually put it on the resident at around 1:30 P.M. daily and he/she administered it for 20 minutes for each area (there were two areas on the resident's leg that were to receive treatment).-When the treatment was completed, he/she removed it, then took the machine to charge it and store it in the medication room.-The bone stimulator remained in the medication room until the next use.-The resident was not authorized to use it himself/herself and should not have it in his/her room without the nurse present.-He/She was not working on 7/29/25, but the nurse in charge should not have put it on and left the resident or given it to the resident to use on his/her own. That never should have happened.-The resident sometimes did not like to have the bone stimulation treatment done and would complain and cuss at him/her but he/she knew it was to help the bone to heal.-LPN A then took the bone stimulator machine from the medication room and followed the resident upstairs and said he/she would be administering it to the resident. During an interview on 8/4/25 at 12:36 P.M. the Director of Nursing (DON) said:-The resident used the bone stimulator because his/her leg bone was not healing properly, and this was supposed to stimulate bone growth.-The resident was not authorized to operate the bone stimulator independently.-The nurse was supposed to place the bone stimulator on the resident's leg and set the timer.-The resident had two areas of his/her leg that were to receive treatment for 20 minutes each.-The nurse was to remove the stimulator once treatment was completed.-Nursing staff was aware the resident had removed the stimulator before.-The nurses had at times placed the bone stimulator on the resident and then left the room.-Once the treatment was completed, the resident usually informed the nurse so the nurse could remove the stimulator or change the position of the stimulator.-The resident should not remove the bone stimulator himself/herself for any reason.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident smoking materials were stored safely for one sampled resident (Resident #40); failed to ensure a safe smoking environment after a resident fell asleep while holding a lit cigarette; failed to re-assess the resident for safe smoking; and failed to develop care plan interventions to prevent the incident from recurring for one sampled resident (Resident #42), out of 24 sampled residents. The facility census was 56 residents. Review of the facility's Smoking Policy dated 2022 showed:-The resident's Safe Smoking ability was to be completed yearly or on quarterly assessments.-Assess resident's safe smoking behavior. Determine needs for safety such as a smoking apron, 1:1 supervision and address in the care plan. -Smoking policy given to the resident at the time of admission and signed by the resident or responsible party to acknowledge understanding of the policy. -Staff will round every hour to monitor resident who are identified with risk behavior from history of smoking in non-designated areas. -If do not follow smoking policy, could result in smoking material removed from the resident's possession. 1. Review of Resident #40 admission Face sheet showed the resident:-Had a diagnosis of 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).-Used tobacco. Review of the resident's admission Smoking Policy and Procedure agreement signed on 8/7/23 showed:-He/She had agreed to the facility smoking policy.-He/She would be responsible for compliance and noncompliance with this policy. Review of the resident's Annual Smoking Safety screen dated 7/4/24 showed:-He/She was safe to smoke without supervision. Review of the resident's Smoking Care Plan dated 4/9/25 showed:-He/She smoked.-Would follow the facility smoking rules and would be safe from any smoking hazards. Observation on 7/28/25 at 10:30 A.M., of the resident's room showed:-The resident had a Styrofoam cup of full of used cigarette butts. -He/She was not in the room at the time of observation. -The resident had a roommate. -No storage container for smoking material. Observation on 7/29/25 at 11:40 A.M. showed the resident:-Had collected old cigarette butts.-Was opening the butts to remove the filter and empty the tobacco out onto newspaper. During an interview on 7/29/25 at 11:40 A.M. the resident said he/she:-Was saving the cigarette butt paper to use to roll the tobacco in.-It was cheaper to collect used cigarette butts and then empty the tobacco out to make his/her own cigarettes. -Did not have new cigarette rolling papers.-Had been using the old cigarette butt paper to roll tobacco into, to be able smoke.-Was made aware of the potential risk when he/she used someone else's cigarette butts by facility nursing staff.-Did not have a safe container to store the used cigarette butts in. During an interview on 8/1/25 3:04 P.M., Certified Medication Technician (CMT) A and Certified Nursing Assistant (CNA) C said:-They were aware some residents collected used cigarettes butts, due to not having money to buy cigarettes. -The residents would obtain the tobacco out of the old (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	butts to make own cigarettes. -They were not aware the resident was removing the filter and used the old cigarette butt paper to roll the tobacco in. -The facility did not provide cigarette rolling paper and some residents were able to get facility bought cigarettes. -He/she was not aware if the facility provides storage container for smoking materials. During an interview on 8/4/25 at 9:59 A.M., Licensed Practical Nurse (LPN) A said: -Some of the residents who smoked were able to store smoking materials in their room.-Social services was responsible for completing the resident's smoking assessment. -He/She was not aware of the facility providing the resident with safe smoking materials storage container. -Most residents kept smoking material in their bedside table drawer. -The facility had open smoking times. During an interview 8/4/25 at 12:35 P.M., Director of Nursing (DON) said:-Most of the residents were able to keep smoking material in their rooms. -The residents who wished to smoke were assessed for safe smoking by social services upon admission and annually. -The resident was not provided a secure box to place store smoking materials in.-If a resident violated the signed smoking agreement, he/she would require supervised smoking and possible safe smoking apron to wear. -Smoking time for the indoor smoking area were posted on smoking room door. -Housekeeping was responsible for monitoring resident's smoking at least every hour. -He/She was not aware Resident #40 was collecting other peoples used cigarette butts.-He/She was not aware the resident was rolling own cigarettes with used cigarette filter papers. 2. Review of Resident #42's Face Sheet showed the resident was admitted to the facility with diagnoses that included heart disease, high blood pressure, depression, anxiety, diabetes and back pain. Review of the resident's Care Plan dated 5/9/23, showed the resident was non-compliant with the facility smoking policy and procedure. Interventions showed the facility staff would:-Educate the resident on the facility smoking policy and consequences for violations.