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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Health Lakewood Medical 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure appropriate storage and labeling of medications throughout the facility's medication carts and medication cabinets which had the potential to affect all residents within the facility. The facility census was 131 residents.Review of the facility's policy titled Medication Purchasing and Storage dated 1/10/24 showed:-Medications would be stored consistently with manufacturers' recommendations and in a manner that reduces the opportunity for a medication error to occur.-When medications were placed into active stock, expiration dates would be reviewed and stock rotated so products with the earliest expiration dates were dispensed first.1. Observation on 8/20/25 at 11:34 A.M. of the Three North (3N) Certified Medication Technician (CMT) medication cart showed:-37 Culturelle (a probiotic supplement to support digestive health) capsules that were outside of their original package and expiration dates could not be found on each packet.-18 Guaifenesin (a common expectorant drug that helps loosen and this mucus in the airways, making it easier to cough up and clear congestion) extended release (ER) 600 milligrams (mg) tablets that were outside of their original packet and expiration dates could not be found on each packet.-23 Allegra (allergy medication) 60 mg tablets that were outside of their original container and expiration dates could not be found on each packet.Observation on 8/20/25 at 11:45 A.M. of the 3N short hall licensed nurse medication cart showed:-Five disinfecting port protectors that expired on 4/15/25.-One tube of Nystatin ointment (used to treat fungal and yeast infections) United States Pharmacopeia (USP) 100,000 units per gram that expired in August 2024.-One tube of Nystatin ointment USP 100,000 units per gram that expired in February 2025.-One, one-ounce tube of original strength Benadryl (a cream used to temporarily relieve itching, pain, and other symptoms from minor skin irritations, such as insect bites, sunburn, minor burns, and rashes) that expired in April 2025.-One, two-ounce tube of hemorrhoidal ointment (used to treat hemorrhoids, which is a swollen vein or group of veins in the region of the anus) that expired in April 2025.-A package of Xeroform (a non-adherent, fine mesh gauze dressing impregnated with petrolatum and three percent bismuth tribromophenate, which was used to create a moist wound environment and prevented the dressing from sticking to the wound) that was opened and had expired on 10/31/24.-A package of Xeroform gauze dressing that expired on 10/31/24.-Five packets of povidone iodine swab sticks that expired in October 2023.-One packet of lubricating jelly that expired 12/31/24.-Five telfa non-adherent pads (used a wound dressing and helps absorb without sticking) that expired 3/1/23.During an interview on 8/20/25 at 11:53 A.M. the Assistant Director of Nursing (ADON) said the nurses and CMTs were to check the medication carts weekly for expired medications and supplies.Observation on 8/20/25 at 12:19 P.M. of the 3N medication refrigerator showed one bottle of mouth rinse solution with a beyond use date of 8/2/25.Observation on 8/20/25 at 12:35 P.M. of the Three South (3S) short hall licensed nurse medication cart showed:-One 16 fluid ounce bottle of betadine solution (a topical anti-septic used to prevent infections in minor cuts, scrapes, and burns) which expired in May 2025.-108 disinfecting port protectors that expired on 4/15/25.-Two 10 mg Dulcolax (a stimulant laxative) suppositories that expired in November 2022.Observation on 8/20/25 (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	at 1:04 P.M. of the Two North (2N) over the counter (OTC) cabinet showed:-One four-ounce bottle of Robafen CF (a multi-symptom, OTC cough and cold medicine) that expired in July 2025.-One bottle of D3-50 (high potency vitamin D3 supplements) that expired in March 2024.-Two tubes of original strength Benadryl that expired in April 2025.-Two tubes of terbinafine hydrochloride cream one percent (used to treat fungal infections on the skin) that expired June 2025.-One bottle of ear wax removal drops that expired in May 2024.-Two bottles of multi-vite liquid and mineral supplement with antioxidant vitamins C and E that expired in April 2025.Observation on 8/20/25 at 1:36 P.M. of the 1 South (1S) medication cart showed:-One Age-Related Eye Disease Study (AREDS) 2 bottle that expired in July 2025.-One bottle of ear wax removal aid that expired on 2/28/25.During an interview on 8/22/25 at 12:46 P.M. CMT B said:-CMTs, nurses, and staff from the pharmacy looked at the medication carts and cabinets to ensure appropriate medication storage.-CMTs and nurses checked the carts daily for expired medications.-The facility did not have any specific system to ensure appropriate medication storage.