STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health and Wellness	2201 Glenn Hendren Dr Liberty, MO 64068

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51166 Based on observation, interview, and record review, the facility failed to ensure services that were provided met professional standards for one of four sampled resident (Resident #3), when staff failed to ensure a physician ordered medication, Protonix (a medication used to treat conditions that cause too much stomach acid), was available for three days. The facility census was 117. Review of the facility's Medication Administration Policy, dated 9/1/22, showed staff are to keep the medication cart stocked with adequate supplies and medications. Review of Resident #3's Quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 10/4/24, showed: -The resident was cognitively intact. -Diagnoses included: Cancer, heart disease, high blood pressure, stroke, and lung disease. Review of Resident #3's Medication Administration Record (MAR) for December 2024, showed three doses Protonix 20 mg were not administered once daily, as ordered, on 12/24/24, 12/25/24, and 12/26/24. Observation on 12/26/24 at 9:43 A.M., showed Certified Medical Technician (CMT) A searching for Protonix to give Resident #3, but could not find the medication in the cart. During an interview on 12/26/24 at 9:29 A.M., Resident #3 said he/she received the medication late the previous night and he/she had to go track the nurse down to get the evening dose. The resident said he/she was frustrated, because he/she had to find the nurse in order to receive his/her medications. During an interview on 12/26/24 at 9:55 A.M., CMT A said he/she called the pharmacy and was told the Protonix was delivered on 12/17/24 and that when medications are delivered to the facility, the medications are checked in and distributed to the medication carts on each hall. He/she was going to look for the Protonix to see if it was delivered. During an interview on 12/27/24 at 10:30 A.M., Licensed Practical Nurse A said the pharmacy delivers medications two to three times a day and when received, the medications should be distributed to the appropriate medication carts. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/26/24 at 3:15 P.M., the Director of Nursing (DON) said when a CMT cannot find the medication to be administered on the medication cart the CMT should check the overflow and then call the pharmacy. The nursing staff searched for the Protonix on 12/26/24 and could not find any of the appropriate dosage on the resident's orders. The DON said the medication had been requested from the pharmacy on 12/26/24 and they were awaiting delivery from the pharmacy. During an interview on 12/31/24 at 9:37 A.M., the DON said the pharmacy only delivers a week supply or a two week supply of medication, depending on what the insurance will pay for. During an interview on 1/3/25 at 2:50 P.M., the pharmacy confirmed they delivered a 30 day supply of 20 mg Protonix to the facility on [DATE] and it was signed for by staff. On 12/26/24 the pharmacy received an order at 12:46 P.M. for a 30 day supply of 20 mg Protonix and delivered it to the facility on [DATE] 3:04 P.M. MO246632

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 50980 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent injury for two residents, Resident #4 and Resident #5 when staff failed to ensure Resident #4 received supervision while receiving Physical Therapy when the resident lost the ability to stand and fell to the ground. The resident sustained a displaced (out of alignment) hip fracture of the right leg with right tibia fracture, which required hospitalization . In addition, staff attempted to transfer Resident #6 from the bed to the wheelchair and failed to use a gait belt (a special belt placed around the waist to provide a handle to hold onto during a transfer) as directed by the facility's gait belt policy and the the resident fell to the floor. Staff then transferred Resident #6 from the floor to the bed without a gait belt. Resident #6 sustained an acute medial malleolar fracture (a break in the bone on the inner side of the ankle) when the facility staff member was unable to transfer the resident to the resident's wheelchair from the bed. The facility census was 117. The Administrator was notified on 01/22/2025 at 12:00P.M. of an Immediate Jeopardy (IJ) which began on 12/18/2024. The IJ was removed on 01/22/2025, as confirmed by surveyor onsite verification. Review of facility policy, Safe Resident Handling/Transfers, dated 9/1/21, showed: - It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury; - The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. -All residents require safe handling when unable to transfer their self and require staff assistance for transfers. Safe handling of residents will include the use of gait belts, transfer boards, and other transfer devices. Review of an undated facility policy titled, Use of Gait Belt, showed it is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. -Gait belts are to be used by staff when assisting residents with transfers they are unable to do own their own. A facility policy regarding Physical Therapy Services was requested and not provided. 