-Evaluate the resident quarterly and as necessary for smoking assessment.-The resident knew that continued non-compliance with smoking and fire safety could result in discharge from the facility.-Ensure the resident had signed the smoking agreement. Review of the facility's undated Smoking Log showed:-The resident was one of the resident's that smoked in the facility-The resident's Smoking assessment dated [DATE] showed the resident was fully capable of understanding the smoking policy and procedure, hold a cigarette properly and dispose of ashes/use the ashtray, able to use a lighter safely and properly and safely discard the cigarette, butts and ashes.-The assessment did not show whether the resident fell asleep when smoking, was easily distracted, or if he/she smoked in prohibited areas. -The assessment did not show if the resident was able to complete return demonstration.-The assessment did not show if the resident was deemed to be fully capable of smoking without assistance or monitoring, or if he/she required any assistive devices. Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 5/5/25, showed the resident:-Was alert and oriented with no cognitive incapacity.-Was independent or needed supervision with bathing, dressing hygiene, eating and toileting.-Had no behaviors or mood disorders.-Ambulated with a walker. Review of the resident's Smoking Safety assessment dated [DATE], showed:-The resident had no cognitive, vision or dexterity impairments.-The resident smoked between 5 and 10 cigarettes daily throughout the day and night.-The resident was able to light his/her own cigarette and did not require any assistance or adaptive equipment to smoke.-The resident was deemed to be able to smoke safely and independently without supervision. Review of the resident's Nursing Notes dated 7/6/25 showed:-Facility staff found the resident in the designated smoking room with his/her head down, asleep while holding a lit cigarette in his/her hand, with his/her hand resting on his/her clothes.-Staff immediately woke the resident and informed him/her that he/she could not sleep in the designated smoke room with a lit (continued on next page)

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	265769	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit, The	3660 Summit Kansas City, MO 64111

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cigarette.-The writer also noticed a hole in the resident's clothing close to where he/she was holding a cigarette.-The resident raised his/her head opened his/her eyes and exited the smoke room after putting out his/her cigarette.-There were no additional notes regarding this incident in the nursing notes and there were no notes showing the resident received any additional monitoring after the incident occurred. Review of the resident's Care Plan showed there was no update to the resident's care plan that showed the resident had an incident of falling asleep while holding a lit cigarette and interventions to try to prevent this from recurring and to promote safety while the resident smokes. Review of the resident's Medical record showed:-There was no smoking re-assessment completed after the incident on 7/6/25.-There was no documentation showing nursing staff completed follow up monitoring of the resident after the incident.-There were any new interventions implemented to keep the resident safe while smoking. Observation and interview on 7/29/25 at 11:50 A.M., showed the resident was in the lobby area dressed for the weather and was clean and well-dressed without odor. There did not seem to be any holes in his/her clothing from smoking. The resident was ambulating with his/her walker and went to smoke in the designated indoor smoking room. There was no staff supervision at the nursing station or in the designated indoor smoking area. The resident was able to light his/her own cigarette and smoke without any issues. When he/she was done, the resident put his/her cigarette in the self-closing smoking container and ambulated out of the smoking room. The resident said:-He/She had been living in the facility for three years and usually smoked in the indoor smoke room, but also smoked outside.-He/She was not having any issues with smoking and was aware of the smoking policy and procedure. During an interview on 8/1/25 at 2:19 P.M., the Administrator said:-The resident was found asleep in the designated smoking area with a lit cigarette in his/her hand, but he/she had not burned a hole in his/her clothing at that time and there was no injury to the resident.-The resident smoked in the designated smoking areas indoors and outside and some of the resident's clothes have holes in them.-They did not document an incident report because the resident did not sustain any injury. During an interview on 8/1/25 at 2:48 P.M., CNA B said:-The resident usually smoked independently and was safe to smoke without supervision.-He/She was unaware of an incident where the resident was found sleeping in the smoke room with a lit cigarette in his/her hand.-If nursing staff found the resident that way, they would take the cigarette out of the resident's hand and wake the resident up.-They would then let the charge nurse know what happened and they would not allow the resident to go back to smoke independently until after the nurse had assessed him/her.-They probably would implement a smoking smock for the resident to use while smoking and if the resident refused, they would no longer be able to smoke without supervision.-The nurse would need to document it in the resident's medical record. During an interview on 8/4/25 at 12:09 P.M., LPN A said:-If the resident was independently smoking and the staff caught the resident asleep with a lit cigarette in his/her hand, they would take the cigarette, wake the resident and assess the resident for any injury if needed.-They should re-assess the resident for smoking safety and they would supervise the resident's smoking until the resident no longer was at risk.-They may also provide a smoking apron for the resident to further protect the resident.-Interventions should have been documented in the nursing notes and care plan because the resident had a change in his/her ability to smoke independently and safely. During an interview on 8/4/25 at 12:36 P.M. the DON said:-Residents ability to maintain their own smoking materials was dependent on the residents ability to smoke independently.-Residents sign a smoking acknowledgement form which had the rules for smoking on it and they explained the rules for smoking.-If the resident was violating a smoking policy, the resident was already aware they could have their cigarettes removed if they were deemed to be unsafe to smoke.-The Social Worker completed smoking assessments annually and as needed.-Smoking times were posted on the door for indoor smoking and they had no designated smoking times for outdoor smoking.