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	05/07/2024

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview, and record review, the facility failed to maintain the commode risers (assistive devices to improve the accessibility of toilets to older people or those with disabilities. They can aid in transfer from wheelchairs and may help prevent falls) in resident rooms [ROOM NUMBERS] in an easily cleanable condition. The facility also failed to maintain three mechanical lifts on the 300 Hall and three mechanical lifts on the 400 Hall in sound condition. This practice potentially affected 12 residents, who resided on the 300 and the 400 Halls, who depended on mechanical lifts for transfers and two residents who used commode risers. The facility census was 105 residents. 1. Observation with the Maintenance Director on 4/30/24, showed: -At 10:17 A.M., there was an area on the commode riser in resident room [ROOM NUMBER] that was not easily cleanable. -At 11:52 A.M., there was a crack in the commode riser in resident room [ROOM NUMBER]. During an interview on 5/10/24 at 12:59 P.M., the Maintenance Director said that he/she checked the commode risers every month but he/she has not documented the checks. The Certified Nursing Assistants (CNAs) also should be checking as well. 2. Review of a list provided by the Director of Nursing (DON) and reviewed on 5/3/24, showed there were 10 residents who resided on the 400 Hall who used mechanical lifts and six residents who resided on the 300 Hall who used mechanical lifts. Observations on 5/3/24 at 10:55 A.M., showed the mast (the metal part of the mechanical lift which attached the base of the lift to the boom (the part of the lift with a cradle to lift a dependent resident), of the mechanical lift on 400 Hall, was very loose at the area where the mast was attached to the base. During an interview on 5/3/24 at 10:59 A.M., CNA A said he/she had not noticed the lift on the 400 Hall was loose on that day. During an interview on 5/3/24 at 11:02 A.M., Restorative Aide (RA) A said he/she had not noticed the lifts on 400 Hall was loose earlier that day. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/3/24 at 11:05 A.M., CNA B said he/she had not noticed the mechanical lift being loose on the morning of 5/3/24. Observations on 5/3/24 at 11:09 A.M., showed the lift outside resident room [ROOM NUMBER] was loose. During an interview on 5/3/24 at 11:12 A.M., CNA C said he/she used the lifts outside resident room [ROOM NUMBER] but had not noticed the mast of that lift was loose. During an interview on 5/3/24 at 11:14 A.M., Licensed Practical Nurse (LPN) B said; -He/She used the mechanical lift outside resident room [ROOM NUMBER], but he/she did not notice that the mast was loose. -He/She expected facility staff to place issues pertaining to the lifts in the work order book. -Facility staff should place a sign on the lift which stated DO NOT USE and place the lift in the shower room. During an interview on 5/3/24 at 1:56 P.M., the DON said the following about the lifts: -If the screws on the lifts were loose, the lift may be a little wiggly. -Facility staff should notify the Maintenance Director any mechanical lifts that may not be in good repair. -He/She expected facility staff to place a sign on the lift to let other staff know that the lift should not be used. -He/She expected facility staff to place the lift in the service hall so that other staff would not use it.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on interview and record review, the facility failed to ensure a resident with a major mental illness diagnosis had a required DA-124C/Level I Preadmission Screening and Resident Review (PASARR - used to evaluate the presence of psychiatric conditions to determine if a PASARR Level II screen is required) in a timely manner for care planning purposes for one sampled resident (Resident #65) out of 21 sampled residents. The facility census was 105 residents. Review of the facility's PASARR policy, revised 11/2016 showed: -The DA-124C (PASARR Level I) must be completed on all potential residents prior to admission to screen individuals for mental illness (MI) and intellectual/developmental disability (ID/DD) or related conditions regardless of the resident's method of payment or known diagnoses. It must be determined if the individual requires the level of services provided by the facility or if they need specialized treatment for MI or ID/DD diagnosis. -For residents appropriate for a PASARR Level II review, the facility will incorporate the recommendations from the PASARR Level II determination and evaluation report into the resident's assessment, care planning, and transitions of care. -The facility shall refer any resident for Level II review upon significant change in status or condition such as a possible mental disorder or intellectual disability or related condition. -A copy of the completed screening is to be placed in the resident's medical record. 1. Review of Resident #65's Admission Record showed he/she was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with a diagnosis of: -Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event. Symptoms may include flashbacks, nightmares, and severe anxiety). -Depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). -Adjustment disorder with anxiety (strong emotional or behavioral reaction to stress or trauma). -Insomnia (difficulty falling or staying asleep or getting good quality sleep). Review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 2/5/24 showed the resident was moderately cognitively impaired and was diagnosed with PTSD. Review of the resident's Psychiatric Conditions care plan, initiated 2/8/24 showed the resident had a history of: -PTSD. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Depression. -Adjustment disorder with anxiety. -Insomnia. Review of the resident's PASARR Level I, dated 5/1/24 showed: -The resident had a diagnosis of PTSD. -Other mental disorders included depression, adjustment disorder with anxiety, and insomnia. During an interview on 5/6/24 at 11:48 A.M. Social Worker A said: -He/She was responsible for ensuring the DA-124C was completed immediately upon the resident's admission if they do not already have one. -The resident was private pay status. He/She knew the PASARR Level I was required for Medicaid residents, but did not realize they were required for private pay residents as well until 5/1/24. -He/She submitted the resident's DA-124C on 5/1/24 when he/she learned it was required of all residents, regardless of method of payment. During an interview on 5/6/24 at 12:44 P.M. the Director of Nursing (DON) said: -The facility social workers were responsible for ensuring the DA-124C was completed prior to or upon admission. -The Level I PASARR was required of all residents regardless of how they pay. -Any resident expected to stay past 30 days should have a Level I PASARR.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to observe the resident while he/she took his/her medications, left the medications on the resident's bedside table for one sampled resident (Resident #88), and to assess the resident for safety of self-administering medications for three sampled residents (Resident #88, #6, #71) out of 21 sampled residents. The facility census was 105 residents. Review of the facility's policy titled Self-Administration of Medications dated 1/1/19 showed: -An assessment should be conducted by a member of the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out the responsibility of self-administration of medications. -A skills assessment should be conducted quarterly or if needed when there was a change in condition. Review of the facility's policy titled Bedside Medication Storage dated 1/1/19 showed there should be a written order for the bedside storage of medication. 1. Review of Resident #88's admission record (printed on 5/2/24) showed: -The resident had been a resident at the facility for about one and a half years. -Some of the resident's diagnoses included depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life), bipolar disorder (a disorder characterized by extreme mood swings from depression to mania), hemiplegia (paralysis of one side of the body) affecting his/her dominant side, diabetes (a deficiency or complete lack of insulin (a hormone that lowers the level of glucose (a type of sugar) in the blood) secretion in the pancreas or resistance to insulin) with use of insulin, and high blood pressure. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff for care planning) dated 2/5/24 showed the following staff assessment of the resident: -Taking high risk medications including insulin, an antipsychotic (to stabilize episodes of mania in people with bipolar disorder) medication, an antidepressant, a diuretic (a medication used to treat heart-related conditions by helping the body get rid of unneeded water and salt through increased urination which helps lower blood pressure and helps make it easier for the heart to pump), an antiplatelet (a group of medicines that stop blood cells (called platelets) from sticking together and forming a blood clot) medication, and a hyperglycemic (medication to treat high sugar (glucose) in your blood) medication. -Cognitively intact. Review of the resident's care plan dated as revised on 2/19/24 showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had cognitive deficits such as forgetfulness and short-term memory deficits. -The resident required minimum to moderate assistance with daily decision making. -Some of the resident's diagnoses included bipolar disorder and depression. -There was nothing in the care plan about self-administration of medications or keeping any medications at bedside. Observation on 4/29/24 at 10:59 A.M. showed the resident was lying in bed and a medication cup with more than four pills was on the resident's overbed tray. During an interview on 4/29/24 at 10:59 A.M., the resident said: -He/She was asleep when staff brought his/her medication, so the staff left the cup of pills on his/her overbed tray. -The staff leave his/her pills in a cup for him/her all the time. Review of the resident's Medication Administration Record (MAR) dated April 2024 showed: -Some of the resident's physician's orders included medications for depression, high blood pressure, diabetes, and bipolar disorder. -A physician's orders for refresh tears solution for dry eyes. Review of the resident's Physician's Order Sheet (POS) dated May 2024 showed no order for self-administration of medications. Review of the resident's medical records showed no assessment or physician's order for self-administration or bedside storage of medication. Observation on 5/2/24 at 5:13 A.M. and on 5/3/24 at 10:14 A.M. showed there was an empty medication cup on the resident's overbed tray. During an interview on 5/3/24 at 10:23 A.M., Certified Nursing Assistant (CNA) A said: -He/She had not seen medications at the resident's bedside. -The nursing staff should not leave medications at the resident's bedside. During an interview on 5/3/24 at 1:43 P.M., Registered Nurse (RN) B said: -He/She had not seen medications sitting out in the resident's room. -They should not have left medications in the resident's room. During an interview on 5/3/24 at 3:14 P.M., Certified Medication Technician (CMT) B said: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident could only have his/her eye drops at bedside. -The resident had not asked him/her to leave his/her medications at bedside. Observation on 5/6/24 at 9:19 A.M. showed: -The resident was lying in bed. -Eye drops and an empty medication cup were on the resident's overbed tray. During an interview on 5/6/24 at 12:43 P.M., the Director of Nursing (DON) said: -The interdisciplinary team should first talk about whether the resident was suitable for leaving medications at the bedside and self-administering them. -If they determined the resident might be capable of administering his/her own medications, they would have to do an assessment. -If it was determined through the assessment that the resident could administer his/her own medication, they would need to get a physician's order. -The resident had not been assessed for self-administration of medications. 