1. Review of Resident #4's Admission Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/13/24, showed: -A Brief interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment; -He/She had clear speech and usually made self understood and understands others; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-He/She used a walker; -He/She required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with toilet transfers, chair to bed transfers, transitioning from sitting to lying, lying to sitting, and siting to standing positions; -Diagnoses included: Hypertension (high blood pressure), Heart Failure, Chronic Respiratory Failure (shortness of breath), Muscle Weakness, Neuropathy (condition that causes numbness and pain in hands and feet), and Chronic Kidney Disease. Review of the resident's care plan, dated 12/9/23, showed: - He/She required short-term rehabilitation with a goal to discharge to home by 12/22/24; - He/She required oxygen therapy, administer oxygen as ordered, monitor for increased heart rate or confusion 12/17/24; - Care plan did not address ADL self-care performance deficits - Care plan did not address that resident required extensive assistance by (1-2) staff for mobility and transfers; - Care plan did not address physical therapy (PT)/occupational therapy (OT) evaluation and treatment per physician orders. - Care plan did not address resident as a risk for falls. - Care plan did not address use of gait belt or that staff should be close to the resident. Review of the Physician Order Summary Report, dated 12/17/24, showed: - OT may evaluate the resident and treat as indicated 12/6/24; - OT to evaluate and treat the resident 5x/week for up to 45 days to include their activity, their exercises, self care management training, and group therapy 12/9/24. Review of the Therapy Notes, dated 12/17/24., showed: - Precautions: Fall Risk; - Treatment Plan: Work on standing activities at the parallel bars to help improve functional mobility; - Fall incurred at parallel, heard a pop, COTA (Certified Occupational Therapy Assistant) turned around still holding gait belt and resident was on the floor; - The resident reported 10 out 10 pain score (10 being highest level of pain) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- The resident was picked up by COTA, Physical Therapy Assistant (PTA), and put back in chair, and returned to bed by therapy. Charge Nurse was then notified. Review of a video, dated 12/17/24, at the hospital, showed that the resident said: - He/She was at PT standing up and holding onto the parallel bars alone while performing marching steps. Staff were sitting 15 feet away and left him/her to do the marches. - He/She had previously told several staff members that he/she had a weak left leg; - He/She saw PT aides sitting at a counter about 15 feet away while he/she did the exercises alone; - His/Her left leg gave out and the right leg followed and he/she fell to the ground with one leg underneath him/her and he/she screamed out in pain, the resident felt an immediate pain in both legs; - The resident believed it occurred at around 10:00-10:15 A.M. that day; - Staff members came running over and provided aid after the fall, but were not close to him/her at the time of the fall. Review of hospital notes, dated 12/18/24 at 11:26 A.M., showed: - The resident arrived to the ER with right lower extremity deformity which resulted after doing therapy; - He/She said he/she was doing therapy when he/she fell and his/her right leg went underneath the other leg and there was a pop sound heard; - Imaging showed displaced hip fracture of the right leg; - Right tibia is mildly fractured; - After admission, his/her conditioned worsened during the night of, 12/17/24 after receiving intravenous (IV) pain medications. He/She was started on bi-level positive airway pressure (BiPAP) and moved to the Intensive Care Unit (ICU); - Orthopedic surgery was planning complete a a repair of the broken bones when the resident was cleared by cardiology for surgery. During an interview on 12/26/24 at 10:30 A.M. and 1/8/25 at 11:55 A.M., COT A said: - Goals of PT for Resident #4 was to increase standing endurance and ambulating tolerance five times a week in therapy. - The resident required staff supervision during exercises and ambulation; - The resident required two person physical assistance with a gait belt when moving from sitting to standing and ambulating; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- The purpose of the gait belt is to secure the resident from falling and to maintain balance during ambulation and exercises; - The gait belt serves as an aid for the therapy staff to provide balance support to the resident; - The resident was always wearing a gait belt while in PT; - He/She could not