-Staff smoke outdoors on the designated smoking patio also and were sometimes outside at the same time as the residents, but they did not have staff assigned to supervise smoking when the residents go smoke.-The expectation regarding the resident's incident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was for staff to arouse him/her then remove the cigarette; educate him/her on falling asleep with her cigarette; then inform the nurse and social worker and let the staff know what happened.-The Social Worker should re-assess the resident for safe smoking.-They should have provided the resident with an apron to wear during smoking, and they should also monitor his/her smoking for at least two weeks.-The resident's care plan should have also been updated.-He/She was informed when the incident occurred the nursing staff immediately implemented the smoking apron and the resident was accepting to that.-He/She had not seen the resident smoking.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure physician's orders for self-administration and care for a colostomy (a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon) were obtained and documented on the Physician's Order Sheet (POS) for one sampled resident (Resident #13) out of 24 sampled residents. The facility census was 56 residents.Review of the facility's undated Ostomy-Colostomy policy and procedure showed the purpose was to prevent infection and ensure proper drainage, enhancing hygiene and dignity. It showed:-The resident will be informed of care for the (colostomy).-A resident who is able to perform self-care will be provided information and education on (colostomy) care. -There was no procedure or documentation showing how physician's orders should be written for self-care of the colostomy. 1. Review of Resident #13's Face Sheet showed the resident was admitted to the facility on [DATE] with diagnoses including heart disease, pain, depression, alcohol abuse, and colostomy. Review of the resident's Physician's Telephone Orders showed there was a telephone order dated 10/11/23, to:-Check the stoma (a surgically created opening on the abdomen that connects the large intestine to the outside of the body) and (skin around the) stoma area for skin issues, redness moisture or mucous daily (ordered 10/11/23).-There was no physician's telephone order for self-care and administration of the resident's colostomy. Review of the resident's Care Plan updated 8/14/24, showed the resident had altered bowel elimination related to colostomy placement. Interventions showed staff would:-Monitor the resident's colostomy site daily and document monitoring on the resident's Treatment Administration Record (TAR).-Make sure the colostomy bag was sealed properly and monitor for odors, gas, obstruction and loose stool.-Monitor for signs and symptoms of infection, bleeding or injury at the site and notify the physician.-Assess the resident for self-care of the colostomy quarterly and as needed with a change in condition.-Provide the colostomy bag as needed and provide assistance as needed. Review of the resident's Assessment for Self-Care of Colostomy dated 5/17/25, showed the resident:-Understood the reason for the colostomy.-Was fully capable of using proper infection control (handwashing, using gloves) during the procedure.-Was fully capable of completing the procedure for emptying and changing the pouch and cleaning the skin.-Completed return demonstration for self-care successfully. Review of the resident's POS dated May 2025 and June 2025, showed physician's orders to:-Check the stoma and (skin around the) stoma area for skin issues, redness moisture or mucous daily (ordered 10/11/23).-There was no physician's order for self-care and administration of the resident's colostomy. Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated, 7/10/25, showed the resident:-Was alert and oriented with no cognitive incapacity.-Had no behavioral symptoms.-Was independent or needed set up assistance only with bathing, dressing hygiene, eating and toileting.-Had lower extremity impairment and used a wheelchair for mobility.-Used a colostomy. Review of the resident's POS dated July 2025, showed physician's orders to:-Check the stoma (a surgically created opening on the abdomen that connects the large intestine to the outside of the body) and (skin around the) stoma area for skin issues, redness moisture or mucous daily (ordered 10/11/23).-There was no physician's order for self-care and administration of the resident's colostomy. Observation and interview on 7/29/25 at 10:01 A.M., showed the resident was in his/her room and had just come from the bathroom. Noted there was a clean colostomy bag that was sitting on top of the dresser under his/her television. The resident was alert and oriented and said:-He/She had a colostomy for at least two years and he/she changed and cared for it himself/herself without staff assistance.-The nursing staff just cut the hole in the bag to make sure it fit on the opening of his/her stoma if needed.-He/She did not want to show the colostomy site or have observation of his/her colostomy cares.-He/She did not have any problem or (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	difficulty caring for it himself/herself. During an interview on 7/30/25 at 2:37 P.M., Licensed Practical Nurse (LPN) C said:-The resident could and did change and empty his/her own colostomy bag and performed colostomy care.-The nursing staff checked it (the colostomy and stoma site) daily to make sure it looked okay and was not red or bleeding.-The nursing staff documented their monitoring on the resident's TAR.-There should be physician's orders for the resident's colostomy bag and self-care of the colostomy and stoma. During an interview on 8/4/25 at 9:10 A.M., LPN A said:-The resident was able to care for and change his/her colostomy independently.-Staff completed quarterly assessments where the resident had to provide demonstration of how to change and care for his/her colostomy in order to continue to be able to do this independently.-The nursing staff only provided minimal assistance as needed and they completed skin checks to ensure the area was not infected or had any issues.-There should be a physician's order for self-care and it should be in the resident's care plan.-Lately nursing staff have had to assist more because the resident had declined in his/her overall health and needed more help. During an interview on 8/4/25 at 12:36 P.M. the Director of Nursing (DON) said:-The resident had been performing self-care of his/her colostomy independently for a long time.-The resident had been re-assessed to continue to provide self-care of his/her colostomy and was able to successfully do so.-There should be a physician's order for self-administration and care of his/her colostomy care but it must have fallen off of the POS.-Self administration and care of the resident's colostomy should be on the resident's care plan.