19016 2. Review of Resident #6's Admission Record showed the resident was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that include 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). Review of the resident's Admission MDS dated [DATE] showed the resident: -Had impaired vision and couldn't see regular newsprint. -Was severely cognitively impaired. Review of the resident's Order Review Report showed an order, dated 4/2/24 for May keep OTC medications at bedside. Review of the resident's medical record showed no self-administration of medication assessment had been completed. Review of the resident's Comprehensive Care Plan on 5/1/24 showed no self-administration of OTC medications care plan had been added and no other individual care plan mentioned self-administration of OTC medications. During an interview on 5/03/24 at 2:30 P.M., CNA C said: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident required total care from staff and didn't do anything for himself/herself at this time. -The resident had dementia and wouldn't be able to self-administer medications of any kind. During an interview on 5/6/24 at 9:48 A.M. Licensed Practical Nurse (LPN) C said: -Self-administration of OTC medications would not be appropriate for the resident because he/she was confused and wouldn't even be considered a candidate for that. -The resident would have to have the capacity to know what medication he/she was taking, know the appropriate amount to use and how to use or take the medication, and when it would be appropriate to take it. The resident was not capable of knowing that. -The resident could always get medication as-needed from the nurse. 3. Review of Resident #71's Admission Record showed he/she was readmitted to the facility on [DATE] with the following diagnoses: -Dementia. -Wandering. Review of the resident's quarterly MDS, dated [DATE] showed: -The resident was visually impaired and couldn't see regular newsprint. -The resident was severely cognitively impaired. Review of the resident's Order Review Report showed an order, dated 4/1/24 for May keep OTC medications at bedside. Review of the resident's medical record showed no self-administration of medication assessment had been completed. Review of the resident's Comprehensive Care Plan on 5/1/24 showed no self-administration of OTC medications care plan had been added and no other individual care plan mentioned self-administration of OTC medications. During an interview on 5/3/24 at 2:28 P.M. CNA C said the resident couldn't safely self-administer OTC medications because he/she had dementia and was confused. 4. During an interview on 5/6/24 at 9:45 A.M. LPN C said: -There was nobody at the facility who self-administered OTC medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility would need to do an assessment to make sure the resident could self-administer safely. The DON would be involved in the assessment process and the resident would need to have a physician order for it. Residents would be evaluated for each medication they were able to safely self-administer and only those specific medications would be indicated on the resident's orders for self-administration. -There was a checkbox on the electronic medical record orders for May have OTC meds at bedside. He/She thought that had been clicked by mistake for Residents #6 and #71. -Neither resident was appropriate for self-administration of OTC medications, and both residents were incapable of using OTC medications safely and as indicated. During an interview on 5/6/24 at 12:44 P.M. the DON said: -Prior to self-administering any medication the resident would need to be assessed for his/her ability to do so safely, and the specific medication they could self-administer would be identified on the orders. -On the electronic medical system there was a box for resident orders where nurses could click all for all generic orders. May keep OTC medication at bedside was one of those orders. After clicking all nurses would need to re-click on the orders they want to get rid of. -He/She thought the order was clicked by mistake for Residents #6 and #71. That was not an appropriate order for either of the residents due to their cognition. Neither resident could safely self-administer any OTC medication. -Managers were responsible for auditing the residents' orders and ensuring accuracy.

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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** 22727 Based on observation, interview and record review, the facility failed to provide an ongoing activity program based on a comprehensive assessment and care plan of each resident's interests, hobbies, and abilities for two sampled residents (Residents #7 and #44) out of 21 sampled residents. The facility census was 105 residents. When a policy for Activities was requested, the facility provided a training manual titled Missouri Health Care Association Activity Director Training Binder dated 3/8/17. There was no facility policy specific to activities included in the manual. The manual did include the State Operations Manual (SOM) Activity Regulation and guidance for this regulation. 1. Review of Resident #7's undated admission record that was printed on 5/2/24 showed: -The resident was receiving hospice care (end of life care). -Some of the resident's diagnoses included psychosis (a mental disorder characterized by a disconnection from reality), anxiety disorder (psychiatric disorder that involve extreme fear, worry, and nervousness), dementia (a progressive mental disorder characterized by memory problems, impaired reasoning and personality changes), bipolar disorder (a disorder characterized by extreme mood swings from depression to mania), and depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life). Review of the resident's Observation Detail List Report dated 11/21/23 showed: -The resident was living in Assisted Living but had declined and moved to this facility. -The resident liked reading his/her Bible, church services, bingo, live music, pet visits, music from the 40's and 50's, family visits, and crafts. -The resident had always been very social. Review of the resident's Admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 11/23/23 showed the following staff assessment of the resident: -The resident was severely cognitively impaired. -Music, pets, and religious activities were very important to him/her. -Reading, keeping up with the news, doing his/her favorite activities, going outside, and doing activities with groups of people were somewhat important to him/her. Review of the resident's recreation/wellness care plan dated 1/5/24 showed: -Activities were important to the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The goal was for the resident to participate in one group activity of preference weekly. -Instructions to assist the resident to and from activities of choice such as exercise, live music, and television. -Instructions to help the resident manage behavior as to not be disruptive such as talking out loudly during events. -Instructions to encourage conversation/socialization with others who have similar interest Bible Study, devotions, live music, and crafts. -Instructions to provide the resident with verbal reminders to scheduled activities of his/her preference which included live music, exercise, and pet visits. -Instructions to put a calendar/schedule of events in his/her room where he/she could clearly see it. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -No hearing impairment. -No vision impairment with corrective lenses. -Clear speech. -Understands others and was understood by others. -Displayed indicators of mild depression. -Did not have any behaviors. -Dependent on staff for all cares except only needed supervision while eating. -Some of his/her diagnoses included heart disease, dementia, anxiety, depression, and bipolar disease. -Was on hospice care. Review of the Activity Progress Note dated 2/19/24 showed: -The resident spent most of his/her time sitting in the unit's living room. -The resident paid some attention to the television during movies and throwback television shows. -The resident called out from his/her room for attention as he/she forgets to push the button. -The resident participated in exercise class the past quarter. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's activity participation records dated February 2024 showed the resident participated in trivia once and left early. Review of the resident's activity participation records dated March 2024 showed the resident participated in bingo twice, pet visits four times, live entertainment once, and Bible study once. Review of the resident's activity participation records dated April 2024 showed the resident participated in beverage cart once and church service once. Observation on 4/29/24 showed: -At 9:51 A.M.: --The resident was in his/her room in his/her broda chair (a wheelchair specialized for the resident's comfort that usually reclines and is padded). --The resident said he/she needed staff assistance. --Staff responded to the resident's call light. -At 1:51 P.M., staff entered the resident's room with a mechanical lift and closed the resident's door. -At 2:36 P.M.: --The resident was in his/her room with the television on. --The resident said he/she was not sure how he/she was doing. --The resident said the television was on all day Saturday, Sunday and today (Monday). --The resident said he/she liked television in general, but he/she didn't like television that much. --The resident talked about his/her cats when he/she looked at a picture of them that was in his/her room. Observation on 4/30/24 showed: -At 9:13 A.M., the resident was not in his/her room. -At 10:23 A.M., the resident was in his/her room and a cooking show was on the television. -At 3:21 P.M.: -The resident was in bed and the television was on a reality show about a restaurant and bar owner and the staff that worked at the restaurants and bars. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident said he/she was watching something about families, but he/she didn't have a remote control to change the channel. -The resident said he/she told the maintenance assistant about his/her missing remote control. Observation on 5/1/24 showed: -At 9:20 A.M. and 9:56 A.M., the resident was in his/her broda between the nurses' station and the back of the couch that faced the television. -At 10:19 A.M., the resident was in his/her room in his/her broda chair with the television on. -At 10:28 A.M., --The resident was in his/her room in his/her broda chair with the television on. --The television was on a reality show about affluent housewives. --The resident read the name of the television show from the television screen. --When asked if he/she liked the television show, he/she said, Well, it's what was on. -At 1:26 P.M., the resident was not in his/her room. -At 2:48 P.M.: --The resident was in his/her room in his/her broda chair. --The resident was calling out the charge nurse's name repeatedly. --The television was on a reality show about a competition between chefs. --The resident said all that's been on his/her television for two days were reality shows and she didn't have the remote control. Observation on 5/2/24 showed: -At 5:06 A.M., the resident was asleep in bed and the television was on loud on a reality show. -At 5:29 A.M., the resident's door was closed. -At 10:02 A.M., the resident's door was closed, and voices could be heard in the resident's room. Observation on 5/3/24 showed: -At 10:06 A.M. and 10:33 A.M., the resident was sitting in the living room area by the television but not looking at the television. (continued on next page)

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	265820	A. Building B. Wing	05/07/2024