-Expired medications and medical supplies should not be stored in the medication carts, refrigerators, or cabinets.-Any medication or supply that was found expired needed to be disposed of appropriately.During an interview on 8/22/25 at 1:00 P.M. Licensed Practical Nurse (LPN) B said:-Nurses and CMTs ensured medications were stored appropriately.-The staff who worked on the medication carts checked the carts daily for appropriate medication storage.-The facility's medication storage system included nurses and CMTs keeping each other accountable for appropriate medication storage.-Expired medications and supplies should not be stored in medication carts, refrigerators, or cabinets.-Any expired medication or supply needed to be taken out of the cart, refrigerator, or cabinet and disposed of appropriately.-He/She thought the medication carts, refrigerators, and cabinets were getting checked on a regular basis.During an interview on 8/22/25 at 1:25 P.M. Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) Coordinator A said:-Floor nurses, the ADON, and the Director of Nursing (DON) were responsible for ensuring appropriate medication storage.-He/She was unsure if there was a specific system in place to ensure appropriate medication storage.-Expired medications and supplies should not be kept in medication carts, refrigerators, or cabinets.-If expired medications and supplies were found then they needed to be disposed of appropriately.During an interview on 8/22/25 at 1:46 P.M. the DON said:-There was a system in place to ensure appropriate medication storage.-He/She checked all medication carts, refrigerators, and cabinets for expired medications and supplies each Monday.-He/She did not document or use a checklist when completing the Monday checks.-He/She was unsure of why staff were unaware of his/her system for medication storage.-Expired medications and supplies should not be stored in medication carts, refrigerators, or cabinets.-He/She expected staff to dispose of any expired medications or expired medical supplies if found.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive, facility-specific infection prevention and control program designed to help prevent the development and transmission of Legionella (A [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease) that included specific assessments and contents, in accordance with State of Missouri rules and Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) standards and guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. The facility failed to ensure appropriate hand hygiene was completed during medication administration for one sampled resident (Resident #90) and one supplemental resident (Resident #59); the facility failed to ensure one sampled resident's (Resident # 81) insulin pen rubber seal was wiped with an alcohol swab before attaching a needle to the insulin pen during medication pass out of 26 sampled residents and one supplemental resident; and the facility failed to follow appropriate infection control practices to ensure facility wide infection control surveillance logs were maintained for twelve months to monitor, track, and identify trends of infections in the facility . The facility census was 131 residents with a licensed capacity for 188 residents at the time of the survey. 1. Review of the facility's policy and procedure entitled Water Management Program, last Current Revised Approval Date listed as 10/12/23 and provided by the FD, showed the following:-No Centers for Disease Control (CDC) toolkit assessment including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens was included.-A completed CDC Legionella Environmental Assessment Form was missing.-There was no facility-specific infection prevention program or plan to deal with outbreaks of Legionella and/or other waterborne pathogens.-Though the last review was listed as 10/12/23 on the Document Metadata page with the next review scheduled for 10/12/26, the first page under the heading WATER MANAGEMENT PROGRAM, sub-section Policy read that the program will be reviewed annually. Observation on 8/19/25 between 10:50 A.M. and 1:27 P.M. during the initial facility Life Safety Code (LSC) walk-through inspection with the Facilities Director (FD) and the Corporate Director of Safety (CDS) showed the following:-The facility was comprised of three separate resident floors, one, two, and three, with one resident room hall on the first floor, two on the second, and four on the third.-The building was equipped with a full fire sprinkler system with its incoming water supplied by the local water company. -There was a fire sprinkler riser room (A dedicated space for fire protection equipment) on the ground floor which served the whole facility's sprinkler system, which in turn was connected to the overall whole campus' system.