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to thoroughly assess the resident's chewing and swallowing ability, failed to re-assess the resident's dietary need and preferences to address the resident's weight and eating status and failed to care plan recent weight loss and nutritional interventions for one sampled resident (Resident #13) with gradual weight loss out of 24 sampled residents. The facility census was 56 residents.Review of the facility's Unplanned Weight Management policy and procedure dated 2006, showed the purpose was to ensure each resident received appropriate nutritional care and ensure significant weight loss or gain be addressed and clinically managed. It showed:-The Director of Nursing (DON)/Assistant Director of Nursing (ADON) will be responsible for establishing a monthly/weekly weight schedule.-The appointed nursing staff responsible for weighing will compare the current weight and the previous weight and shall re-weigh if there is a 5-pound variance.-The weight record shall be communicated with the Quality Assurance Committee or the weight committee.-Residents with a weight loss or gain of more than 5 percent in a 30 day period; 7.5 percent in a 90 day period and 10 percent in a 180 day period will be assessed by a licensed nurse for causative factors, referred to the Registered Dietician for further evaluation, notified to the physician for medical interventions and referred to the weight committee for reviewing and revising the care plan.-Charge Nurses will be responsible for documentation, progress, implementation of treatments. -Documentation of exceptions shall reflect the change in status, condition, implementation of the care plan and physician's orders.-Residents who are observed declining in feeding ability or refuse to eat; consumes less percent of intake (compared to normal intake) will be evaluated by the weight committee.-The care plan shall reflect the interventions recommended by the Registered Dietician.-The Quality Assurance Committee/weight committee shall meet at least monthly or more frequent if needed to monitor for progress and successful implementation in order to develop or revise the care plan.-All weight gain or loss within the parameter of concerns above will be documented on the weight gain/loss assessment. 1. Review of Resident #13's Face Sheet showed the resident was admitted to the facility on [DATE] with diagnoses including heart disease, pain, depression, alcohol abuse, and colostomy (a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). Review of the resident's annual Registered Dietician assessment dated [DATE], showed:-The resident had no significant changes during the year.-The resident ate a regular diet and ate independently with a few broken teeth.-His/Her weight was stable with health shakes three times daily.-The resident's weight fluctuated between 138 and147 pounds. Current weight was 140 pounds.-The resident consistently refused nutritional supplements.-The resident had an order for Remeron (an appetite stimulant) which favors (his/her) appetite.-There was an undated addendum to discontinue the nutritional supplement due to resident refusal. Review of the resident's Care Plan showed the most recent update was 8/14/24. The care plan showed the resident was at risk for infection and gastrointestinal disturbance due to improper food storage, keeping perishable items past the expiration date, storing food and dishes from the dietary department in his/her room. It showed the resident refused dietary supplements as recommended by the Registered Dietician (protein snacks and liquid nutritional supplements). The care plan showed the resident was at risk of overall health decline due to alcohol abuse and intoxication. Interventions showed staff would:-Check the resident's refrigerator weekly.-Check the resident's room daily for food from prior meals and throw them away.-Educate the resident not to keep food from the previous meals and explained that improper storage of meals could cause the resident to become sick.-Dietary staff would encourage the resident to take supplements and offer flavors of choice.-Staff will complete monthly weights. Review of the resident's Registered Dietician Note dated 1/25/25, showed:-The resident had weight loss over the past year.-The resident continued to abuse alcohol and refused the nutritional (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supplement.-The physician recently increased Remeron to 15 milligrams (mg).-There were no additional notes regarding the resident's nutritional status or interventions that may assist with the resident's weight loss (re-evaluating preferences, evaluating the resident's swallowing/chewing status). -There was no documentation showing the resident was educated on his/her current health status and consequences of continued weight loss. Review of the resident's Weight Record showed the resident was receiving weekly weights. The resident's monthly weights showed-On 2/26/25 he/she weighed 128.5 pounds.-On 3/19/25 he/she weighed 130 pounds.-On 4/30/25 he/she weighed 129 pounds. Review of the resident's quarterly Dietary Notes dated 5/21/25, showed:-The resident continued on a regular diet with no changes.-Dietary staff continued to provide the resident paperware related to the resident holding dishes in his/her room.-Dietary staff would continue to monitor for any changes.-The quarterly note did not show the resident's weight status over the last quarter, any weight loss concerns, eating habits and preferences, behaviors, whether he/she was on a nutritional supplement or had any nutritional interventions during the quarter. -There were no additional dietary notes documented in the resident's medical record. Review of the resident's Physician's Notes dated 5/26/25, showed the physician completed a physical exam and reviewed the resident's medicines, labs and review of medical symptoms. The physician documented the resident had been doing well with no recent mental status changes and no medical concerns. There were no medication changes. The physician did not address the resident's nutritional status, weight loss/changes or nutritional interventions. Review of the resident's Weight Record showed on 5/28/25 he/she weighed 125.5 pounds (a weight loss of 3.5 pounds since the prior month). Review of the resident's Physician's Order Sheet (POS) dated June 2025 showed physician's orders for:-A regular diet with a protein snack between meals twice daily.-Remeron 15 mg at bedtime for depression and appetite (ordered 12/6/24). Review of the resident's Nursing Notes dated 6/18/25, showed:-Nursing staff documented the resident had weight loss of five pounds in two weeks. -Nursing staff notified the resident's physician. -The resident stated that he/she did not have an appetite. -There was no documentation showing nursing staff made a referral to the Registered Dietician for follow up. Review of the resident's Physician's Notes dated 6/24/25, showed:-The physician completed a physical exam and reviewed the resident's medicines, labs and review of medical symptoms. -The physician documented the resident's presenting problem was anorexia (an eating disorder that causes people to weigh less than is considered healthy for their age and height, usually by excessive weight loss). -Facility staff reported the resident had not been eating regularly over the last few weeks and the resident had lost five pounds in one week due to the food served in the facility. -The physician documented he/she discussed this with the resident and nursing staff at length and ordered labs. -Recommendations included weekly weights, push fluids and the resident would likely need supplements. -He/She documented the resident was at high risk for decline with ongoing weight loss. Review of the resident's Nursing Notes dated 6/24/25, showed:-The Nurse Practitioner visited the resident regarding weight loss and gave orders for lab work.