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 1:40 P.M., the resident was asleep in bed. -At 3:16 P.M., the resident was in bed, was yelling for help, and calling out his/her room number. Staff entered the room and asked if the resident was ready to get out of bed. During an interview on 5/3/24 at 10:16 A.M., Certified Nursing Assistant (CNA) A said the resident got along with two other residents that watched television together in the television area of the living room. Observation on 5/6/24 at 9:15 A.M. showed the resident was in his/her room in his/her broda chair and the television was on a talk show where people are arguing and yelling at each other. During an interview on 5/6/24 at 10:37 A.M., Activities Director said: -The resident had hysteria (exaggeratedly or inappropriately emotional behavior). -When the resident attended activities, he/she was disruptive. -The resident did participate successfully in exercise recently. -The resident had less calling out recently. -The resident liked pet visits and live entertainment. During an interview on 5/6/24 at 11:28 A.M., the Activities Director said: -The resident was much more apt to converse recently, with less calling out. -The resident did great with exercise recently. 2. Review of Resident #44's undated admission record that was printed on 5/2/24 showed: -The resident was receiving hospice care. -Some of the resident's diagnoses included delusional disorder (a mental health condition in which a person can't tell what's real from what's imagined), anxiety disorder, dementia, bipolar disorder, and depression. Review of the resident's annual MDS dated [DATE] showed the following staff assessment of the resident: -Had minimal hearing impairment, clear speech, usually understood others and others usually understood him/her. -Was severely cognitively impaired. -Displayed indicators of mild depression. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had no behaviors. -Reading, music, pets, doing his/her favorite activities, and being outside were somewhat important to the resident. -The resident used a wheelchair. -The resident was dependent upon staff for most cares except eating required set-up only. -Some of his/her diagnoses included a stroke, dementia, anxiety disorder, depression, and bipolar disorder. -Was receiving hospice care. Review of the resident's Recreation/Wellness assessment dated [DATE] showed: -The resident did not use the phone. -Preferred to be at the nurses' station or sitting in his/her doorway visiting with staff and others or resting in bed. -Reading, music, pets, going outside, and doing his/her favorite activities were somewhat important to him/her. -The resident flipped through a magazine occasionally at the nurses' station but was no longer a reader. -The resident liked live music. -The resident's favorite activities included resting, visits with family and staff and having snacks. Review of the resident's Recreation/Wellness progress note dated 2/7/24 showed: -The resident was content to rest, watch some television and sit in the living room for movies. -The resident visited with care staff, enjoyed snacks, and pet visits. -The resident liked cola from the beverage cart and ice cream. -The resident would be taken outside when the weather is warmer. Review of the resident's Recreation/Wellness care plan updated 2/7/24 showed: -The goal was that the resident would have positive responses to activities of his/her choice such as talking to family on the phone, pet visits, snacking on bananas, large print books or magazines about gardening. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included: --Check with the resident weekly to determine my satisfaction of leisure activities. --Encourage conversation/socialization with others who have similar interests in family, gardening, Methodist church, and sewing. --Provide modification/adaptations such as large print books or magazines. --Put a calendar/schedule of events in my room where I can clearly see it. --Consider a small version of the calendar for his/her table tray for easier access and sight. Review of the resident's activity participation records dated February 2024 showed the resident participated in guitar music once. Review of the resident's activity participation records dated March 2024 showed the resident participated in bingo once, church once, Bible study once, a movie once, exercise once, and pet visits four times. Review of the resident's activity participation records dated April 2024 showed the resident participated in the beverage cart once and church once. Observation on 4/29/24 showed: -At 10:07 A.M., the resident was sitting in his/her wheelchair in his/her room and was not engaged in any activity. -At 2:48 P.M., the resident was asleep in bed. Observation on 4/30/24 showed: -At 9:14 A.M., the resident was not in his/her room. -At 10:24 A.M., the resident's door was closed. -At 3:23 P.M., the resident was asleep in bed. Observation on 5/1/24 showed: -At 9:20 A.M., the resident was in his/her wheelchair in the living room area between the nurses' station and couch that faced the television, not engaged in any activity. -At 9:56 A.M., the resident was in his/her wheelchair in the living room area between the nurses' station and couch that faced the television, not engaged in any activity. -At 10:15 A.M., the resident was in his/her wheelchair in the living room area between the nurses' station and couch that faced the television, not engaged in any activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 10:17 A.M., CNA A told the charge nurse the resident asked to be laid down. -At 1:25 P.M., the resident was asleep in bed. -At 2:54 P.M., the resident was asleep in bed. Observation on 5/2/24 showed: -At 5:07 A.M., the resident was in his/her wheelchair in the living room area across from the nurses' station, not engaged in any activity. -Continuous observation from 5:15 A.M. to 6:40 A.M. showed: -At 5:15 A.M.: --The resident was in his/her wheelchair in the living room area across from the nurses' station with his/her head down and eyes closed. --The resident opened his/her eyes, and looked toward the television, which was about 12 feet away. -At 5:16 A.M.: --The resident was looking towards the piano to his/her right. --Staff turned the television on to the news. -At 6:40 A.M., a staff member took the resident to his/her room and came back out and placed the resident in the living room area. -At 10:03 A.M., the resident was in his/her wheelchair in the living room area by the bird aviary with his/her head down, not engaged in any activity. Observation on 5/3/24 showed: -At 10:07 A.M., --The resident was by the bird aviary with his/her wheelchair sideways to the bird aviary. --The resident said he/she watched the birds every day. -At 10:33 A.M., the resident was sitting by the nurses' station, not engaged in any activity. During an interview on 5/3/24 at 10:16 A.M., CNA A said the resident: -Had good days and bad days. -Liked to lie down in the afternoon. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Would talk to anyone passing by. -Liked it when the staff were goofy. -Would not play bingo. -Would listen to music entertainers. Observation on 5/6/24 at 9:16 A.M. showed the resident was sitting in his/her wheelchair behind a lazy boy chair in the living room area, not engaged in any activity. During an interview on 5/6/24 at 10:37 A.M., the Activity Director said the resident liked pet visits, snack cart, cola, movies, throwback television. During an interview on 5/6/24 at 11:28 A.M., the Activity Director said: -The resident stayed by the nurses' station and visited with staff there. -The resident often sat in the living room and watched television or movies. -The resident liked pet visits and live music/entertainment. 3. During an interview on 5/6/24 at 10:37 A.M., Activities Director said: -They used a program from 3/1/24 to 4/9/24 to record attendance but they could no longer get into those records. -The participation sheets he/she provided were the participation sheets for each individual activity. -The participation sheets were a resident roster with all the residents in the facility with a mark next to the residents that participated in that specific activity. -They began using a new electronic health records system on 4/10/24. During an interview on 5/6/24 at 12:08 P.M., the Activities Director said: -They could do more for all the residents when there were three staff in the Recreation/Wellness department. -They have a core group of about 20 residents that go to the group activities. -They could do more with the residents like these residents with different capacities when they had the third person in the department. -They have thematic memory sets and things for the residents to twiddle with. -It's a time issue. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She has supplies needed but not the time to do everything needed for all the residents. During an interview on 5/6/24 at 1:20 P.M., the Administrator said: -He/she thought the Activity Director provided activities for dependent residents like these two residents. -There is a second staff member in the Recreation/Wellness department who works in the Assisted Living Facility but also helps at this facility.

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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** 19016 Based on observation, interview, and record review, the facility failed to ensure adequate fall prevention interventions were added to a care plan in a timely manner and implemented for one sampled resident (Resident #6)with a history of falls. The facility failed to ensure staff utilized a gait belt (a safety device placed around the waist of residents requiring assistance with transfers and walking) for one sampled resident (Resident #226) who required assistance with transfers out of 21 total sampled residents. The facility census was 105 residents. Review of the facility's Investigating and Reporting Accidents and Incidents policy, revised July, 2017 showed: -The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document investigation of an accident/incident and shall complete a Report of Incident/Accident form. -The Director of Nursing (DON) shall ensure the Administrator receives a copy of the Report of Incident/Accident form. -Incident/Accident reports will be reviewed by the safety committee for trends or safety hazards and to analyze individual resident vulnerabilities. Review of the facility's Falls Risk Assessment policy, dated March, 2018 showed staff and the attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize consequences of risk factors. 1. Review of Resident #6's Admission Record showed the resident was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with the following diagnoses: -Multiple Sclerosis (MS, a neurological disease that attacks the protective covering of the nerves, leading to impaired sensory and motor nerve function, and in most cases some degree of disability), onset date 1/15/24. -Muscle weakness, onset date 1/16/24. -Fracture of right lower leg, subsequent encounter for closed fracture with routine healing, onset date 2/18/24. -History of falling, onset date 4/18/24. Review of the resident's Risk for Falls care plan, initiated 1/17/24 showed: -The resident was at risk for falls related to his/her need for Activities of Daily Living (ADL - dressing, grooming, bathing, eating, and toileting) assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff were to: --Encourage resident to assume a standing position slowly. --Give verbal reminders not to transfer and ambulate without assistance. --Keep call light within reach. --Keep frequently used personal items within reach. --Provide a clutter-free environment. Review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/22/24 showed the resident: -Had impaired vision. -Was severely cognitively impaired. -Used a walker and a wheelchair. -Was dependent on staff for toileting, showers, wheeling his/her wheelchair, dressing, and transfers. -He/She had no falls in the last two to six months prior to admission. -Had no fractures in the six months prior to admission. -Had no falls since his/her re-admission. Review of the resident's Fall Incident Report, dated 2/17/24 showed: -The resident was found on the floor in his/her room. -The resident had bare feet and could have been moving about in bed. -The resident did not complain of pain and was alert; extremity movement and hand grasps were at baseline; pupil size and response were within normal limits; there was no change from the resident's baseline; and no injury was noted at the time. -There were no known contributing factors to the fall other than the resident could have been moving about in bed. -An immediate intervention was put into place to lower the resident's bed and to evaluate the resident's toileting schedule needs. -The fall was unwitnessed and 72-hour post fall follow up (neurological checks and assessments for injuries) started on 2/17/24 and were expected to end on 2/20/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The physician and resident representative were notified and the care plan was reviewed by the nurse by 2:49 A.M. Review of the resident's nursing note, dated 2/17/24 at 7:15 P.M. showed: -A family member reported concerns with the resident's knee and said the resident had increased pain. -A Certified Nursing Assistant (CNA) reported when wheeling the resident to a meal the resident put his/her feet down, stopping the wheelchair. The resident had grimaced in pain. The CNA reported no changes with resident transfers, but the resident always complained of knee pain when moving. -The nurse looked at the resident's knee with no findings and a Lidocaine Patch (a local pain anesthetic) was placed on the resident's knee. -The family member asked about the resident's fall and the resident's roommate (no longer at the facility) said he/she heard a big bump at 2:00 A.M. and asked the resident if he/she fell . The resident told the roommate yes and the roommate pushed the call light and called the facility phone