STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265820	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Creek Post Acute	3980 South Jackson Drive Independence, MO 64057

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview and record review, the facility failed to notify one sampled resident's (Resident #1) physician of the resident's refusal of his/her dialysis medication and late administration of the resident's sliding scale insulin, out of seven sampled residents. The facility census was 99 residents. Review of the facility Change in a Resident Condition or Status policy dated 2001 showed: -The facility was to promptly notify the resident's attending physician of changes in the resident's medical/mental condition and/or status. -The licensed nurse would notify the resident's attending physician or physician on call when a resident refused treatment or medications at least two consecutive times. 1. Review of Resident #1's Physician's Orders Sheet (POS) dated April 2025 showed: -Diagnoses of end stage renal disease, dependence on renal dialysis, and diabetes. -Insulin Lispro (a fast-acting insulin that starts to work about 15 minutes after injection, has its most significant effect on lowering blood sugar levels in about 1 hour, and keeps working for 2 to 4 hours) Subcutaneous (under the skin) solution cartridge 100 units/milliliter (ml) inject per sliding scale (a method to determine how much insulin to give based on a person's current blood sugar) including for a blood sugar of 401 to 450 give 12 units after meals. -Sevelamer (medication used to control high blood levels of phosphorus in people who are on dialysis) 800 milligrams (mg), give two tablets with meals for dialysis. Observation and interview with the resident on 4/8/25 at 12:35 P.M. showed: -The resident had finished eating his/her lunch. -He/she said he/she was to take two large capsules with each meal, and no one had brought in that medication. During an interview on 4/8/25 at 2:07 P.M. Certified Medication Technician (CMT) A said: (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was very emotional that morning and had refused to take his/her Sevelamer with his/her breakfast. -He/she knew the resident would not take the Sevelamer at lunch because he/she had refused it at breakfast. -He/she did not offer the Sevelamer to the resident with the resident's lunch. -He/she marked that the resident had taken the Sevelamer at breakfast and at lunch. -He/she had not told the charge nurse that the resident had refused the Sevelamer at breakfast and had not told the charge nurse that he/she had not offered the Sevelamer to the resident with his/her lunch meal. -He/she knew the medication the resident was to take with meals was very important for him/her to take. -The resident was often emotional and usually did not take the Sevelamer for him/her and he/she would document that he/she had given the medication to the resident. -He/she knew he/she should tell the charge nurse if a resident refused a medication or if he/she did not give a resident a medication to a resident. During an interview on 4/8/25 at 2:55 P.M. Agency Registered Nurse (RN) A said: -He/she had not done the resident's lunch time blood glucose monitoring (the test system includes a handheld meter and test strips to measure how much glucose is in a small sample of blood) and had not administered any sliding scale insulin to the resident after his/her lunch meal. -He/she had not had time to talk to anyone about the resident's lunch time blood glucose monitoring and sliding scale insulin. -CMT A had not told him/her that the resident had refused his/her Sevelamer with breakfast or that he/she had not given the resident his/her Sevelamer with lunch. During an interview on 4/10/25 at 3:16 P.M. Nurse Unit Manager A said: -The resident's physician should have been notified when the resident refused or did not receive medications. -He/she did not see progress notes that the resident's physician had been notified regarding any refused or missed medications. -If a resident did not receive a medication, it was to be documented correctly on the resident's Medication Administration Record (MAR), there were codes for showing reasons a medication was not administered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's MAR showed his/her 4/8/25 after lunch sliding scale insulin was administered at 3:44 P.M.; there was no progress note that the resident's physician had been notified. During an interview on 4/10/25 at 3:50 P.M. the Director of Nursing (DON) said: -The CMT should have told the charge nurse, or the Unit Manager that the resident had refused medications. -Then the charge nurse or the Unit Manager should have notified the resident's physician the resident had refused or did not receive medications. -Agency RN A should have told the Unit Manager that he/she had missed administering the resident's after lunch sliding scale insulin. -Either Agency RN A or the Unit Manager should have notified the resident's physician that the resident's after lunch sliding scale insulin had not been done after his/her lunch and these were not done until later that afternoon that way the resident's physician could decide if he/she wanted to give any additional orders. MO00252435