-A follow up appointment with the gastrointestinal clinic was set for 6/30/25 and the resident was informed of the appointment scheduled for 6/30/25. -There was no documentation showing the resident went to the appointment or that staff obtained the result of the consultation (there were no further notes until 7/8/25). Review of the resident's Weight Record showed:-On 6/25/25 he/she weighed 120 pounds (a loss of 5 pounds since the prior month). -The weight record showed the resident continued to lose weight. Review of the resident's Medical Record showed:-There was no documentation showing the facility staff evaluated the resident for a chewing or swallowing problem. -Re-evaluated his/her diet for appropriateness and texture (mechanical soft (ground meat) or puree (like pudding)), food preferences (based on the resident's likes/dislikes or type of food items he/she would eat), re-established nutritional supplements that the resident may accept, or re-evaluated current nutritional interventions for continued appropriateness to try to encourage the resident to eat. -There was no documentation showing the Registered Dietician re-evaluated the resident's nutritional status, diet order or nutritional interventions to try to address (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's continued weight loss. Review of the resident's Physician's Notes dated 7/8/25, showed:-The physician completed a physical exam and reviewed the resident's medicines, labs and review of medical symptoms. -The physician documented the resident was seen due to abnormal lab results. -The resident's labs showed several results were low (potassium, sodium, calcium, albumin). -The resident was noted to have difficulty eating and was still not eating well. -The physician started calcium supplements and added Prosource (provide the nutrients necessary for the dietary management of protein-energy malnutrition and protein deficiency) 30 milliliters (ml) twice daily. -Encourage hydration and nutrition. -The resident was at high risk if he/she continued to not be able to optimize nutrition. Review of the resident's POS dated July 2025 showed a physician's order for Prosource 30 ml daily for protein (ordered 7/8/25). Review of the resident's Nursing Notes showed:-7/8/25 showed the resident needed assistance with daily cares to include bathing and dressing. -7/21/25 showed nursing staff documented the physician ordered the resident to be sent to the hospital for a non-emergency evaluation (reason undocumented). The resident returned to the facility with a physician's order for Amoxicillin (an antibiotic) daily every 12 hours for 7 days. -7/22/25 the nurse documented the resident had an abscess (a swollen area within body tissue, containing an accumulation of pus) to his/her left side of his/her neck that was cool to the touch. The resident had no complaints of neck pain. Review of the resident's Physician's Notes dated 7/22/25, showed:-The physician completed a physical exam and reviewed the resident's medicines, labs and review of medical symptoms. -The physician documented the resident was seen due to a follow up to a hospital visit. -The physician documented the resident was sent to the hospital due to a mass to the left side of his/her neck. -The area was golf ball sized and was slightly painful to the touch. -The resident was diagnosed with left sided parotid gland (salivary gland that is located just beneath and in front of each ear and produce saliva) infection and was prescribed an antibiotic for seven days. -The physician documented the resident may need hospitalization if the area was not improved and ordered staff to continue to monitor the resident's weights and to encourage hydration and nutrition. Review of the resident's Care Plan showed there were no changes in the resident's nutritional care plan that showed there were concerns with the resident's weight or nutrition, changes in nutritional interventions since the resident had continued weight loss, that the facility re-evaluated the resident's diet, diet texture or food preferences to try to manage the resident's weight loss. Review of the resident's Weigh Record showed:-On 7/30/25 he/she weighed 117 pounds (a loss of 3 pounds since the prior month). -The Weight Record showed a loss of 8.56 percent in 6 months; a loss of 6.4 percent in 3 months and a loss of 2.50 percent in 30 days. -The resident had gradual weight loss that was not yet significant weight loss. Review of the resident's POS dated July 2025 showed physician's orders for:-A Regular diet with a protein snack between meals twice daily.-Remeron 15 mg at bedtime for depression and appetite (ordered 12/6/24).-Prosource 30 ml twice daily for protein (ordered 7/8/25). Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated, 7/10/25, showed the resident:-Was alert and oriented with no cognitive incapacity.-Had no behavioral symptoms.-Was independent or needed set up assistance only with bathing, dressing hygiene, eating and toileting.-Had lower extremity impairment and used a wheelchair for mobility. -Had no chewing or swallowing difficulty, had no significant weight loss and did not receive a mechanically altered diet. Review of the resident's Medication Administration Record (MAR) dated July 2025, showed physician's orders for Remeron 15 mg at bedtime for depression and appetite (12/4/24) and Prosource 30 ml twice daily for protein (7/8/25). The MAR showed:-The resident was administered Remeron 15 mg daily as ordered.-Prosource was not administered according to physician's orders. --Prosource was not administered at the morning dose on 7/8/25, 7/18/25, 7/19/25, 7/20/25, and from 7/21/25 to 7/31/25. ---Documentation showed the resident refused most morning doses. (on 7/20/25 and 7/27/25 there was no documentation).--The resident was administered the Prosource evening dose every day except on 7/8/25, 7/18/25, 7/19/25, 7/26/25, 7/27/25 and 7/28/25. Review (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the resident's daily Meal Consumption Record dated July 2025, showed daily areas to document the percent of food the resident ate at each meal and how much fluid the resident drank at each meal. The documentation showed:-The resident's meal percentages were not consistently documented for every meal (many of the meals were left blank)-For dates that were not left blank, showed the resident ate zero percent of meals.