for staff assistance. Review of the facility's Post Fall Investigation Report, dated 2/18/24 showed: -The resident fell on [DATE] at 2:00 A.M. -The resident: --Had no history of falls. --Was identified as being at risk for falls on his/her care plan. --Was found on the floor and was unable to describe the fall. -The bed was in the low position and there were no known injuries. -Neurological assessments (checking the resident's level of consciousness, pupil response, motor functions, hand grasps, movement of extremities, pain response, and vital signs) were started and monitoring was to continue for 72 hours post fall. -Planned systemic interventions/changes would be frequent rounds and low bed. Family at bedside as able. -On 2/18/24 radiology took x-ray images of the resident's right hip, knee, and ankle. Review of the resident's Fall Risk Care Plan, dated 4/5/24 showed: -The following interventions, all dated 4/5/24: --Anticipate and meet resident needs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Remind resident to call for assistance with transfers. --Encourage participation in activities that promote exercise and physical activity for strengthening and improved mobility. --Keep call light and frequently used personal items within reach. -There was no mention of a lowered bed or frequent rounds for toileting needs. Review of the resident's nursing note, dated 4/9/24 at 10:50 P.M. showed: -At approximately 6:45 P.M. the resident was observed lying on the floor by roommate's family. -The day nurse reported resident was lying face down on the floor next to his/her bed on the side closest to the bathroom. -Range of motion to upper and lower extremities without complaints of pain. -Resident noted to have hematoma (A pool of mostly clotted blood that forms in an organ, tissue, or body space) to his/her right forehead. -Neurological assessments initiated. -Resident alert and able to answer simple questions. At baseline cognitively. -Resident complained of pain, but would not say where pain was. -Resident assisted back into bed with assistance of two. -Medical doctor and nurse manager notified. -Order obtained to send to ER for evaluation. Review of the resident's Post Fall Investigation Report, dated 4/10/24 showed: -The resident had an unwitnessed fall in his/her room on 4/9/24 at 7:00 P.M. -The resident was found on the floor. -His/Her bed was in the low position. -Non-compliant resident was indicated as the contributing factor to the fall. -The resident was sent to the ER for assessment of hi/sher right knee swelling and was found to be febrile upon arrival. --No documentation of his/her right forehead hematoma. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident family members were notified. Review of the resident's hospital Discharge Summary, for the 4/9/24 hospitalization showed: -The resident was admitted to the hospital related to an unwitnessed fall. -A family member reported the resident was dealing with a right knee effusion (fluid accumulation) for a few months. -Arthrocentesis (a procedure in which a needle is used to take fluid out of a joint for diagnostic purposes) performed and showed inflammatory effusion. No evidence of infection. Started back on gout (a form of arthritis causing pain, swelling and redness in joints) medication. -CT of head with no acute intracranial hemorrhage (bleeding). Right frontal scalp swelling. No displaced skull fractures. -Found to have a multidrug resistant (bacteria that have become resistant to certain antibiotics) bacteria in urine. -Treatment for Urinary Tract Infection (UTI). Review of the resident's Fall Risk Care Plan showed the following interventions were added on 4/28/24: -Keep the bed in the low position with brakes locked. -Monitor for changes in condition affecting risk for falls and notify physician if observed. -Safety devices as ordered. Observation on 4/29/24 and 5/1/24 showed: -On 4/29/24 at 2:22 P.M. the resident was in the common area near the television. He/She had light bruising and mild swelling to the outside of his/her left eye. He/She was wearing a knee length hard boot on the right lower leg. The resident said he/she did not remember falling. -On 5/1/24 at 10:25 A.M. the resident was in bed and appeared to be sleeping. His/Her bed was lowered. A fall mat was under, not beside, his/her bed. During an interview on 5/2/24 at 7:12 A.M. Family Member A said: -The resident fell out of bed in February and broke his/her right leg. -The resident fell again in April and got a lump on his/her head and continued to have a bruised and swollen left eye for weeks following the fall. During an interview on 5/3/24 at 2:40 P.M. CNA C said: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She thought the resident had an intervention for a lowered bed prior to his/her first fall in February. -After the February fall he/she thought they added the fall mat which was supposed to be beside his/her bed when occupied in case the resident fell . During an interview on 5/6/24 at 11:38 A.M. Licensed Practical Nurse (LPN) C said: -He/She thought the resident had an intervention for a lowered bed after his/her fall in February. It should be on the resident's care plan. -He/She didn't know when a fall mat intervention was added. During an intervention on 5/6/24 at 11:39 A.M. the 300 Hall Unit Manager said: -He/She didn't recall what intervention had been added after the February fall. -After the resident's fall in April the fall mat was added to the resident's care plan. During an interview on 5/6/24 at 12:06 P.M. MDS Coordinator A said: -After the resident fell in February he/she had instructions not to bear weight. -He/She couldn't see in the resident's record that an intervention to lower the resident's bed or any other intervention had been added to the care plan at the time of the fall. -Typically the team discussed resident falls the next morning in the clinical meeting and new interventions were developed and added then. During an interview on 5/6/24 at 2:12 P.M. the Director of Nursing (DON) said: -The Unit Manager (UM) was responsible for the resident's fall investigation and should have added the lowered bed intervention into the resident's fall risk care plan. -It should have been added after the resident returned from the ER visit in February. 2. Record review of Resident #226's Admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses: -Fracture of superior rim of right pubis (hip/pelvic area), subsequent encounter, with routine healing. -History of falling. Review of the resident's Admission MDS, dated [DATE] showed the resident: -Was severely cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required maximal assistance with transfers including chair to bed, bed to chair, and chair to chair. -Had no falls in the last two to six months and no fractures related to falls in the six months prior to admission. -He/She had no falls since admission. Review of the resident's Baseline Care Plan, dated 4/26/24 showed the resident: -Had a history of falls prior to admission. -The resident required maximal assistance with all transfers. Observation on 5/2/24 at 6:26 A.M. showed: -CNA F walked into the resident's room announcing he/she was getting the resident up. -A gait belt was hanging on the wall just inside the door to the right. CNA F did not grab it or any other gait belt. -The resident was lying on his/her back in bed. -CNA F told the resident he/she was getting him/her up and put his/her left arm under the resident's left underarm and assisted the resident in sitting up on the side of the bed. -CNA F placed the resident's wheelchair near to and facing the bed and locked it. -The resident said he/she felt sick to his/her stomach. -CNA F put his/her hands under the resident's underarms and asked the resident to stand. -After the resident stood up CNA F grabbed the back of the resident's stretch pants and assisted the resident in pivoting to face the bed and sit in his/her wheelchair. -When standing and pivoting the resident was hunched over and his/her knees were bent throughout the transfer. During an interview on 5/2/24 at 6:26 A.M. CNA F said: -Staff have to assist residents in transfers until therapy assessed them to determine if they can transfer on their own. -Residents were supposed to wear a gait belt at all times if they can't bear full weight. -Residents should all have a gait belt in their room. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was the first time he/she had ever met the resident or transferred him/her. He/She knew the resident needed staff assistance for transfers and was supposed to wear a gait belt for all transfers. -The resident said he/she felt sick so he/she just tried to quickly transfer him/her into his/her wheelchair by grabbing the back of the resident's pants during the transfer. During an interview on 5/2/24 at 6:52 A.M. LPN A said: -Staff need to use a gait belt any time they help transfer a resident. There could be problems with transfers if staff weren't using a gait belt. -The resident needed help with transfers and should have a gait belt on during all transfers. During an interview on 5/3/24 at 2:49 P.M. CNA C said: -Staff should always use a gait belt if they need to assist with a resident transfer. -Gait belts should be in the drawers of each resident's bedside table or hanging on the resident's wall. During an interview on 5/3/24 at 3:11 P.M. the Director of Therapy said: -If a resident needs assistance with transfers the first step is to always put a gait belt on the resident. -The resident required moderate assistance to go from a seated to a standing position and needed assistance of one staff for transferring from the bed to the wheelchair. -Staff were to lift a little on the gait belt. The resident could currently bear about 75 percent weight and staff were to do the other 25 percent of the work. During an interview on 5/6/24 at 9:58 A.M. RN A said: -If a staff person was doing a one-person assist for transfers they should put on a gait belt first, place the wheelchair as close to the bed as possible and lock the wheelchair. -Before helping the resident stand they should ask the resident if they felt dizzy. If not, they can proceed in assisting the resident to stand and transfer. During an interview on 5/6/24 at 2:12 P.M. the DON said: The charge nurse should call the shift manager when a resident has a fall. If they can't get hold of the on-call manager, they call him/her. -The charge nurse adds an immediate intervention for the resident following a fall. -The team discusses the fall and immediate intervention the following morning in clinical meeting and decides what interventions will be added into the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A root cause analysis should be done by the whole team which should be added to the fall investigation. -The Unit Manager had been responsible for the fall investigations. -A manager should audit to make sure fall interventions have been added into resident care plans. -Staff assisting residents with transfers should always use a gait belt. MO00234543

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on observation, interview, and record review, the facility failed to ensure a resident who required dialysis (process of cleansing the blood by passing it through a special machine - necessary when the kidneys were not able to filter the blood) received ongoing assessments of the dialysis site and accurate description of resident's the dialysis site for one sampled resident (Resident #374) out of 21 sampled residents. The facility census was 105 residents. Review of facility policy End-Stage Renal Disease (ESRD - inability of the kidneys to excrete wastes, concentrate urine, and conserve electrolytes), policy revised September 2010 showed: -Residents with ESRD, would be cared for according to currently recognized standards of care. -Type of assessments data that was to be gathered about the resident's condition on a daily or per shift basis. A policy was requested for dialysis care was requested but the facility had no policy. 1. Review of Resident #374's Admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses: -End Stage Renal Disease. -Dependence on renal dialysis. Review of the resident's Order Summary Report 4/25/24 showed: -Dialysis pre weight in the morning every Monday, Wednesday, and Friday. -Dialysis post weight in the afternoon every Monday, Wednesday, and Friday. -No orders for the resident to receive dialysis treatments, including location for dialysis and days for dialysis. -No orders for site care and type of access the resident had. -No orders for the frequency of how often the dialysis site was to be assessed. Review of resident's base line care plan dated 4/25/24 showed: -The resident needed dialysis management. -Did not show when dialysis was to be performed. -Did not show type of dialysis access. (continued on next page)