-There were some housekeeping closets with floor mop sinks or ceramic service sinks (Mop/service sinks are used in janitorial and maintenance areas to fill and empty mop buckets, clean mops, and dispose of dirty water) and water heaters throughout the eight resident room hallways.-There were approximately (app.) 10 resident rooms with private or shared bathrooms and/or sinks on the first floor, 25 on the second floor, and 50 on the third.-There were at least three bathhouses throughout the facility. -There were two dining rooms with sinks, ice machines, and steam tables (also referred to as hot food tables, specifically, steam tables are designed to hold food at steady, safe serving temperatures, but not designed to cook or warm foods from a raw state). During an interview on 8/20/25 at 3:21 P.M. the FD said the following:-He/She was a voting member (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the water management team for policy updates. -They had also helped create the policy itself.-He/She had been educated on the program's requirements by virtual seminars and a monthly magazine from the American Society for Healthcare Engineers (ASHE). During an interview on 8/21/25 at 11:09 A.M. the Administrator said the following:-He/She had been working at this facility as their Administrator for about a year.-They had not yet had the chance to review the Legionella water management program here.-They were familiar with all the CMS requirements for it. 2. Review of the facility's policy titled Eye Drop Administration in Long Term Care dated 7/30/25 showed:-Hand hygiene was to be completed before and after the task.-The policy did not indicate when staff were supposed to put on gloves during the procedure. Review of the facility's policy titled Transdermal Medication Patches dated 9/11/24 showed:-Hand hygiene was to be completed before and after the task.-The policy did not indicate if gloves needed to be worn during the procedure. Review of Resident #90's admission record showed he/she admitted to the facility with the following diagnoses:-Diabetes Mellitus (DMII- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin) With Hyperglycemia (high blood sugar).-Chronic Kidney Disease (a condition where the kidneys are damaged and cannot filter blood effectively, leading to buildup of waste in the body), Stage 5. Review of the resident's Physician Order Sheet (POS) dated August 2025 showed an order for Refresh Tears Ophthalmic (related to the eye) Solution, instill two drops in both eyes every morning and at bedtime for dry eyes. Observation on 8/20/25 at 8:15 A.M. of the resident's medication administration completed by Certified Medication Technician (CMT) A showed:-He/She sanitized his/her hands and prepared the resident's other medications.-He/She entered the resident's room and grabbed gloves.-He/She gave the resident his/her oral medications and put on gloves.-He/She gave the resident water that was at his/her bedside.-He/She then administered the resident's eye drops with the same gloved hands.-He/She then removed his/her gloves and exited the resident's room. 3. Review of the facility's policy titled Hand Hygiene dated 9/13/23 showed:-Hand hygiene was the most important means of preventing the spread of infection.-Hand hygiene needed to be completed:--Before resident contact.--Before an aseptic (free from contamination caused by harmful bacteria, viruses, or other microorganisms) task.--After body fluid exposure risk.--After resident contact.--After contact with the environment. Review of Resident #59's admission record showed he/she admitted to the facility with a diagnosis of Parkinson's Disease (a progressive neurodegenerative disorder that primarily affects movement). Review of the resident's POS dated August 2025 showed an order for Aspercreme Lidocaine External Patch 4%, apply to affected area topically, on in the morning, and off at night for pain. Observation on 8/20/25 at 8:33 A.M. of the resident's medication administration completed by CMT A showed:-He/She sanitized his/her hands, prepared the resident's medication, and unpackaged the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	patch.-He/She put on gloves and labeled the resident's patch.-He/She gave the resident their oral medications and assisted the resident in taking them.-He/She then applied the resident's patch with\ the same gloved hands.-He/She then removed his/her gloves and sanitized his/her hands. 4. During an interview on 8/20/25 at 8:45 A.M. CMT A said he/she would not have done anything differently during Resident #90's and Resident #59's medication administration. During an interview on 8/22/25 at 12:51 P.M. CMT B said:-Hand hygiene during medication administration needed to be done before and after each resident and in between each route of medication for the same resident.-CMT A had not performed hand hygiene correctly during Resident #90's and Resident #59's medication administration.-CMT A should have removed his/her gloves, sanitized his/her hands, and put on new gloves before administering Resident #90's eye drops.