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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 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. Based on observation, interview and record review, the facility failed to ensure one sampled resident's (Resident #1) refusal of medications, omission of and late administration of medications was correctly documented and communicated to facility management; and failed to revise the resident's care plan to address the resident's refusal of medications, out of seven sampled residents, and failed to have a policy to address sliding scale insulin. The facility census was 99 residents. Review of the facility Insulin Administration policy dated 2001 showed: -Rapid-acting insulin has an onset of 10-15 minutes, a peak of 30 minutes to one hour and a duration of 3-6 hours. -The policy did not address sliding scale insulin. Review of the facility Administering Medications policy dated 2001 showed: -Medications are administered in accordance with prescriber orders, including any required time frame. -Medication administration times are determined by resident need including enhancing optimal therapeutic effect of the medication. -Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 1. Review of Resident #1's Physician's Orders Sheet (POS) dated April 2025 showed: -Diagnoses of end stage renal disease, dependence on renal dialysis, and diabetes. -Insulin Lispro (a fast-acting insulin that starts to work about 15 minutes after injection, has its most significant effect on lowering blood sugar levels in about 1 hour, and keeps working for 2 to 4 hours) Subcutaneous (under the skin) solution cartridge 100 units/milliliter (ml) inject per sliding scale (a method to determine how much insulin to give based on a person's current blood sugar) including for a blood sugar of 401 to 450 give 12 units after meals. -Sevelamer (medication used to control high blood levels of phosphorus in people who are on dialysis) 800 milligrams (mg), give two tablets with meals for dialysis. Observation and interview with the resident on 4/8/25 at 12:35 P.M. showed: -The resident had finished eating his/her lunch. -He/she said he/she was to take two large capsules with each meal, and no one had brought in that medication. During an interview on 4/8/25 at 1:58 P.M. the resident said: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No one had checked his/her blood sugar, and no one had given him/her any insulin after his/her lunch meal and also had never given him/her the two capsules that he/she was to take with his/her lunch. -He/she had not been taking the large binder capsules because of an increase in the dose to three capsules with meals, that was too much to swallow, but the dose had recently been changed to two capsules and he/she had decided he/she would take it, but no one brought the medication to him/her at lunch. During an interview on 4/8/25 at 2:07 P.M. Certified Medication Technician (CMT) A said: -The resident was very emotional that morning and had refused to take his/her Sevelamer with his/her breakfast. -He/she knew the resident would not take the Sevelamer at lunch because he/she had refused it at breakfast. -He/she did not offer the Sevelamer to the resident with the resident's lunch. -He/she marked that the resident had taken the Sevelamer at breakfast and at lunch. -He/she had not told the charge nurse that the resident had refused the Sevelamer at breakfast. -He/she had not told the charge nurse that he/she had not offered the Sevelamer to the resident with his/her lunch meal. -He/she knew the medication the resident was to take with meals was very important for him/her to take. -The resident was often emotional and usually did not take the Sevelamer for him/her and he/she would document that he/she had given the medication to the resident. -He/she knew he/she should tell the charge nurse if a resident refused a medication or if he/she did not give a resident a medication to a resident. -He/she knew that he/she should not document that he/she gave a medication that had not been given. During an interview on 4/8/25 at 2:55 P.M. Agency Registered Nurse (RN) A said: -He/she had not done the resident's lunch time blood glucose monitoring (the test system includes a handheld meter and test strips to measure how much glucose is in a small sample of blood) and had not administered any sliding scale insulin to the resident after his/her lunch meal. -He/she had not had time to do the resident's blood glucose monitoring because of other resident care he/she had been doing. -He/she had not had time to talk to anyone about the resident's lunch time blood glucose monitoring and sliding scale insulin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CMT A had not told him/her that the resident had refused his/her Sevelamer with breakfast or that he/she had not given the resident his/her Sevelamer with lunch. During an interview on 4/8/25 at 3:05 P.M. Unit Nurse Manager A said: -He/she was not aware the resident had not had his/her Sevelamer with his/her breakfast and lunch. -CMT A should have told the charge nurse, or