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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	Review of resident's Progress Notes 4/24/24 thru 5/1/24 showed: -Note dated 4/24/24 showed the resident had a dialysis catheter to the right side of the resident's chest. -No other progress notes showed the resident had a dialysis catheter to the right side of the resident's chest. Observation on 4/29/24 at 11:53 A.M. of the resident showed: -He/She was sitting in a wheelchair. -He/She had a dialysis catheter that exited from the right side of his/her chest with a clean, dry, intact dressing. During an interview on 5/2/24 at 9:22 A.M., the resident said: -He/She went to dialysis three times a week. -Staff did not assess the dialysis site. -He/She only had the dialysis access through the catheter in his/her chest. During an interview on 5/3/24 at 9:30 A.M. Registered Nurse (RN) A said: -The resident was at dialysis and left before his/her shift started. -The dialysis site was not given in report. -He/She did not know what kind of dialysis access the resident had or where the dialysis access was located on the resident. -The dialysis site would have been assessed before the resident left for dialysis and upon the resident's return for signs of bleeding and infection. -The dialysis site should be assessed every shift for signs of infection and bleeding. -The assessment should have been documented on in the computer. -He/She was unable to produce the assessments. -He/She said that if the assessments were not documented then he/she would have to assume the assessments were not performed. -There should be orders to assess the site and how often, and there should be orders for when the resident goes to dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the orders to assess the dialysis site and when the resident had dialysis were not in the system the doctor would be called and orders obtained and documented for these items. During an interview on 5/6/24 at 12:43 P.M., DON said: -It was his/her expectation that a nurse would know the type of dialysis access a resident had. -It was his/her expectation that the nurses would know how to assess the dialysis access and to chart the assessment in the computer. -It was his/her expectation that the dialysis site would be assessed every shift. -It was his/her expectation that the resident would have orders to assess the dialysis site, and where to send the resident for dialysis and when. -The orders for assessment should have been placed in the computer within the first eight hours after the resident was admitted . -The assessment should be documented on the Treatment Administration Record as being done. -If the assessment showed any abnormal findings, there would a be nurses note stating what the abnormal finding was and the doctor's response. -If the dialysis assessments were not documented in the computer system, then it would be assumed the assessments were not performed. -The unit manager was responsible for auditing the dialysis orders and assessment, but the unit manager had recently quit and not been replaced. -Ultimately he/she was responsible to the audits.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on interview and record review, the facility failed to ensure a comprehensive Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event. Symptoms may include flashbacks, nightmares, and severe anxiety) care plan was in place and that staff were educated on ways to decrease the resident's exposure to triggers and decrease the effects of a trigger for one sampled resident (Resident # 65) out of 21 sampled residents. The facility census was 105 residents. The facility's Trauma Informed Care process, undated, showed: -The Abbreviated PTSD Checklist for Civilians (PCL -C), a two-item version, would be used within 72 hours of admission. -If there were positive screen results a six-item version of the PCL-C would be completed for the resident's five-day assessment. -Residents who have a trauma history will have access to trauma-sensitive and behavioral health treatment as appropriate. -Staff members will need skills and guidance on identifying symptoms of trauma and acting in a trauma-responsive manner. 1. Review of Resident #65's Admission Record showed he/she was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with a diagnosis of PTSD. Review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 2/5/24 showed the resident was moderately cognitively impaired and was diagnosed with PTSD. Review of the resident's Psychiatric Conditions care plan, initiated 2/8/24 showed: -The resident had a history of: --Adjustment disorder with anxiety (strong emotional or behavioral reaction to stress or trauma). --Depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). --Insomnia (difficulty falling or staying asleep or getting good quality sleep). --PTSD. -PTSD triggers were loud noises. Note: There was no separate care plan specifically to address the resident's PTSD needs. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions listed were: --Approach in calm manner. --Encourage venting of feelings. --Explain changes in routine and procedures. --Help resident recall past accomplishments. --Listen attentively to concerns and fears. --Observe for changes in behavior and mood and consult physician as needed. --Redirect and offer reassurance as needed. -There was no identified history of the resident's trauma. -There was no information on how a the resident typically reacted or how the resident's mood or behavior were affected when triggered. -There was not a comprehensive list of what staff should do to decrease the resident's exposure to triggers that might re-traumatize him/her. -There was no clear guidance on how staff could best decrease the effects of a trigger on the resident. During an interview on 4/29/24 at 3:08 P.M. the resident said: -He/She had PTSD from being in the Vietnam war. -Triggers were: --War and other violent and loud movies. --[NAME]. --The 4th of July especially was a trigger. --Talking with people sometimes triggered PTSD. -PTSD still affected his/her life. -He/She used to see a psychologist through the VA system for at least a couple of years. He/She didn't think he/she needed to see one now. During an interview on 5/03/24 at 2:38 P.M. Certified Nurse Assistant (CNA) C said: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She didn't know the resident was diagnosed with PTSD or what trauma he/she had experienced. -He/She hadn't been told what might trigger the resident's PTSD or how staff would know if the resident was experiencing a trigger. -He/She didn't know what staff were to do to decrease the likelihood of a trigger or what staff should do if the resident was triggered. During an interview on 5/6/24 at 9:56 A.M. Licensed Practical Nurse (LPN) C said: -He/She knew the resident was diagnosed with PTSD, but wasn't sure where he/she saw that. -In the old electronic records system there was a PTSD assessment nurses filled out, but he/she didn't know if the assessment was in the new system. -He/She didn't know what the resident's triggers were. During an interview on 5/6/24 at 12:44 P.M. the Director of Nurses (DON) said: -A PTSD care plan should show: --All the resident's known triggers. --What staff should do to decrease the likelihood of a trigger. --What staff should do if the resident was triggered. -Staff should be able to see what the resident's triggers were from their PTSD care plan.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on observation, interview, and record review, the facility failed to ensure the facility considered all appropriate alternatives prior to installing bed rails for one sampled resident (Resident #6) with a history of falling from bed out of 21 sampled residents. The facility census was 105 residents. Review of the facility's Bed Entrapment Prevention policy, dated 11/18/21 showed: -The facility was restraint-free. -Full, half or quarter rails were only used by rare exception and only after proper assessment. -Bed canes (a device attached to the bed) were considered assistive devices. Review of the facility's in-service training for bed entrapment and bed rail utilization, dated 8/4/22 showed: -Bed rails were considered restraints and the facility didn't use them. -Bed assist bars were enablers that allowed the resident more mobility and needed to be properly identified on the Bed Rail Observation/Assessment form since they could still potentially be an entrapment risk, depending on the resident and their assessed needs. -Signatures of those in attendance included several nursing staff and the current Maintenance Supervisor. 1. Review of Resident #6's Admission Record showed the resident was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included: -Multiple Sclerosis (MS, a neurological disease that attacks the protective covering of the nerves, leading to impaired sensory and motor nerve function). -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). -Muscle weakness. -History of falling. Review of the resident's Risk for Falls care plan, initiated 1/17/24 showed: -The resident was at risk for falls related to his/her need for ADL assistance. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff were to: --Encourage the resident to assume a standing position slowly. --Remind the resident not to transfer without assistance. --Keep call light and personal items within reach. --Provide a clutter-free environment. Review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/22/24 showed the resident: -Had impaired vision. -Was severely cognitively impaired. -Was dependent on staff for transfers and Activities of Daily Living (ADL - dressing, grooming, bathing, eating, and toileting). Review of the facility's Post Fall Investigation Report, dated 2/18/24 showed: -The resident fell on [DATE] at 2:00 A.M. -The resident was identified as being at risk for falls on his/her care plan. -Planned systemic interventions/changes would be frequent rounds and a low bed. Review of the resident's physician orders, dated 4/2/24, showed bed cane(s) for positioning and bed mobility. Review of the resident's Fall Risk Care Plan, dated 4/5/24 showed: -The following interventions, all dated 4/5/24: --Anticipate and meet the resident needs. --Remind resident to call for assistance with transfers. --Encourage participation in activities that promote exercise and physical activity for strengthening and improved mobility. --Keep call light and frequently used personal items within reach. Note: There was no mention of a lowered bed, frequent rounds, or a toileting schedule. There was no intervention for bed canes. Review of the resident's Post Fall Investigation Report, dated 4/10/24 showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had an unwitnessed fall in his/her room on 4/9/24 at 7:00 P.M. -The resident was found on the floor. -His/Her bed was in the low position. Note: There was no mention of adding bed canes to the resident's bed. Review of the resident's Required Devices Care Plan, initiated 4/10/24, showed: -Partial bed rails on both sides of the bed. -Registered Nurse(s) (RN) and/or Licensed Practical Nurse(s) (LPN) were to assess appropriateness of bed rail use and complete a Bedrail Observation/Assessment. -CNAs and nurses were to encourage compliance with the device. Review of the resident's Bed Rail Observation/Assessment, dated 4/23/24 showed: -The resident's family requested the bedrails for safety reasons. -The resident had a balance deficit, pain, and was unable to support his/her trunk in an upright position. -The resident leaned forward and to the right and was cognitively impaired. -He/She had a history of falling out of bed, sliding onto the floor, and acted impulsively. -The bedrails would assist the resident in holding himself/herself on one side and would not impede his/her movement. -Alternates attempted were a lowered bed and bedside mat. -Bedrails were recommended when the resident was in bed due to the above-mentioned reasons and would consist of left and right upper quarter rails. -There were no gaps between the mattress and bed rail or the bed rail and the headboard on the right or left sides of the bed. -The bed dimensions were appropriate for the resident's size and weight based on visual inspection of the resident in bed and the resident's verbalized comfort level. -Bed rail assessments would be completed on a quarterly basis. -Risks, benefits, and informed consent included: --Risks and benefits were explained to the resident and/or resident representative regarding the medical necessity for the use of bed rails and entrapment risks. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Benefits of bed rails included increased mobility, transfers in and out of bed, supporting self during cares, repositioning, boundary identification, and providing a feeling of security. --Risks of bed rails included risk of entrapment; skin tears, bruises, and lacerations; debility; and chest, head, or neck injury, including strangulation, suffocation, bodily injury, and death. -The form was signed by the Director of Nursing (DON) on 5/2/24 with a hand-written note showing the resident's family member was educated by phone. Note: There was no documentation that any other device was attempted that could have assisted the resident with boundary identification or justification why such a device would not be appropriate. There was no documentation of interventions attempted other than the lowered bed and bed mat or justification why other interventions would be ineffective or inappropriate. Review of the resident's Fall Risk Care Plan, dated 4/28/24, showed: -The resident's family required one-fourth bedrails for fall prevention. The family was educated regarding risk of entrapment and were informed the facility does not promote the use of bed rails. The family refused bed canes, verbalized understanding of risks, and asked for bilateral rails. Staff were educated to monitor positioning of resident and rails during rounds. -Staff were to: --Keep bed in the low position with brakes locked. --Monitor for changes in condition affecting risk for falls and notify physician if observed. --Utilize safety devices as ordered. --Use bed rails while resident was in bed to aid in bed mobility and repositioning. Review of the resident's physician orders on 5/1/24 showed orders for bed cane(s) for positioning and mobility were still active and there were no orders for bed rails. Observation on 5/1/24 at 10:25 A.M. showed: -The resident was in bed and appeared to be sleeping. -The resident had what looked like quarter bed rails covered with linens or fabric on both sides. A pillow was against one rail beside the left side of the resident's head and bedding was near the right side of the resident's head, hiding the details of the bed rails. Observation on 5/2/24 at 6:08 A.M. showed the resident was in bed with his/her quarter bed rails up. The rails were covered with linens on both sides. During an interview on 5/2/24 at 7:12 A.M. Family Member A said: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a fall from the bed in February and fractured his/her ankle and fell from the bed again in April and got a bruised and swollen area to his/her head. -He/She believed the only way to keep the resident safe was to use bed rails. During an interview on 5/3/24 at 2:40 P.M. Certified Nurse Aide (CNA) C said: -The resident had bed rails because his/her family member requested it. -The resident tended to place his/her upper body close to the edge of his/her bed facing the hallway door. -Before the bed rails were used the facility lowered the resident's bed. After the resident's first fall a fall mat was used beside the bed when occupied. The resident also had U-shaped grab bars attached to his/her bed which were taken off when the rails were installed. Those were the resident's only interventions prior to the bed rails. -The resident was able to grab both the U-shaped bars and the bed rails to assist in turning. -He/She had never seen the facility use any other interventions prior to the bed rails being installed. The resident never had a parameter mattress (a mattress with slightly raised edging, usually made of foam, typically with an open mid-section allowing egress) or any other device or method to help the resident identify where the edge of his/her bed was and had never used a larger bed. -The resident had the bed rails for about two weeks. During an interview on 5/3/24 at 3:00 P.M. the Director of Rehabilitation said: -The resident received therapy services off and on since his/her original admitted . -Therapy provided maximal assistance (staff does more than half the effort) when the resident sat on the side of his/her bed. -The resident had always used bed canes for repositioning in bed. -The Rehabilitation Department had not recommend bed rails and was not involved in the resident's bed rail assessment. -Nursing would have recommended the bed rails. During an interview on 5/3/24 at 3:35 P.M. the Director of Nursing (DON) said: -The facility told the resident's family they would not allow the bed rails, but they kept insisting after the resident's second fall. -The resident's family member said he/she was going to buy a bed rail on-line and install it himself/herself. That was why the facility had the Maintenance Supervisor install the rails. He/She thought that would be safer than something the family brought in. (continued on next page)

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Jackson Creek Post Acute	3980 South Jackson Drive Independence, MO 64057

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-NOTE: The physician's order and the Bed Rail assessment was for bed mobility and positionings, not as a fall precaution intervention. During an interview on 5/6/24 at 11:38 A.M. Licensed Practical Nurse (LPN) C said: -Fall interventions he/she was aware of included a lowered bed after the resident's fall in February and at some point a fall mat was added. -In April the bed rails were added. -NOTE: The physician's order and the Bed Rail assessment was for bed mobility and positionings, not as a fall precaution intervention. During an interview on 5/6/24 at 12:44 P.M. the DON said: -Prior to bed rails being installed nursing was responsible for assessing the resident for appropriateness of the bed rails. This included an assessment of benefits and risks for the resident. -Interventions attempted prior to the use of bed rails should be identified and there should be documentation why those interventions were not appropriate or enough. -The resident's family was educated on the benefits and risks of bed rails. -A lowered bed was put in as an intervention for the resident prior to the use of bedrails. The resident's family did not think it was enough and thought only bed rails could prevent the resident from falling. -NOTE: The physician's order and the Bed Rail assessment was for bed mobility and positionings, not as a fall precaution intervention.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview and record review, the facility failed to make pureed (cooked food, that has been ground, pressed, blended or sieved to the consistency of a creamy paste or liquid) eggs in a palatable manner and to maintain hot foods on room trays during the breakfast meal, at or close to 120 F (degrees Fahrenheit) when those trays were delivered to the residents. This practice potentially affected at least six residents who resided on the 300 Hall. The facility census was 105 residents. 1. Review of the undated recipe for pureed eggs showed: -Boil eggs for three minutes and allow to sit in the water covered for 20 minutes. -Remove eggs from water and immerse in cold water to cool. -Crack shells and rinse well with water to remove all shells. -For puree diets, prepare items per regular recipe. Portion number of servings needed based on diet census and puree. Refer to therapeutic menu for appropriate portion size of puree foods. -There were no seasonings such as salt or any spices that were mentioned in this recipe. Observations on 5/2/24 from 6:25 A.M. through 6:31 A.M., during the breakfast meal preparation, showed: -The Dietary Manager (DM) placed four boiled eggs into the food processor. -The DM did not have a recipe book open at the time. -The DM added an unmeasured amount of butter to the boiled eggs. -The DM processed the boiled eggs with the butter in the food processor to a pureed consistency Observation on 5/2/24 at 7:42 A.M., showed the pureed eggs were not flavorful. During an interview on 5/2/24 at 7:44 A.M., the DM said the following after he/she tasted the pureed eggs: -He/She has not asked the Registered Dietitian (RD) for any kind of flavor enhancements. -He/She had not tasted the pureed eggs before that day. During a phone interview on 5/13/24 at 11:01 A.M., the Consultant Registered Dietitian (RD) said: -He/She was at the facility twice per week. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She he has tried some of the pureed products, but not regularly. -He/She does not eat eggs or dairy products. -When they (he/she and the Dietary Manager) discussed the taste of pureed foods before, they just want salt and pepper at the table. -The residents do not want a bland egg. 2. During the resident group interview on 4/30/24 at 10:32 A.M., the residents who attended said the food was served cold. Observation on 5/2/24 from 8:03 A.M. through 8:19 A.M., showed Certified Nursing Assistant (CNA) E delivered room trays to residents in the following rooms: -At 8:03 A.M., he/she delivered a room tray to resident room [ROOM NUMBER]. -At 8:05 A.M., he/she delivered a room tray to resident room [ROOM NUMBER]. -At 8:06 A.M., he/she delivered 2 room trays to resident room [ROOM NUMBER]. -At 8:08 A.M., he/she delivered a room tray to resident room [ROOM NUMBER] -At 8:09 A.M., he/she delivered a room tray to resident room [ROOM NUMBER]. -At 8:10 A.M., he/she delivered a room tray to resident room [ROOM NUMBER] -At 8:13 A.M., he/she delivered a room tray to resident room [ROOM NUMBER] -At 8:13 A.M., CNA E left from resident room [ROOM NUMBER] to where the cart was at room [ROOM NUMBER] to get a a cup of coffee for the resident in resident room [ROOM NUMBER] -At 8:17 A.M., CNA E delivered a room tray to resident room [ROOM NUMBER] -At 8:19 A.M. the temperature of the sausage on the test tray was measured in front of CNAs D and E showed: --The temperature of the sausage was 115.7 F. --The temperature of the scrambled eggs was 115 F. -At 8:23 A.M., the temperature of the mechanical sausage on another tray that was for a resident who was no longer at the facility, was 95.9 F. During an interview on 5/2/24 at 8:23 A.M., CNA E said there were too many trays on the food cart at once. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 8:27 A.M., CNA C said he/she has not seen anyone from dietary department check the temperatures of room trays. During an interview on 5/2/24 at 8:29 A.M., CNA D said he/she has not seen anyone from the dietary department check the temperatures of foods on the room trays except for one time. During an interview on 5/2/24 at 8:45 A.M., CNA E said he/she has not seen anyone from dietary department check the temperatures of foods on trays for the 300 Hall. During an interview on 5/2/24 at 8:58 A.M., the DM said: -There were 18 room trays for the 300 Hall. -The Registered Dietitian (RD) used to measure the temperature of test trays but has not done so in a while. 3. Review of Resident #56's quarterly Minimum Date Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated 4/17/24 identified the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 of 15. During an interview on 5/2/24 at 10:19 A.M., the resident said: -The food was cold for all meals. -He/She received a room tray, and he/she did not go to the dining room. 4. Review of #36's quarterly MDS dated [DATE], identified the resident as cognitively intact with a BIMS score of 15. During an interview on 5/2/24 at 10:21 A.M., the resident said the food was always cold at all three meals and he/she just want the meals to be better. 5. Review of Resident #375's Admission's MDS dated [DATE], identified the resident as having moderate cognitive impairment, with a BIMS score of 11. During an interview on 5/2/24 at 10:29 A.M., the resident said: -The food temperatures have not been warm enough. -Sometimes the food arrived to him/her a little cool because of the time it took to get the food from the kitchen to his/her room, because his/her room was far from the kitchen. 6. Review of Resident #374's Admission's MDS dated [DATE] identified the resident as cognitively intact with a BIMS score of 14 of 15. During an interview on 5/2/24 at 10:32 A.M. the resident said that the breakfasts and dinner meals were the meals that were mostly cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During a phone interview on 5/13/24 at 11:01 A.M., the Consultant Registered Dietitian (RD) said: -He/She was at the facility twice per week. -He/She has not gotten with the Dietary Manager about testing the temperatures of room trays. -He/She did not get involved with the testing the temperatures of the foods. -The residents eating in their rooms should have appropriate temperature.