-CMT A should have removed his/her gloves, sanitized his/her hands, and put on new gloves before placing Resident #59's patch. During an interview on 8/22/25 at 1:03 P.M. CMT A said:-He/She thought he/she had performed hand hygiene correctly during Resident #90's and Resident #59's medication administration.-He/She thought he/she had removed his/her gloves and sanitized his/her hands and put on new gloves prior to administering Resident #90's eye drops.-He/She thought he/she had removed his/her gloves, sanitized his/her hands, and put on new gloves before placing the patch on Resident #59. During an interview on 8/22/25 at 1:23 P.M. Licensed Practical Nurse (LPN) A said:-Hand hygiene during medication administration needed to be done before and after each resident and in between each route of medication for the same resident.-CMT A had not performed hand hygiene correctly during Resident #90's and Resident #59's medication administration.-CMT A should have removed his/her gloves, sanitized his/her hands, and put on new gloves before administering Resident #90's eye drops.-CMT A should have removed his/her gloves, sanitized his/her hands, and put on new gloves before placing Resident #59's patch. During an interview on 8/22/25 at 1:46 P.M. the Director of Nursing (DON) said:-He/She expected staff to perform hand hygiene before and after each resident and in between different routes of administration during medication administration.-CMT A had not performed hand hygiene correctly during Resident #90's and Resident #59's medication administration.-He/She would have expected CMT A to have removed his/her gloves, sanitized his/her hands, and put on new gloves before administering Resident #90's eye drops.-He/She would have expected CMT A to have removed his/her gloves, sanitized his/her hands, and put on new gloves before placing Resident #59's patch. 5. Review of the facility Insulin Injection Administration policy dated 11/11/23 showed:-Swab the rubber cap with an alcohol wipe prior to attaching the needle to the insulin pen. Review of Resident #81's POS dated August 2025 showed:-He/She had a diagnosis of DM II. -Insulin Lispro Junior KwikPen subcutaneous (under the skin) Solution Pen injector 100 units (U) per milliliters (ml), inject 10 units under the skin with meals for DM II, dated 7/9/25. Observation on 8/20/25 at 7:45 A.M. showed:-LPN C removed the cap from the resident's insulin pen.-He/She did not wipe the rubber seal on the resident's insulin pen with alcohol.-He/She attached a needle to the resident's insulin pen.-He/she then dialed the resident's dose of insulin and administered the resident's insulin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/20/2025 11:33 AM LPN C said:-He/she had not wiped the rubber seal on the resident's insulin pen with an alcohol swab prior to attaching the needle to the resident's insulin pen.-He/she usually did wipe the rubber seal with an alcohol swab before attaching the needle to the pen.-He/she had forgotten to use the alcohol swab because he/she was nervous due to being observed. During an interview on 8/22/25 at 1:45 P.M. the DON said:-He/she expected licensed nurses to wipe the rubber seal on insulin pens with an alcohol wipe prior to attaching the needle to the pen.-The facility policy did not address insulin pens, but he/she expected the rubber seal on insulin pens be wiped with alcohol just as he/she expected the seal on insulin vials (bottle) be wiped with alcohol prior to inserting the needle into the vial. 6. Review of the facility's Antibiotic Stewardship Program revised 7/17/24 showed:-The facility would monitor use, stewardship actions, and outcomes related to antibiotic use to guide practice change and track Antibiotic Stewardship Program (ASP) impact.-What would be measured/tracked:--Antibiotic use: antibiotic starts; days of therapy.--Stewardship actions: record-keeping protocol compliance, use of antibiotic reviews, compliance with urine culture specimen submission guidelines.--Outcomes: identified the infection-The Infection Preventionist (IP) would have developed a protocol for tracking antibiotic use.-The protocol would include tracking of specific key aspects of antibiotic use data for each resident.-Antibiotic use data would be complied monthly and reviewed by the consulting pharmacist.-Consulting pharmacist and IP would interpret the monthly data, define any necessary action steps, and information for the Monthly ASP Tracking Report.-Outcomes data will be complied monthly by IP, who would interpret monthly data, define any necessary action steps, and compiled information for the Monthly ASP Tracking Report. Review of the facility's Infection Prevention and Control Program revised 3/21/25 showed the infection prevention program process included a system for identifying, reporting, investigating, and controlling infections and communicable diseases within the facility. Review of the facility's facility-wide tracking and trending Infection Control Logs by units showed:-The One South unit showed:--A map of the unit for the month of July 2024 with no infections written on it.