remember who put the gait belt on the resident that day; - The resident was working with PTA A on 12/17/24, the date the fall occurred and he/she did not see the resident fall; - At the time of the fall, PTA A was assigned to the gait belt for the resident; - He/she did not hear the resident say anything before the fall. He/she was sitting on a stool with his/her back turned away from the resident: - He/She heard the resident say aloud that his/her knee buckled; and heard the resident fall; - He/she turned and saw PTA A holding onto the gait belt with one hand and standing over the resident who was on the ground with leg under their body; - He/She heard the resident express pain while sitting on the floor; - He/she did not know the resident had a weak left leg or that there was anything wrong with the resident's legs or he/she would have been more prepared to prevent an accident. - He/She did not believe the resident was at risk for falls, but should have a gait belt for safety measures. During an interview on 12/26/24 at 10:50 A.M. and 1/8/25 at 1:30 P.M., PTA A said: - He/she had worked with the resident about six times in the past month; - Goal was to increasing strength in lower extremities, improved transferring, walking, and sitting to standing position; - He/She was unsure when the last evaluation was done on the resident. Updates on residents were provided once a week at lunch time training; - The resident was not to do exercises unsupervised or to be left alone standing; - PTA A was working with the resident and a group of two other residents at the same time. - The resident was wearing a gait belt for safety; - The resident was wearing a gait belt on 12/17/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- PTA A had access to the resident's care plan, but had never reviewed it prior to working with the resident; - The resident had both hands on one parallel bar standing at the side of the bar, PTA A was standing to the left of the resident with one hand inserted under the gait belt; - COT A was at the right side of the resident a few feet away, but was standing and turned away from the resident; - There was a wheelchair chair located directly behind the resident to help the resident in case of a fall; it was not utilized; - The resident was doing step up exercises at the parallel bar while PTA A was holding onto the underside of the resident's gait belt; - PTA A was not looking at the resident and had turned his/her head away to talk with other people at the time of the fall; - The resident did not make any sound and suddenly dropped straight down from a standing position to the floor with his/her left leg landing on the ledge of the parallel bars; - PTA A did not witness the fall, but was aware the resident had fallen when his/her arm was pulled downward and he/she heard the resident cry out in pain; - He/She was not expecting the resident to fall and did not have time to do anything to keep the resident from hitting the ground; - Therapy staff immediately went to provide assistance to the resident and the resident was yelling out that his/her leg hurt; - He/She believed the resident was a high risk for falls. During an interview on 12/26/24 at 10:15 A.M. and 1/8/25 at 3:15 P.M., the Director of Rehabilitation said: - An external physical therapist did the initial evaluation and therapy plan for the resident, but a reevaluation would not be done until session ten and only eight sessions had been done so far; - Goals included: skills for going home, functional mobility, sitting to standing to walking, and improved endurance; - All staff therapists and aides have access to the therapy treatment plan and are expected to review the goals and any precautions; - The resident was considered a fall risk; - Gait belts are used for anyone that is a fall risk; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- If a resident is wearing a gait belt they would be supervised with a staff member right beside them and a chair positioned directly behind the resident to act as a safety net when working with the parallel bars; - Goal of PT is to provide safe mobility for residents; - PTA A and COT A were working with the resident at the parallel bars when the fall occurred. - He did not observe the fall, but earlier had seen the aides working with the resident using a gait belt and a chair; - Expectations of the PTAs is to implement daily treatment for the resident and ensure the resident's safety during therapy activities; - He expects therapy staff to keep visual contact with the resident and focus on the resident; - When he heard the fall, he came out of his office and saw the resident lying on the ground with PTA A holding onto the gait belt in a bent over position; - PTA A, PTA B, and himself lifted the resident into the wheelchair and took him/her to the nurse for assessment, he then called the Director of Nursing (DON) to report the event; - All eyes and focus should be on the resident while holding on to the the gait belt when a resident is