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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 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. 19916 Based on observation and interview, the facility failed to remove grime from the top of the garbage disposal (a device, installed under a kitchen sink between the sink's drain and the trap used to shred food waste into pieces small enough--less than 2 mm -- in diameter, to pass through plumbing); to remove a buildup of grime and debris including drinking cups from under the ice machine; to remove debris from around the nozzles of the juice machine; to ensure that Dietary Aide's (DA) A's hair was fully covered; to place a label to identify an unknown substance that was in a bottle on the shelf above the stove; to label a white powdery substance in a container in a dry goods' storage to identify that item; and to maintain the milk at 400 Hall kitchenette at a temperature of 41 F (degrees Fahrenheit) or colder. This practice potentially affected all residents. The facility census was 105 residents. 1. Observation on 4/29/24 from 9:11 A.M. through 9:36 A.M., during the initial kitchen observations, showed: -A buildup of grime under the dishwasher. -A small leak from the garbage disposal. -A buildup of grime and debris including cups and dust under the ice machine. -The presence of grime around nozzles of juice machine. 2. Observations on 5/2/24 from 6:25 A.M. through 8:37 A.M., showed: -A buildup of grime under the dishwasher. -A small leak from the garbage disposal. -A buildup of grime and debris including cups and dust under the ice machine. -The presence of grime around nozzles of juice machine. -The presence of dust on light fixtures above the steam table. -DA A's hair was not completely covered by a hair restraint. -The temperature of the milk that was in a tub was 48.3 F (degrees Fahrenheit). During an interview on 5/2/24 at 7:43 A.M., DA A said he/she did not know the lower part of his/her hair was not covered by the hair net. During an interview on 5/2/24 at 8:39 A.M., DA B said he/she did not check the temperature of the milk before that day and the tub that the container of milk was in did not have ice in it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interviews on 5/2/24, from 8:49 A.M. through 8:57 A.M., the Dietary Manager (DM) said: -He/She had not scraped off the debris from the outside of the garbage disposal and that in the past, maintenance tried to repair it. -The Maintenance Director attempted to fix garbage disposal about 2-3 weeks prior to the survey. -He/She was not sure why they did not label the sugar. -The bottle with the unidentified liquid on the shelf above the stove was filled with water.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview and record review, the facility failed to ensure that food in the resident use refrigerator was labeled and resident's name and the date the food item was brought in in accordance with the facility's policy. This practice potentially affected an unknown number of residents who have foods brought in by visitors. The facility census was 105 residents. Review of the facility's policy entitled Safe Food Handling for Food Brought in From Outside Sources, dated , d+[DATE], showed: -Food and/or beverages brought into the healthcare center from the outside will be monitored by center partners for contamination, spoilage, and overall food safety. -Food and/or beverage items brought into the center should be securely packaged and labeled with the patient's name and the date the item(s) were brought into the center. The center should have large zip type storage bags and markers, or other appropriate supplies, available for packaging, labeling and identifying food brought in from an outside source. -Food or beverage items will be monitored and discarded by the center as follows: Perishable foods will be discarded within three days, or per manufacturer's Use by or Best by or expiration date. -Note: If a food or beverage item appears to be spoiled, contaminated or unsafe, the item will be discarded by the center regardless of the specified use by date. -Cold food items must be stored in a refrigerated unit to maintain an appropriate cold temperature; frozen food items must be stored in the freezer and maintained frozen solid. 1. Observation on [DATE] from 9:51 A.M. through 10:01 A.M., showed the following in the resident use refrigerator: -An expired bottle of Italian flavored salad dressing, ranch dressing, mayonnaise, coffee creamer, relish, restaurant sauce, all of which were not labeled with a resident's name, or the date those containers were brought in. -Three containers of unidentified food which were not labeled with a resident's name or the date those containers were brought in. -One cup of an unidentified item which was not labeled with resident's name or the date that item was brought in. -A bag of corn dogs which was not labeled with a resident's name or the date that item was brought in. -Numerous containers of dietary supplements. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:01 A.M., Licensed Practical Nurse (LPN) C said every item in the refrigerator needed to be labeled with a name of the resident for whom the food item was for, the date the item was brought in, and there was a separate refrigerator for supplements. During an interview on [DATE] at 10:08 A.M., the 300 Hall Unit Manager said he/she has notified the housekeeping employees to clean the refrigerator in the past. During an interview on [DATE] at 10:10 A.M., the Housekeeping Supervisor said the resident food use refrigerator should be cleaned twice per week and ideally, the housekeeper should see the expired items if the refrigerator was being cleaned regularly. During an interview on [DATE] at 10:14 A.M., Housekeeper A said he/she normally cleaned the refrigerator every other Saturday but not recently.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09895 Based on observation, interview, and record review, the facility failed to ensure hand hygiene, use of a barrier for supplies and cleansing of the glucometer during blood glucose monitoring (a blood sugar reading obtained from a small sample of blood from the finger) and administration of insulin (mediation that helps blood sugar enter the body's cells for use as energy) for three sampled residents (Resident #68, #91, and #39) out of 21 sampled residents and to ensure a policy to ensure staff correctly sanitized the glucometer between use for residents. The facility census was 105 residents. Review of the facility Hand Hygiene policy, updated August 2021 showed: -Hand hygiene included both handwashing with soap and water and use of alcohol-based products (gels, rinses, foams) that do not require the use of water. -In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbiocidal (ability to kill germs) activity, reduced drying of the skin, and convenience; the exception is in the case of spore forming (microorganisms that produce dormant bodies that can reproduce even after exposure to antimicrobial agents), which require soap and water with friction. -Provide hand hygiene before and after contact with each resident, after toileting, smoking or eating, and before and after removal of gloves. Review of the facility Blood Glucose Monitoring Systems policy, undated showed: -Wash hands. -Put on gloves. -Clean blood glucose meter with wipe, keep wet for two minutes, do not put in pocket or case. Note: The instruction did not specify what type of wipe to use, for example a product or wipe that is effective against microorganisms on surfaces. -Remove gloves. -Wash hands. -Put on gloves. -Obtain blood sample. -Remove gloves. -Wash hands. -Put on gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clean blood glucose meter with wipe then return to case. Note the instruction did not specify to keep the glucometer wet for two minutes. -Remove gloves. -Wash hands. 1. Review of Resident #68's Face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of diabetes (a disease of inadequate control of blood sugar). Review of the resident's May 2024 Physician's Orders Sheet (POS) showed Novolog (medication that manages your blood sugar levels) Injection Solution 100 units per milliliter (mL), inject per sliding scale (progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges), subcutaneously (under the skin) with meals, dated 4/4/24. Observation on 5/2/24 at 7:40 A.M. showed: -Without first sanitizing his/her hands, Registered Nurse (RN) C entered the resident's room and placed a storage tray with supplies on the resident's bed without placing a barrier on the resident's bed. -Without first sanitizing his/her hands, he/she put on gloves and completed the resident's Accu check with supplies from the storage tray. -He/She then left the resident's room with the storage tray, placed the storage container lancet (sharp used for obtaining a drop of blood) in the sharp container on the medication cart, removed his/her gloves and recorded the resident's blood glucose level in the resident's electronic medical record (EMR). -Without first sanitizing his/her hands, he/she returned to the resident's room and again placed the storage tray on the resident's bed without using a barrier. -Then without sanitizing his/her hands, he/she put on gloves, removed the resident's insulin pen from the storage tray, wiped the top of the insulin pen with an alcohol wipe, put a needle on the tip of the insulin pen, wiped the resident's skin with an alcohol wipe and injected the resident's insulin. -He/She then exited the resident's room with the resident's insulin pen and the storage tray. -He/She placed the storage tray on top of the medication care without using a barrier, placed the needle in the sharp's container, removed his/her gloves, did not sanitize his/her hands and charted the resident's insulin injection in his/her EMR. -Then without sanitizing his/her hands he/she proceeded to the next resident's care. 2. Review of Resident #91's Face Sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of diabetes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's May 2024 POS showed NovoLog inject as per sliding scale with meals. Observation on 5/2/24 at 7:40 A.M. showed: -Without first sanitizing his/her hands, RN C entered the resident's room and placed a supply tray with on the resident's bed without placing a barrier on the resident's bed. -Without first sanitizing his/her hands, he/she put on gloves, wiped the top of the resident's insulin pen with alcohol and placed a needle on the resident's insulin pen, wiped the resident's ski with alcohol and completed the resident's insulin injection. -He/She then removed the storage tray from the resident's bed, entered the resident's bathroom, placed the supply tray on the resident's shower chair, removed his/her gloves and washed his/her hands. -He/She then left the resident's room, placed the supply cart on top of the medication cart, disposed of the resident's insulin pen needle in the sharp's container and recorded the resident's insulin injection in his/her EMR. -Then the 400 Hall Unit Manager placed a container of hand sanitizer on top of the medication cart and instructed RN C to sanitize the blood glucose meter, opened the bottom drawer of the medication cart and finding no disinfectant wipes left the area to get disinfectant wipes, returned and instructed RN C to use the disinfectant wipes on the glucose meter and wait five minutes before using the glucose meter. -RN C sanitized the blood glucose meter with a disinfectant wipe, placed the meter first on top of the medication cart without using a barrier and then placed the glucose meter in the supply cart, sanitized his/her hands and proceeded to the next resident without waiting five minutes after having sanitized the glucose meter. 3. Review of Resident #39's Face Sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of diabetes. Review of the resident's May 2024 POS showed Fingerstick (Accu check) blood sugar every morning and at bedtime for diabetes. Observation on 5/2/24 at 7:53 A.M. showed: -RN C went to the 400 Hall dining area and propelled the resident to a resident's room other than his/her room. -He/She placed the supply tray on the first night stand without a barrier, and without first sanitizing his/her hands, put gloves on, wiped the resident's finger with an alcohol wipe, completed the resident's blood glucose monitoring, propelled the resident back to the dining room, placed the supply cart on top of the medication cart without using a barrier, discarded the lancet in the sharps container, removed his/her gloves and without first sanitizing his/her hands, documented the resident's blood glucose in his/her EMR. 4. During an interview on 5/2/24 at 8:01 A.M. RN C said: (continued on next page)

