STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265845	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Health Lakewood Care Center	7900 Lee's Summit Road Kansas City, MO 64139

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720 Based on interview and record review, the facility failed to provide residents and/or the resident's responsible party's timely notifications (verbal and/or in writing) prior to a roommate change for three sampled residents (Residents #1, #2, and #3) out of five sampled residents. The facility census was 149 residents. Review of the facility's Resident Right's policy dated 11/16 showed: -Notification of changes: --A facility must immediately inform the resident, consult with the resident's physician; and notify, consistent with his/her authority, the resident representative(s) when there is a change in room or roommate assignment. Review of the facility's current Census List dated 2/27/24 showed Resident #1 and Resident #2 were currently roommates. 1. Review of Resident #1's Face Sheet showed the resident was admitted to the facility on [DATE]. Review of the resident's Care Center Resident's Rights dated 11/9/16 showed: -The resident had the right to receive notice before the resident's room or roommate in the facility is changed. -The Care Center Resident's Rights document was reviewed and a copy given to the resident on 2/23/23. Review of the resident's Progress Notes showed: -An undated noted timed at 2:30 P.M. showed the resident's family member/Durable Power of Attorney (DPOA- a person previously identified to make decisions for an individual in the event of inability to make wishes known) arrived to the facility and was upset the resident now had a roommate. Staff explained to the DPOA that the resident had a double room and could have a roommate. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) met with the family member to discuss the situation. (continued on next page)

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

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Note: No documentation the resident's DPOA was notified verbally or in writing he/she would be getting a new roommate prior to Resident #3 being admitted to Resident #1's room on 12/28/23. -On 1/8/24 the resident's family member/DPOA was notified verbally he/she would be getting a roommate that week. -No documentation the resident's DPOA was notified in writing he/she would be getting a new roommate prior to Resident #2 being admitted to Resident #1's room on 1/10/24. During an interview on 2/27/24 at 9:14 A.M., the resident's DPOA said: -The resident had a roommate change several times in the past few months and he/she was not notified of the roommate changes prior to them moving in to the resident's room. -He/She was told by staff they did not need to notify him/her if the facility was moving someone into the resident's room. -He/She was not notified verbally or in writing of the new roommate a couple months ago. He/She only knew about it because a nurse stopped him/her before he/she entered the resident's room to let him/her know there was a roommate in the room now. -He/She denied being notified verbally or in writing of the new roommate that is currently in the resident's room when that resident was moved into the room in January 2024. During an interview on 2/27/24 at 11:20 A.M., Registered Nurse (RN) A said: -He/She wrote the undated Progress Note. He/She was not sure what day it was but it was not 12/25/23 (the date on the note above his/her progress note). -He/She is not sure why he/she did not date the note, he/she was usually good about making sure notes have dates and times when written. -The resident's family member/DPOA was upset when he/she came to visit the resident because the resident had a roommate. -The resident had a semi-private room, but did not have roommates prior to that day. -He/She tried to explain to the resident's DPOA that he/she should anticipate the resident could have a roommate at any time since the resident did not have a private room. -He/She did not notify the resident's DPOA verbally or in writing the resident was getting a new roommate. -He/She would verbally notify the responsible party of resident that is being moved of a room change. -He/She would not necessarily notify the responsible party of the resident that is getting the new roommate of the change. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/24 at 2:23 P.M., the resident's DPOA said he/she was not notified either verbally or in writing of the resident's transfer on 1/1/24 from the 2nd floor to the 1st floor until he/she arrived at the facility to visit the resident. During an interview on 2/27/24 at 12:43 P.M., Licensed Practical Nurse (LPN) A said: -Resident #3's spouse was at the facility and knew the resident was changing rooms on 1/1/24. -He/She did not document the resident's spouse was verbally notified of the room change since he/she was already at the facility. -He/She does not do the notifications if a resident is moving rooms, but he/she thinks that both the person who is moving and the person who is getting a new roommate are verbally notified of the room change. 4. During an interview on 2/27/24 at 1:19 P.M., the Admissions Coordinator said: -When Resident #3 was readmitted to the facility from the hospital, he/she was told to put the resident in a room with another COVID positive resident (Resident #1). -He/She called Resident #3's DPOA to let him/her know of the room change upon readmission and that it would be a temporary room move. -He/She does not notify in writing either resident/responsible party (the one moving or the one getting a roommate) of room changes. -Usually verbal notification is given to the resident/responsible party of a room change to the person who is moving from one room to another. -He/She thought staff may give verbal notification to the resident getting a new roommate. -He/She did not document verbal notification of room changes. During an interview on 2/27/24 at 1:43 P.M., the QAPI Manager said: -When Resident #3 was readmitted to the facility from the hospital, he/she was positive for COVID. -The facility decided to admit the resident in a room currently occupied with a resident positive for COVID in the same timeframe for infection control/isolation protocol purposes, so he/she was admitted to the room Resident #1 occupied. -He/She would expect staff to verbally notify the resident/resident's responsible party prior to moving a resident from one room to another in the facility. -He/She would expect staff to verbally notify the resident/resident's responsible party when they are getting a new roommate or a roommate change. -He/She would expect staff to document the verbal notifications in both resident's medical record. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had not given written notifications to either party when room/roommate changes were made. -He/She was not sure if Resident #1's family/DPOA were given verbal notifications when he/she received new roommates. During an interview on 2/27/24 at 1:50 P.M., the Social Worker said: -He/She would verbally notify the resident/resident's responsible party prior to the resident moving to a new room. -He/She would expect staff to notify the resident/resident's responsible party if they were getting a new roommate. -He/She was not involved with the room changes in December 2023, he/she was out on personal leave during that incident. He/She does not know if staff notified Resident #1's DPOA of the roommate at that time. -He/She does not always notify the resident/resident's responsible party prior to a new admission being moved into the resident's room. He/She thought they should know there was a possibility of a new roommate if the resident was in a semi-private room. -He/She expected room change notifications would be documented in the resident's medical record. -He/She had not given written notifications to either party when room/roommate changes were made. During an interview on 2/27/24 at 2:45 P.M., the Administrator said: -He/She had only given verbal notifications to the resident's who are being moved when a room change occurred. -He/She was not aware the resident getting a new roommate also required notification when a new roommate was admitted to the room. -He/She was not aware a written notification when a room/roommate change occurred. MO00231605