working at therapy. Review of Resident #5's Quarterly MDS, dated [DATE], showed: - No hearing or vision deficiencies, could understand and make themselves understood; - A BIMS score of 14, indicating no cognitive impairment. During an interview on 1/24/25 at 9:48 A.M. Resident #5 said: -He/she would not forget the day, Resident #4 fell and was hurt. -Resident #4 fell hard and fast and had been standing alone at the walking bars. -The surveyor confirmed this statement a second time and Resident #5 said, before Resident #4 fell , he/she was alone standing at the walking bars. -Another resident whom she was visiting with in the therapy room made a comment about Resident #4 having swollen legs and feet, I heard the words swollen legs so I turned to look at Resident #4 and saw he/she was standing alone and then fell straight down fast. -Resident #5 did not recall if Resident #4 had a belt around his/her waist or not. -Resident #5 said he/she observed the therapy staff all rushing toward Resident #4 when he/she started to fall, but he/she went down fast before they could catch him/her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-Resident #5 said he/she watched the therapy staff pick Resident #4 up off the floor and put him/her in a wheelchair and take him/her out of the therapy room. Resident #4 was crying out. During an interview on 12/26/24 at 2:15 P.M., Licensed Practical Nurse B said: - Resident #4 required two staff members to stand up, but once the resident was up he/she was mobile; - Resident #4 came from the hospital and needed PT for improving strength; - When using a gait belt the staff member should walk with a resident positioned on their side with their hand gripping the underside of the gait belt; - The staff member's main function when assisting with the gait belt is to take pressure off of a fall when a resident is going down; - Staff members need to be focused with their full attention on the resident and their surroundings when working with a gait belt; - Staff members should pay close attention to the resident when providing assistance and use visual and audio cues such as a stumble or hesitation which might contribute to the resident falling so they are ready to take action; During an interview on 12/26/24 at 3:30 P.M., Administrator and DON said: - A gait belt's effectiveness is more dependent on the mobility of a person and not the size of the person a staff member has to care for; - You can't prevent a person from falling in a gait belt, you can only help them lower to the ground, but if it happens suddenly there's nothing you can do to prevent them from hitting the ground; - A staff member assigned to a gait belt on a resident is there to reduce the impact of a fall; - Resident #4 had a history of his/her knee buckling and it was not uncommon for that to occur; - PT reported they heard a pop then the resident went down immediately. 2. Review of the Resident #6's Annual MDS, dated [DATE], showed: -Cognitive skills intact. -Upper and lower extremities impaired on one side. -Required supervision with upper dressing. -Dependent on the assistance of staff for toilet use and showers. -Required substantial assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-Always incontinent of bowel and bladder. -Diagnoses included a fracture, stroke, hemiparesis (a medical condition that causes weakness on one side of the body), Multiple Sclerosis (a chronic, autoimmune disease that affects the central nervous system (brain and spinal cord)), anxiety, and depression. Review of the resident's care plan showed falls risk and interventions were not care planned. Review of an incident report, dated 12/19/24, regarding Resident #6 showed: -Description: 3:09 P.M. Registered Nurse (RN) A was called into the resident's room by the shower aide who had just finished giving the resident a shower. The shower aide said the resident was lowered to the floor during the transfer from the bed to the electric wheelchair and he/she needed help to get the resident up from the floor. Upon arrival in room, the resident was found sitting on the floor with his/her legs extended in the front. The resident was assisted back to the electric wheelchair. No injury noted. The resident did complain of pain in right ankle. Skin on right ankle looked intact, no swelling noted upon assessment. Tramadol administered for pain. The resident stated relief from pain after medication administered. The resident stayed in his/her electric wheelchair for the rest of the afternoon. No skin impairment noted. -Immediate action taken, right ankle assessed. Transferred to his/her wheelchair, pain assessed, and pain medication administered. The resident was not transferred to the hospital. -Injuries observed at the time of the incident: no injuries noted at the time of the incident. -Agencies/people notified: The DON and the physician were notified on 12/20/24 at 10:00 A.M. -Notes: The resident was being transferred by staff from bed to his/her electric wheelchair with gait belt when the