-During the week of 7/26/25 to 7/31/25 showed the resident only ate breakfast on 7/29/25 (he/she ate 100 percent); only ate lunch on 7/28/25 (he/she ate 10 percent) and only ate dinner on 7/26/25 and 7/28/25 (he/she ate 100 percent on these dates). Observation and interview on 7/28/25 at 10:37 A.M., showed the resident was sitting in his/her wheelchair in the hallway. The resident had a small round mass on the left side of his/her neck. He/she was alert and oriented and said:-He/She was doing well here, he/she tried to do all of his/her own care and ate independently.-The food could be better but he/she understood the staff had to cook to meet everyone's needs so he/she always put extra condiments on his/her food.-He/She preferred to eat in his/her room. Observation and interview on 7/29/25 at 10:01 A.M., showed the resident was in his/her wheelchair in his/her room. He/she was dressed for the weather and had a small round mass on the left side of his/her neck. There were two plates that were covered with a napkin that were sitting on top of his/her dresser under his/her television. There were several packaged snacks surrounding the plates such as donuts, snack cakes, chips and granola type snacks. On the first plate was partially eaten chicken leg with uneaten fries (less than 15 percent eaten). On the second plate was two pieces of chicken with mashed potatoes and green beans that looked untouched (zero percent eaten). The plates were both cold. On the dresser next to the resident's bed were more donuts and bags of chips, cup of noodles (unopened) and unopened cans of Vienna sausage and soup. The resident was alert and oriented and said:-He/She was not eating well and didn't have an appetite.-He/She had snacks and food items in his room he could eat when he/she wanted to.-He/She did not always like what was served at meals in the facility but those foods he/she would eat he/she took to his/her room.-He/She was not concerned with his/her weight.-He/She had some pain and received pain medications every 6 hours as needed.-He/She spoke with the physician about his/her pain last week and the physician said he/she would look at trying a different medication to better manage it. During an interview on 7/30/25 at 2:30 P.M., Certified Nursing Assistant (CNA) B said:-The resident was able to feed himself/herself independently and did eat in the dining room, but he/she had been taking his/her food to his/her room and then he/she still would not eat it.-He/She had seen the resident just eat bites of food before taking it to his/her room.-He/She was aware that the resident had weight loss and had recently gone to the hospital but he/she came right back to the facility.-When they go in to check on the resident, and see that he/she had not eaten, they tried to remove the plate and the resident would become angry and not allow them to take it, so the plate would remain in his/her room until he/she left the room and they could go in and remove it.-He/She had also seen where there may be two plates in the resident's room that the resident had not eaten, and the resident could not eat it because the food had either been there overnight or it was cold.-Usually if the resident was in pain or had difficulty eating (chewing/swallowing), he/she would let the nurse know or ask for pain medication.-To his/her knowledge the resident did not have any difficulty chewing or swallowing.-The nursing staff was supposed to document the resident's meal intake on the meal intake records for each meal daily.-They had not been documenting the resident's intake like they should but he/she knew that the resident had not been eating many meals in the facility.-The resident did not receive a nutritional supplement at meals-he/she refused them in the past. During an interview on 7/30/25 at 2:37 P.M., Licensed Practical Nurse (LPN) C said:-The resident had always been non-compliant with a variety of cares to include medications, smoking, following care instructions and he/she had recently been refusing to eat.-The resident had a mass that developed on his/her neck that they sent him/her to the hospital for and the hospital staff wanted to admit the resident but the resident refused.-The resident had an infection and the hospital prescribed an antibiotic that the resident had been refusing to take.-The (continued on next page)

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	265769	A. Building B. Wing	08/04/2025

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Summit, The	3660 Summit Kansas City, MO 64111

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had been refusing to eat over the past couple months and had been losing weight.-The resident had been prescribed liquid nutritional supplements but the resident refused to drink it so it was discontinued.-The resident currently had orders for Prosource but he/she had been refusing it also.-The resident would go to the dining room and get his/her meal, take it to his/her room and then would not eat it.-The resident did not have any difficulty with chewing or swallowing.-They had not gotten a swallow study completed on the resident to rule out swallowing difficulty.-The resident went out in the community and had come back smelling of alcohol then he/she did not want to eat or have an appetite.-Drinking alcohol seemed to be more important to the resident and he/she just chooses not to eat.-They had care planned weight loss interventions for the resident.-The Registered Dietician had come to see the resident and reviewed his/her nutritional status and weight loss but was not sure how recent this was.-To his/her knowledge they had not spoken to the resident about Hospice/palliative care (if the resident continues to decline food). During an interview on 8/1/25 at 9:13 A.M., the Dietary Manager said:-The resident had a history of coming to the dining room to get meals, but he/she would then take his/her plate to his/her room.-The resident did not eat the meal and when dietary staff went in his/her room to get the plate, they saw the resident had not eaten or had eaten very little and they threw away full plates of food.-The resident went out in the community and drank alcohol so he/she was not wanting to eat when he/she came back to the facility.-He/She did not know if or whether the resident was eating in the community.-The resident continued to be on a regular diet and did not have a chewing or swallowing problem.-They tried to give the resident foods he/she liked and food preferences. He/she would eat anything with gravy so they made extra gravy and put that on his/her food to try to entice him/her to eat.-The resident was prescribed a nutritional supplement, but he/she refused to drink it so they discontinued it.-The resident's weight fluctuated and they have done what they could to try to get him/her to eat since he/she ate independently.-The Registered Dietician had assessed the resident and tried to implement interventions to address the resident's nutritional status. During an interview on 8/1/25 at 11:10 A.M., Certified Medication Technician (CMT) A said:-The resident had weight loss and had been refusing medications lately because he/she was having trouble swallowing.