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	265820	A. Building B. Wing	05/07/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had not washed his/her hands as he/she was supposed to have when he/she completed Resident #68's Accu check and insulin, Resident #91's insulin injection and Resident #39's Accu check, had not used a barrier for supplies and had not sanitized the glucose meter after use for Resident #68. -He/She was aware he/she was supposed to wash his/her hands before each resident's care, after completing Accu checks, before and after insulin injections and after completing care for resident's. -He/She had hurried and had been nervous. During an interview on 5/2/24 at 8:07 A.M. the 400 Hall Unit Manager said: -RN C had been nervous. -He/She had just provided education with RN C to get him/her back on track. During an interview on 5/3/24 at 11:21 A.M. the 400 Hall Unit Manager said: -The Director of Nursing (DON) had him/her do education that morning with RN C regarding handwashing, and infection control with Accu checks and insulin injections. During an interview on 5/6/24 at 12:45 P.M. the DON said: -He/She expected staff to complete hand hygiene before starting to do any resident care, during resident care as indicated for going from clean to soiled and after resident care. -He/She expected staff to sanitize the blood glucose monitor after use and allow it to stay wet for the duration specified on the disinfectant wipe label and store the meter in the medication cart for next use; each care used for insulin administration should have two blood glucose monitors so that there is a cleansed meter always ready for use. -The licensed nurse completing blood glucose monitoring and insulin administration should roll the cart to the resident's room before starting and should use a Styrofoam plate for a barrier for the blood glucose monitor, Accucheck supplies and for insulin pens and needles. -After completing an Accucheck, the licensed nurse should dispose of the lancet in the sharps container on the medication cart, remove his/her gloves, use hand sanitizer, enter the resident's blood glucose in the resident's EMR, check the physician's order for the resident's insulin, sanitize his/her hands, gather the insulin pen, needle, and alcohol wipe, place then on a barrier, return to the resident's room, sanitize his/her hands, put on gloves and administer the resident's insulin, return to the medication cart, remove his/her gloves, return supplies to the medication cart, chart the insulin administration in the resident's EMR and sanitize his/her hands. -During new employee orientation, licensed nurses are trained on hand hygiene and infection control with Accuchecks and insulin administration. -Licensed nurses were observed about every three months by the Unit Managers or by other management nurses. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had the 400 Hall Unit Manager do training with RN C. -When a problem is identified, and inservice was conducted, annual training was conducted, and random observations were done by licensed nurse management staff.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #6) with bed rails had rails that were compatible with the bed and were installed and maintained in a safe manner out of 21 sampled residents. The facility census was 105 residents. Review of the facility's Bed Entrapment Prevention Policy, dated 11/18/21 showed: -The facility's goals were: --Improved bed safety. --Mitigating the risk of entrapment. --Testing bed rails across all seven potential zones of entrapment. -Full, half, or quarter rails were only used by rare exception. Review of the facility's Bed Entrapment/Bed Rail Utilization training report, dated 8/4/22, showed: -A hospital bed manufacturer's Bed Entrapment diagram and information, dated 2009, was part of the training. The manufacturer's information referenced the Food and Drug Administration (FDA) Hospital Bed Safety webpage. -Signatures for the training included several nursing staff and the facility's current Maintenance Supervisor. 1. Review of Resident #6's Admission Record showed the resident was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included: -Multiple Sclerosis (MS, a neurological disease that attacks the protective covering of the nerves, leading to impaired sensory and motor nerve function). -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). -Muscle weakness. -History of falling. Review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/22/24 showed the resident: -Had impaired vision. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was severely cognitively impaired. -Was dependent on staff for transfers and Activities of Daily Living (ADL - dressing, grooming, bathing, eating, and toileting). Review of the resident's physician orders, dated 4/2/24, showed bed cane(s) (a device attached to the bed for grasping) for positioning and bed mobility. Review of the resident's Required Devices Care Plan, initiated 4/10/24, showed partial bed rails on both sides of the bed. Review of the resident's Bed Zone Measurement Log, dated 4/23/24 and completed by the Maintenance Supervisor, showed: -The bed manufacturer's Bed Entrapment information, dated 2009, referencing the FDA's Hospital Bed Safety webpage was used as a reference for installing the bed rails. -Measurements for all zones were recorded on the form. -The bed manufacturer's instructions for Zone Six (the space between the end of the rail and the side edge of the head or foot board) showed the space presented a risk of entrapment. -The facility's form showed Zone Six gaps should be less than two and three-eighths inches or greater than twelve and one-half inches. -Documentation was hand written on the form showing Zone Six measured three-fourth's inch. Review of the resident's Bed Rail Observation/Assessment, dated 4/23/24 showed: -The resident's family requested the bedrails for safety reasons. -Bedrails were recommended when the resident was in bed. -There were no gaps between the mattress and bed rail or the bed rail and the headboard on the right or left sides of the bed. -Risks of bed rails included risk of entrapment: skin tears, bruises, and lacerations; debility; and chest, head, or neck injury, including strangulation, suffocation, bodily injury, and death. -The form was signed by the Director of Nursing (DON) on 5/2/24 with a hand-written note the family member was educated by phone. Review on 5/1/24 of the resident's physician orders showed orders, dated 4/2/24, for bed cane(s) for positioning and mobility and there were no orders for bed rails. Observation on 5/1/24 at 10:25 A.M. showed: -The resident was in bed and appeared to be sleeping. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had quarter bed rails covered with linens or fabric on both sides. A pillow was beside the left side of the resident's head and bedding was near the right side of the resident's head, hiding the details of the bed rails. Observation on 5/2/24 at 6:08 A.M. showed the resident was in bed with his/her quarter bed rails up. The rails were covered with linens on both sides. During an interview on 5/3/24 at 2:40 P.M. Certified Nursing Assistant (CNA) C said: -The resident had the bed rails for about two weeks. -Maintenance installed the bed rails. -If staff noticed problems with the rails they were to report it to the charge nurse or Maintenance Supervisor. -He/She hadn't noticed any safety issues with the resident's rails. Observation on 5/3/24 at 3:20 P.M. showed: -The resident's bed had been stripped of all bedding and the resident's quarter rails were on the bed. -The seven bed rail entrapment zones were measured and Zone Six measured seven and one-half inches between the end of the rail and the headboard. (Note: According to the facility's Bed Zone Measurement Log guidance, Zone Six spacing should be less than two and three-eighths inches or over twelve and one-half inches.) -The bed rail had a metal lever that when lifted caused the rail to fall quickly and with force. The lever was on the outside of the rail near the level of the bed's mattress frame. There were several vertical bars on the rail. There were five spaces in the middle section of the rail that measured two and one-eighth inches and four spaces (two on either end of the bar) that measured three and one-fourth inches. The surveyor could put his/her hand and forearm through the bar spaces where the release lever could be accessed if someone was in bed. -The bed rail was secured to the bed by an adjustable tightening knob located near the mattress frame. The knob had been loose upon observation and the entire bed rail could be moved in a circle to the right or the left. -There were no observations of the rail being loose when the resident was in the bed; however, the knob could easily be loosened by staff, visitors, or a person while in the bed. With the rail loose the spacing between the rail frame and mattress changed and posed a risk for entrapment. The rail would not have provided repositioning support for the resident when loose. -The Director of Nursing (DON) was shown the spacing, release lever, and knob adjustability observations and said the bed rail was not safe. During an interview on 5/3/24 at 3:35 P.M. the DON said: (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's family member said he/she was going to buy a bed rail on-line and install it himself/herself. -That was why the facility had the Maintenance Supervisor install the rails. During an interview on 5/6/24 at 11:38 A.M. Licensed Practical Nurse (LPN) C said: -The resident's bed rails were installed in April. -Staff had not reported any problems with the bed rails. During an interview on 5/6/24 at 12:44 P.M. the DON said: -The Maintenance Supervisor: --Was responsible for installing the bed rail and making sure it was safe for use. --Was trained on the Bed Entrapment Prevention policy and entrapment risks. --Had information on measurements for installing the bed rail. -Bed rails should be compatible with the bed when installed. -Nursing should observe the bed rails each shift. If the rails didn't feel stable or if spacing wasn't safe they should notify the Maintenance Supervisor. During an interview on 5/6/24 at 1:27 P.M. the Maintenance Supervisor said: -He/She had been trained on installing bed rails. -He/She had access to the bed rail policy and information on appropriate bed rail spacing. -He/She had to measure and document spacing for the bed entrapment zones, including spacing within the bed rail, between the mattress and bed rail and between the rail end and the headboard. -He/She was surprised at how loose the bed frame was on 5/3/24. He/She hadn't installed it that way. -Staff might have loosened the bars and should be educated to not leave the bed rails loose. -He/She didn't do audits on bed rail safety. He/She relied on nursing staff to report if the bed rail was loose or if there were other problems. He/She was responsible for fixing any issues with bed rails or grab assist bars.