--A map of the unit for the month of August 2024 with nine infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.---None of the required documentation from the Antibiotic Stewardship policy. --A map of the unit for the month of September 2024 with three infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.---None of the required documentation from the Antibiotic Stewardship policy. --A map of the unit for the month of October 2024 with no infections written on it.--A map of the unit for the month of November 2024 with one infection depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.---None of the required documentation from the Antibiotic Stewardship policy. --A map of the unit for the month of December 2024 with no infections written on it.--A map of the unit for the month of January 2025 with no infections written on it.--A map of the unit for the month of February 2025 with no infections written on it.--A map of the unit for the month of March 2025 with no infections written on it.--A map of the unit for the month of April 2025 with no infections written on it.--A map of the unit for the month of May 2025 with no infections written on it.--A map of the unit for the month of June 2025 with no infections written on it.--There was no tracking for the month of July 2025.-The Two North unit showed:--A map of the unit for the month of July 2024 with no infections written on it.--A map of the unit for the month of August 2024 with one infection depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of September 2024 with one infection depicted by (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of October 2024 with 10 infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of November 2024 with two infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of December 2024 with no infections written on it.--A map of the unit for the month of January 2025 with no infections written on it.--A map of the unit for the month of February 2025 with no infections written on it.--A map of the unit for the month of March 2025 with one infection depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of April 2025 with one infection depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of May 2025 with two infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--There was no infection tracking for June 2025 and July 2025.-The Three South unit showed:--A map of the unit for the month of July 2024 with one infection depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of August 2024 with 14 infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of September 2024 with four infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of October 2024 with three infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of November 2024 with one infection depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of December 2024 with one infection depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of January 2025 with two infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of February 2025 with no infections written on it.--A map of the unit for the month of March 2025 with three infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of April 2025 with seven infections depicted by room number.---No antibiotic listing report.---No laboratory reports or X-ray reports.--A map of the unit for the month of May 2025 with no infections written on it.--There was no infection tracking for June 2025 and July 2025.-The Three North Unit showed no infection tracking for any month from July 2024 to July 2025.-For the month of August 2025, all the units were combined and showed 18 residents had infections with no lab or X-ray results. During an interview on 8/21/25 at 1:27 P.M., the IP said:-He/She had been asked to be the IP three weeks ago.-The infection tracking material he/she provided was all the prior IP had left. -He/She knew that items like lab and X-ray results were not included.-He/She knew the infection tracking book was not complete and was deficient.-He/She was starting over with the infection tracking book starting from when he/she assumed the position. -The facility had recently hired an IP and that person would be taking over the infection tracking for the facility. During an interview on 8/22/25 at 1:30 P.M., the DON said:-It was the IP's job to maintain the infection prevention responsibilities and that included the infection tracking book. -The current IP had only been in the position for three weeks.-The facility had hired a new staff member who would assume the IP position. -The previous IP did not have an infection tracking book. -The infection tracking book should have in it:--A map of each unit that showed where the infections were and all residents on enhanced barrier precautions (EBP).--The required reports from the ABS policy.