-They sent him/her to the emergency room about a week or two ago and the hospital wanted to keep him/her, but the resident refused to stay and came back to the facility.-He/She looked at the resident's MAR dated July 2025 and said he/she started refusing medications around 7/18/25, and had only taken them on a few occasions since then.-The resident did have physician's orders for Remeron for appetite stimulant and Prosource due to his/her weight loss. During an interview on 8/4/25 at 9:10 A.M., LPN A said:-The resident had not been eating meals and had been having difficulty swallowing.-The resident was sent to the hospital and they wanted to keep him/her due to the mass that developed on his/her neck, but the resident refused to be admitted .-Since the resident had returned to the facility he/she had not been eating and had been taking his/her plate from the dining room to his/her room and then it sat there until staff eventually threw it away.-The resident would eat soups and biscuits with gravy but he/she did not receive these items routinely and he/she did not know why.-They should provide soft foods to the resident and food items they know he/she would eat, since they were easier to swallow.-The resident's diet was still regular and had not been adjusted to accommodate his/her ability to swallow.-The resident also used to receive liquid nutritional supplements but they were discontinued due to him/her refusing.-He/She did not know if it was the flavor of the supplement that he/she did not like or if they had tried a variety of flavors to see if he/she would drink any of the flavors.-It really did not matter if the resident liked to drink alcohol, they should provide foods that he/she could and would eat and encourage him/her to eat as much as possible until they could resolve his/her swallowing issue.-When he/she worked with the resident he/she tried to get him/her something that he/she would eat, not just what was being served, because the resident had told them that he/she did not like all of the food items/meals being served there.-The resident would eat any foods with gravy so they should give him/her gravy with all of his/her foods served and serve foods that he/she could eat (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or that are soft and easier to swallow.-The Registered Dietician had been in the facility, but there had been no new recommendations for the resident.-The resident was going to the hospital today for follow up because he/she was declining. -Nursing staff now have to assist him/her more with dressing and bathing and personal cares due to weakness.-He/She had spoken to the resident about the mass on his/her neck, the possibility that his/her health condition may be more serious and that he/she probably should have remained in the hospital so they could have completed further testing. During an interview on 8/4/25 at 12:36 P.M. the Director of Nursing (DON) said:-The Registered Dietician completed an annual nutritional assessment and then quarterly notes on the residents unless there was a nutritional concern.-The Registered Dietician came to the facility monthly, but he/she also had access to the resident's electronic medical record and could see the resident weights and changes at any time.-The Dietary Manager and nursing staff also informed the Registered Dietician of changes in resident nutritional status/weight loss so if the Registered Dietician needed to visit someone more frequently he/she could.-When they know a resident was having weight loss they would notify the Registered Dietician and the physician so nutritional interventions could be implemented.-They reviewed weights weekly and reviewed interventions to determine if they were adequate or needed to be changed and then they implemented new interventions or maintained the current interventions if they were working.-When the resident initially stopped eating and they noticed he/she was losing weight, they started the resident on liquid nutritional supplement but the resident wouldn't drink it, so they discontinued it.-The resident was also prescribed an appetite stimulant that he/she received daily and started weekly weights.-They obtained labs on the resident, and they notified the physician when the resident's labs were abnormal.-The physician addressed the abnormal labs and they sent the resident to the hospital for further evaluation, but he/she refused to be admitted .-They initiated Prostat most recently to try to support the resident's nutritional status.-They tried to give the resident foods that he/she liked, but he/she did not know if the resident's preferences were re-evaluated and documented.-The resident was not having difficulty swallowing until the mass was noted on 7/21/25 when he/she was sent to the hospital.-They had not ever gotten a swallow study for the resident to rule out swallowing difficulty.-Nursing staff was supposed to document the resident's meal intake on the daily meal intake sheets for each meal and it should be accurate.-All of the interventions regarding the resident's nutritional status and weight loss should have been in his/her care plan.-They asked the resident this weekend if he/she wanted to try a mechanical soft diet and he/she declined.-The resident liked gravy and would eat gravy on most foods but they did not put gravy on all of his/her food to try to get him/her to eat more.-They have gotten a physician's order to crush his/her medications to make them easier to take and he/she may not continue to refuse them.-They have not discussed Hospice/palliative care with the resident.-The resident went to the hospital regarding the mass on his/her neck today for further evaluation.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure physician's orders were followed for monitoring and documenting one sampled resident's (Resident #1) dialysis access site (a surgically created pathway that allows blood to be removed from and returned to the body during hemodialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally) out of 24 sampled residents. The facility census was 56 residents.Review of the facility's undated Dialysis policy and procedure showed staff was to:-Palpate (to feel) the vascular access to feel for a thrill (vibration) that indicates arterial and venous blood flow and patency.-Auscultate (to listen) the vascular access with a stethoscope (a medical instrument for listening to the action of someone's heart, breathing or internal system) to detect a bruit (swishing sound) that indicates patency.-Check the patient's circulation by palpating the pulses further from the vascular access site and assessing for numbness, tingling, altered sensation, coldness, in the affected area.-Document assessment findings, any interventions, and patient responses, patient teaching and the patient's level of understanding. 