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720 Based on interview and record review, the facility failed to ensure a resident's discharge notification contained the correct contact information for appeal rights for one sampled resident (Resident #1) out of 5 sampled residents. The facility census was 149 residents. On 2/27/24, the Administrator was notified of the past noncompliance which occurred on 10/31/23. The facility administration was notified during the resident's appeal process that the discharge notification contact information was incorrect. Inservices were provided to staff who were involved in preparing the discharge notification notices on 11/2/23. Discharge notices sampled after 11/2/23 contained the correct contact information for the appeal process. The deficiency was corrected on 11/2/23. Review of the facility policy Transfers and Discharges/Notice of Proposed discharge date d 3/5/19 showed: -Transfers and discharges will be handled appropriately to ensure proper notification and assistance to residents and families in accordance with federal and state-specific regulations. 1. Review of Resident #1's Face Sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's 30 day discharge notice dated 10/31/23 showed: -The notice was sent to the resident's Durable power of Attorney (DPOA- a person previously identified to make decisions for an individual in the event of inability to make wishes known) with an effective date of 11/30/23. -The notice had incorrect contact information for a hearing request for the Department of Health and Senior Services (DHSS) Appeals Unit. -The notice did not include the contact information for the Missouri Protection and Advocacy Agency as required for Medicare and Medicaid certified facility residents with developmental disabilities. Review of the resident's Appeals Hearing results notification dated 11/6/23 showed the 30 day discharge notice was dismissed due to the following reasons: -The facility did not provide the correct contact information for a hearing request for the DHSS Appeals Unit. -The notice did not include contact information for the Missouri Protection and Advocacy Agency as required for Medicare and Medicaid certified facility residents with developmental disabilities. Review of the facility's Educations Program Attendance Record dated 11/2/23 showed: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The education was titled 30 Day Notice Education. -The purpose was for the correct process for 30 day notices. -Staff who prepare 30 day notices were in attendance. -A copy of the discharge regulation with the correct contact information to be included on 30 day notice letters was attached to the education provided to the staff who attended the inservice. During an interview on 2/27/24 at 2:35 P.M. the Operations Coordinator said: -He/She received education on the correct contact information for 30 day notice letters. -He/She provided a copy of the inservice handouts. -He/She ensured the contact information on any 30 day notices given to residents and/or the resident's responsible party was correct since the time of the education. During an interview on 2/27/24 at 3:30 P.M., the Administrator said: -A 30 day notice was given to the resident's responsible party on 10/31/23. -The 30 day notice had the incorrect contact information on the letter, which was discovered during the appeals process. -The facility provided education to the staff regarding the correct contact information for a 30 day discharge letter as soon as it was discovered. MO00231618