--The monitoring criteria for infections.--Lab and X-ray results.--A list of residents on antibiotics and which antibiotics were being used.--Any education provided when trends were identified. -He/She was responsible for ensuring the infection tracking book was done and for auditing the infection tracking (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one sampled resident (Resident #31) was invited to their care plan meeting out of 26 sampled residents. The facility census was 131 residents.A facility policy related to care plan invitations was requested and not received prior to exit.1. Review of Resident #31's admission record showed he/she admitted to the facility with a diagnosis of Hemiplegia (paralysis to one side of the body) and Hemiparesis (partial weakness affecting one side of the body) following Cerebral Infarction (ischemic stroke- occurs as a result of disrupted blood flow and restricted oxygen to the brain) affecting the left non-dominant side.Review of the resident's Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) note dated 6/12/25 at 4:51 P.M. completed by MDS Coordinator B showed he/she had reached out to the resident's Durable Power of Attorney (DPOA- a legal document that gives a designated person the authority to make medical, financial, or legal decisions for the person who created the document) related to scheduling a care plan meeting.Review of the resident's MDS note dated 6/12/25 at 5:16 P.M. completed by MDS Coordinator B showed he/she had heard back from the resident's DPOA and they declined a care plan meeting at that time.Review of the resident's annual MDS dated [DATE] showed the resident was cognitively intact. During an interview on 8/19/25 at 9:46 A.M. the resident said:-He/she had not been getting invited to his/her care plan meetings.-He/she could make his/her own medical decisions.During an interview on 8/20/25 at 10:14 A.M. MDS Coordinator A said:-The resident's DPOA had not been enacted.-He/She had read the MDS note that was completed by MDS Coordinator B.-He/She thought MDS Coordinator B may have thought the resident's DPOA had been enacted.-The resident should have been invited to his/her care plan meeting.During an interview on 8/21/25 at 2:35 P.M. MDS Coordinator B said:-The resident was his/her own person.-The resident had initially declined a care plan meeting.-The resident had asked that his/her family member be invited to the care plan meeting.-He/She did not give residents written invitations to care plan meetings.-He/She normally documented the invitations in a note in the residents' charts.-He/She dropped the ball and should have documented a better note related to the care plan invitation.During an interview on 8/22/25 at 12:40 P.M. Certified Medication Technician (CMT) B said:-The resident was his/her own person.-The resident was able to make his/her own medical decisions.-Social Services and the MDS Coordinators invited residents to their care plan meetings.-He/She thought that the invitations were written and that residents signed the invitation.-The resident should have been invited to his/her care plan meeting.During an interview on 8/22/25 at 12:55 P.M. Licensed Practical Nurse (LPN) B said:-He/She was unsure if the resident was his/her own person.-He/She was unsure if the resident could make his/her own medical decisions.-He/She was unsure of who invited residents to care plan meetings.-Residents could be invited to their care plan meetings by phone call or written invitation.-The resident should have been invited to his/her care plan meeting.-It was important that residents were a part of their care plan meetings because the care about them.During an interview on 8/22/25 at 1:10 P.M. LPN A said:-The resident was his/her own person.-The resident was able to make his/her own medical decisions.-The MDS Coordinators were responsible for care plan invitations.-He/She was unsure if the resident was invited to his/her care plan meeting.-He/She had given MDS Coordinator B a format on 8/21/25 on how to invite residents to their care plan meetings.During an interview on 8/22/25 at 1:46 P.M. the Director of Nursing (DON) said:-The resident's DPOA had not been enacted.-The resident was his/her own person.-He/She thought the resident had been invited to his/her care plan meeting.-MDS Coordinator B's note should have been written better to indicate the resident had been invited.-Care plan meeting invitations needed to be written.-All residents who were their own responsible party should be invited to their care plan meetings.