him/her that the resident refused his/her breakfast dose of Sevelamer. -Agency RN A had not told him/her that he/she had not done the resident's after lunch blood glucose monitoring and sliding scale insulin. -He/she had been available and could have helped RN A if he/she had notified him/her that he/she needed help. -The resident's blood glucose monitoring and sliding scale insulin should have been completed as soon as possible after he/she finished his/her lunch. -The resident's lunch was typically served by noon. During an interview on 4/10/25 at 2:25 P.M. the Care Plan Coordinator said: -He/she had not previously known that the resident sometimes refused his/her dialysis medications, and the residents care plan had not addressed refusal of medications. -The resident's care plan should have addressed the refusal of medications. During an interview on 4/10/25 at 3:16 P.M. Nurse Unit Manager A said: -If a resident did not receive a medication, it was to be documented correctly on the resident's Medication Administration Record (MAR), there were codes for showing reasons a medication was not administered. -CMT A had documented that the resident's Sevelamer had been given at breakfast and at lunch on 4/8/25. -CMT A should have correctly documented the resident did not take the medication and the reason. -Any refusal of his/her medications needed to have been communicated to him/her and the care plan coordinator so the resident's care plan would address his/her refusal of medications. -The resident's MAR showed his/her 4/8/25 after lunch sliding scale insulin was administered at 3:44 P.M. -The resident's noon meal sliding scale should have been given as close to him/her finishing his/her lunch meal as possible. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 3:50 P.M. the Director of Nursing (DON) said: -The CMT should have correctly documented the resident had not taken medications and the reason the resident did not take the medications. -The CMT should have told the charge nurse or the Unit Manager that the resident had refused medications. -The resident's after meal blood glucose monitoring and sliding scale insulin should have been completed as close to the end of his/her meal as possible. -The licensed nurse should have told the Unit Manager that he/she had missed administering the resident's after lunch blood glucose monitoring and sliding scale insulin. MO00252435

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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 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. Based on interview and record review, the facility failed to ensure communication between the facility and dialysis (a procedure that uses a machine to filter blood when the kidneys were no longer able to do so) provider to provide coordinated and consistent care for one sampled resident (Resident #1) with end stage renal disease (permanent kidney failure that requires a regular course of dialysis) out of seven sampled residents. The facility census was 99 residents. Review of the facility End-Stage Renal Disease policy dated 2021 showed: -The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. -There would be communication between the dialysis clinic and the facility. 1. Review of Resident #1's Physician's Orders Sheet (POS) dated April 2025 showed: -Diagnoses of end stage renal disease, dependence on renal dialysis. -Dialysis Monday, Tuesday, Wednesday and Friday. During an interview on 4/9/25 at 2:20 P.M. the resident's dialysis clinic nurse said: -For about two months there had been no written communication between the facility before or after the resident's dialysis. -The facility had not provided a form for the dialysis clinic to provide information to the facility regarding the resident's dialysis treatments. -The facility also had not called the facility to get a verbal report regarding the resident's dialysis treatments. During an interview on 4/9/25 at 2:50 P.M. Licensed Practical Nurse (LPN) B said: -There used to be a paper that came back with the resident from dialysis but for at least four weeks there had been not written communication returned from his/her dialysis appointments. -He/she had not called the resident's dialysis provider to get a report on the resident and to ask that the dialysis provider send a written report back to the facility with the resident. During an interview on 4/10/25 at 1:40 P.M. the resident said: -Facility nurses put a form in a bag on the back of his/her wheelchair with his/her weight and vital signs. -The dialysis nurses had stopped looking in his/her bag for the form and he/she had gotten tired of telling them to get the form out of his/her bag a couple of months ago. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The dialysis nurses hadn't given any information back to the facility after his/her dialysis treatments for a long time. -He/she had gotten tired of telling everyone about the form and stopped saying anything about the dialysis papers. During an interview on 4/10/25 at 3:50 P.M. the Director of Nursing (DON) said: -He/she expected licensed nurses to fill out and send a report sheet with the resident to his/her dialysis appointments. -He/she expected licensed nurses to print a sheet for the dialysis provider to use an provide a written report back to the facility following dialysis. MO00252435