1. Review of Resident #1's Face Sheet showed the resident was admitted on [DATE], with diagnoses including End Stage Renal Disease (ESRD a condition where the kidneys are damaged and cannot filter blood effectively), left leg fracture, depression, anxiety disorder, high cholesterol, low iron, and dependence on dialysis. Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 3/24/25, showed the resident:-Was alert and oriented with no cognitive incapacity.-Was independent or needed supervision with bathing, dressing hygiene, eating and toileting.-Had lower extremity impairment and used a wheelchair for mobility. -Received dialysis treatments. Review of the resident's Dialysis Notes and Communication dated March 2025 to July 2025, showed:-The communication was being completed with each visit. -Dialysis notes showed the resident's access site was checked at each dialysis treatment. Review of the resident's Physician's Order Sheet (POS) dated July 2025, showed physician's orders to:-Check the resident's left upper extremity access shunt (a surgically created connection between an artery and a vein, typically in the arm, to provide a reliable access point for dialysis) site for thrill and bruit every shift (ordered 10/4/23).-Assess the shunt area for blisters, check pulses distal to access for circulation, tingling, numbness, infection, warmth, tenderness and open sores daily (ordered 10/4/23).-Resident had dialysis Monday, Wednesday and Friday (location documented). Review of the resident's Treatment Administration Record (TAR) dated July 2025, showed physician's orders to check the resident's shunt for bruit and thrill every shift, assess the shunt area for blisters, check pulse distal to vascular access for circulation, tingling, numbness, signs of infection, redness warmth, tenderness, and open sores daily. Documentation on the TAR showed:-Assessment of the shunt area was completed daily except on 7/11/25, 7/20/25 and 7/30/25 (areas were left blank with no rationale as to why it was not completed).-Assess the shunt for thrill and bruit every shift was not completed at all on 7/11/25, and 7/29/25; was only completed twice daily on 7/3/25, 7/8/25, 7/9/25, 7/14/25, 7/20/25 and 7/28/25 (6 of 30 days) and was only completed as ordered on 7/5/25,7/6/25, 7/12/25, 7/13/25, 7/15/25, 7/16/25, 7/19/25, 7/26/25 and 7/27/25 (9 of 30 days). -For those dates and times the nurse did not assess the resident's shunt and check for thrill and bruit, there was no documented rationale showing why it was not completed as ordered. Observation and interview on 7/29/25 at 2:21 P.M., showed the resident was in his/her room, laying on his/her bed. The resident showed on his/her left upper arm was the shunt site and it was intact with no redness, swelling or open areas indicating any concern. The resident said:-He/She performed all of his/her own care and did not need much assistance from staff for bathing, dressing, toileting, eating or ambulating.-He/She went to dialysis three times weekly, on Monday, Wednesday and Friday, and he/she had no concerns with dialysis treatments or his/her dialysis shunt at this (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time.-The nursing staff did not check his/her dialysis shunt before he/she left to go to dialysis because he/she left before 5:00 A.M. to go to dialysis, but the nurse did assess and check his/her shunt after he/she returned from dialysis. During an interview on 7/30/25 at 1:48 A.M., Licensed Practical Nurse (LPN) C said:-They kept the resident's dialysis communication book at the nursing station.-The nurse documented the resident's vital signs and weight on the communication sheets and the dialysis center sent their communication back on dialysis days.-When the resident returned from dialysis, the nurse was supposed to check the thrill and bruit of the resident's access site and document it on the resident's TAR.-Upon looking at the TAR dated July 2025, he/she said they were to assess the shunt and check the thrill and bruit on every shift daily and document it on the TAR, and they were supposed to also assess the site for any redness, bleeding or bruising and document that information on the TAR also. -The TAR did not show that the nurses had been documenting their assessment and monitoring according to the physician's orders. During an interview on 8/4/25 at 12:36 P.M. the Director of Nursing (DON) said:-The physician's order should be complete and show where and how often the nursing staff was to monitor and care for the resident's dialysis access site.-He/She expected the nurses to follow physician's orders to check thrill and bruit daily on every shift and document their access of the resident's dialysis access site on the resident's TAR.-The resident used to have his/her access site checked three times daily when he/she first had the shunt placed, but now they probably only need to check it once daily and only check the thrill and bruit once daily.-They needed to follow the physician's orders as written until the order was changed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medication refrigerator temperatures were checked daily and documented on the facility temperature log sheet to maintain safe storage of temperature controlled refrigerated medication; and failed to ensure to medication refrigerators were cleaned as scheduled and free of spills. This deficient practice had the potential to affect all residents with medication stored in the medication refrigerators. The facility census was 56 residents.Review of the facility's Storage of Medications policy dated 2024 showed:-Medications are to be stored in a safe, secure, and orderly manner.-Drugs are to be stored at proper temperatures. -Temperature logs are to be completed daily by the 11:00 P.M. -7:00 A.M. night shift. 1. Observation on 7/31/25 at 9:59 A.M of the facility second floor medication room showed:-The current refrigerator temperature was 34 degrees.-The refrigerator side door and inside had a sticky purplish substance noted. -The temperature log for July 2025 had 10 missing temperatures out 30 opportunities.-The refrigerator had unopened diabetic insulin and house stock emergency kit of insulin. During an interview on 7/31/25 at 9:59 A.M., Certified Medication Technician (CMT) A said: -The night nursing staff were responsible for checking and documenting medication refrigerator temperatures nightly.-Night nursing staff was scheduled to clean the medication refrigerators as needed. During an interview on 8/4/25 at 9:59 A.M., Licensed Practical Nurse (LPN) A said: -Night shift nursing staff were responsible for cleaning the medication refrigerator as scheduled and check refrigerator temperatures nightly and document findings on the posted temperature log.During an interview on 8/4/25 at 12:35 P.M., the Director of Nursing (DON) said:-Night nursing staff were responsible for checking refrigerator temperatures and cleaning the medication refrigerator as needed.-Night nursing staff were responsible for documenting the medication refrigerator temperature nightly on the posted temperature log.-He/She was responsible for oversite to ensure the safe medication storage in the refrigerator and cleanness of the medication refrigerator.