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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Health Lakewood Medical 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered with an error rate of less than five percent (%). Two medication errors were detected out of 38 observed opportunities resulting in a medication rate of 5.26 %. One error involved administration of insulin (medication used to treat high blood sugars) with an insulin pen (an injection device that delivers preloaded insulin by dialing a desired dose) and one error involved the correct method for measuring the quantity of a liquid medication). In addition, the facility failed to have a policy that addressed insulin pens, including to follow manufacturers' instructions regarding how many units of insulin to use in priming differed insulin pens. The facility census was 131 residents.Review of the facility Insulin Injection Administration policy dated 11/11/23 showed:-Use of insulin pens (an insulin delivery system that generally looked like a large pen, used an insulin cartridge rather than a vial, and used disposable needles for injection of insulin) was not addressed in the policy.Review of https://pi.lilly.com/insulin-lispro-kwikpen-us-ifu.pdf, dated July 2023 showed the following instructions:-Pull the pen cap off.-Wipe the rubber seal with an alcohol swab.-Check that the liquid in the pen is clear and colorless.-Attach a new needle to the pen.-Prime the pen before each injection.-Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the Pen is working correctly.-To prime the pen, turn the dose knob to select 2 units.-Hold the pen with the needle pointing up.-Tap the cartridge holder gently to collect air bubbles at the top.-Continue holding the pen with needle pointing up. -Push the dose knob in until it stops, and 0 is seen in the dose window.-Hold the dose knob in and count to 5 slowly.-You should see insulin at the tip of the needle.- If you do not see insulin, repeat the priming steps, no more than 4 times.-If you still do not see insulin, change the Needle and repeat the priming steps.-Turn the dose Knob to select the number of units you need to inject.-Check the number in the dose window to make sure you have dialed the correct dose.1. Review of Resident #81's Physician's Order Sheet (POS) dated August 2025 showed:-He/She had a diagnosis of type 2 Diabetes Mellitus (DM II a chronic condition in which the body either didn't produce enough insulin or didn't use it effectively resulting in high blood sugar levels). -Insulin Lispro Junior KwikPen subcutaneous (under the skin) Solution Pen injector 100 units (U) per milliliters (ml), inject 10 units under the skin with meals for DM II, dated 7/9/25.Observation on 8/20/25 at 7:49 A.M. showed:-Without first priming the resident's Lispro insulin pen with 2 units of insulin, he/she dialed the dose selector to 10 units.-He/she then administered the resident's insulin.During an interview on 8/20/25 at 11:33 A.M. Licensed Practical Nurse (LPN) C said:-He/she had not primed the resident's insulin with two units of insulin before dialing the resident's insulin pen to 10 units and administering the resident's insulin.-He/she had not ever heard or read anything regarding priming insulin pens.-He/she had never primed insulin pens before dialing the intended units of insulin he/she administered.2. Review of Resident #35's POS dated August 2025 showed:-He/She had a diagnosis of Percutaneous Gastrostomy Tube status (PEG tube a surgically created opening in the stomach through which a tube could be placed and used for feeding, providing fluids and for administration of medications).-His/Her physician ordered Levetiracetam (medication for preventing and controlling seizures) oral solution 100 Milligram (mg)/ml, give 11 ml via his/her PEG tube every 12 hours.Observation on 8/20/25 at 9:08 A.M. showed:-LPN C poured the resident's liquid Levetiracetam into a graduated medication cup (a plastic cup with increasing markings for measuring liquids in ml, including a marking for 10 ml followed by the next increase to 15 ml and no markings for 11 ml) to slightly above the line for 10 ml.-LPN administered the resident's Levetiracetam via the resident's PEG tube.During an interview on 8/20/25 at 11:33 A.M. LPN C said:-He/She always used a medication cup to measure the resident's Levetiracetam.-The resident's physician's order was for 11 ml's of Levetiracetam. -The medication cup he/she used did not have a mark for 11 ml.-He/she poured the resident's Levetiracetam to a little over the marking for 10 ml's.--That was the way he/she had always measured the resident's (continued on next page)

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	265845	A. Building B. Wing	08/22/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Levetiracetam.-He/she could have used a syringe to measure the resident's Levetiracetam. -He/she had never used a syringe to measure the resident's Levetiracetam.3. During an interview on 8/22/25 at 1:45 P.M. the Director of Nursing said:-He/she expected licensed nurses to prime insulin pens.-The facility practice was to prime all insulin pens with one unit of insulin.-He/she expected licensed nurses to use a syringe to measure 11 ml's of a liquid medication; that would be the only way to accurately measure the correct dose of the resident's Levetiracetam.