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure infection control measures when applying a dressing over one sampled resident's (Resident #1's) central venous catheter (CVC - a tube inserted into a large vein, often in chest, or groin, and used for various purposes, including hemodialysis - dialysis a procedure that uses a machine to filter blood when the kidneys were no longer able to do so), out of seven sampled residents. The facility census was 99 residents. Review of the facility Central Venous Catheter Care and Dressing Changes policy dated 2001 showed: -The purpose of the procedure was to prevent associated complications including catheter-related infections associated with contaminated (exposed to germs, bacteria, or other foreign particles), loosened, soiled (dirty, regardless of the source of the dirt), or wet dressings. -Perform site care and dressing change immediately if the integrity of the dressing is compromised- damp loosened or visibly soiled. -Open sterile dressing kit. -Apply mask. -Apply sterile gloves. -Clean catheter insertion site with approved antiseptic solution. -Apply sterile dressing. Review of the facility Enhanced Barrier Precautions (EBPs - extended use of infection control measures that extends use personal protective equipment - PPE, like gowns and gloves) policy dated 2001 showed: -EBPs are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDRO) to residents. -EBPs employ targeted gown and glove use in addition to standard precautions (basic infection prevention practices used in healthcare settings for all patients, regardless of their suspected or confirmed infection status) during high contact resident care activity, including central line care. Review of the Centers for Medicare & Medicaid Services (CMS), Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, QSO-24-08-NH, posting date - effective date 4/1/24 showed: -CMS issued new guidance for long term care (LTC) facilities on the use of (EBP) to align with nationally accepted standards. -EBP recommendations now include use of EBP for residents with indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-For residents for whom EBP are indicated, EBP is employed when performing central line care. 1. Review of Resident #1's care plan dated 2/4/25 showed: -He/she required hemodialysis related to end stage renal failure and had an implanted port to his/her right chest. -His/her dialysis center was to provide dialysis catheter access site care. -May change the dressing if it became soiled or fell off. Review of the resident's Physician's Orders Sheet (POS) dated April 2025 showed: -Diagnoses of end stage renal disease and dependence on renal dialysis. -Change central line dressing every seven days and as needed for infection prevention and accidental dressing removal. Observation on 4/8/25 at 2:05 P.M. showed: -Unit Nursing Manager A entered the resident's room without first putting on a gown or mask, put a prepackaged dressing on a surface without first putting a barrier (a disposable cover placed on frequently touched surfaces to prevent contamination and reduce the need for frequent cleaning and disinfection), washed his/her hands and put the gloves. -He/she then picked up the packaged dressing, opened the dressing and without first cleansing the resident's dialysis access site on his/her right chest applied an adhesive dressing over the resident's dialysis site. Observation on 4/9/25 of the contents of the facility Central Line Dressing Kit showed the kit included: -Two masks. -Gloves. -Alcohol wipe. -Dressing. During an interview on 4/9/25 Nurse Manager B said: -The Central Line Dressing Kits had two masks. -One of the masks was for the nurse and one was for the resident to use during the dressing change. During an interview on 4/10/25 at 2:10 P.M. Unit Nurse Manager A said: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she should have cleansed the resident's central line site before applying the dressing. -He/she should have worn a mask and gown. -He/she should have used a barrier for the resident's dressing before placing it on a surface. -He/she could have reached out to see if there was a central line dressing kit on the other nursing unit. During an interview on 4/10/25 at 3:50 P.M. the Director of Nursing (DON) said: -He/she expected licensed nurses to follow EBP, when having direct contact with dialysis residents. -When applying dressings to central lines he/she expected the licensed nurses to wear the appropriate PPE that included a mask and gown and to provide a mask for the resident. -He/she expected all residents with central lines to have their own Central Line Dressing Kit available. -If a resident did not have a Central Line Dressing Kit, he/she expected the licensed nurse to reach out to other nurses to see if a kit was available. -A barrier should be used for any supplies used for dressing changes. -The resident's central line insertion site should have been cleansed with an alcohol wipe prior to application of the new dressing. MO00252435