resident's electric wheelchair was not angled correctly causing staff member to lower him/her to the floor. As the resident was being lowered to the floor, resident's right leg twisted inward. No body parts struck anything when lowered to the floor. The resident stated he/she was having some pain in ankle. The resident's ankle was assessed, and no impairment noted, and pain pill was administered. Staff to ensure the resident's electric wheelchair was positioned properly prior to transferring. Review of the resident's progress notes, dated 12/20/24 at 10:44 A.M., showed: -Registered Nurse (RN) A was called into the resident's room by the shower aide who just finished giving the resident his/her shower. The shower aide told the nurse that resident was lowered to the floor during transfer from bed to wheelchair and the shower aide needed help getting the resident off the floor. Upon arrival in room, the resident was found sitting on the floor with his/her legs extended in the front. The resident was assisted back to the electric wheelchair. No injury noted. The resident did complain of pain in right ankle. Skin on right ankle looked intact, no swelling noted upon assessment. Tramadol administered for pain. The resident stated relief from pain after medication administered. The resident stayed in his/her electric wheelchair for the rest of the afternoon. No skin impairment noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the resident's fall risk assessment, dated 12/20/24 at 11:01 A.M., showed the fall risk score was 26. High risk indicates a score of 18+. Review of the resident's physician order sheet (POS) showed: -Start date: 10/19/24 - Tramadol 50 mg one tablet every six hours as needed for pain. -Start date: 12/21/24 - Oxycodone tablet five milligrams (mg) one tab every six hours as needed for severe pain of the right lower leg/foot. Review of the resident's medication administration record (MAR), dated December 2024 showed: -Tramadol 50 mg one tablet every six hours as needed for pain. Staff documented as administered on 12/19/24. -Start date: 12/20/24 - X- Ray 2 view of right ankle, pain, swelling, bruising. Portable due to immobility. -Oxycodone tablet five mg one tab every six hours as needed for severe pain. Staff documented as administered once on 12/22/24 and 12/27/24. Review of the resident's radiology results report, dated 12/20/24 at 1:24 P.M., showed acute medial malleolar fracture (a break in the bone on the inner side of the ankle). Review of the resident's care plan, initiated on 1/22/25, showed: -The resident is at risk for falls. Interventions included anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it. Educate the resident/family/caregivers about safety reminder and what to do if a fall occurs. Ensure the resident is wearing appropriate footwear. Follow facility fall protocol. -The resident had an activities of daily living (ADL) self-care performance deficit related to stroke with left hemiparesis and multiple sclerosis. Interventions included: the resident is totally dependent on the assistance of one staff for showers. The resident required limited assistance of one staff for bed mobility. The resident required limited assistance of one staff for dressing. The resident required extensive assistance of two staff for transfers. Review of the facility's undated investigation summary showed: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-The interdisciplinary team (IDT) completed a review of the resident's witnessed fall on 12/19/24. Per record review and statement, it is determined the resident experienced a witnessed fall, where the resident was lowered to the floor by CNA with use of a gait belt, when the resident was unable to fully complete his/her transfer from bed to chair and the resident was not able to make it back to the bed. The resident was gently lowered to the floor to reduce potential injury from a fall at standing height. While being lowered to the floor, the resident's ankle twisted. Immediately after, the resident's pain was treated and there was no obvious injury at the time. The physician was notified, and X-ray was obtained the following day. The X-ray revealed a fracture to the right ankle. Orthopedics was consulted for the resident. After analysis of the event detail, it is determined that the root cause of the event was the resident was unable to fully complete transfer, as was their previous baseline of transfers with one person staff assistance. The staff involved was educated on the resident's new level of care including positioning of the resident's wheelchair, and this intervention was added to the resident's care plan and Kardex (a desktop file system that gives a brief overview of each resident and is updated every shift). -At the time of the incident, the following interventions were in place, in accordance with the resident's care plan: anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; educate the resident/family/care givers about safety reminders and what to do if a fall occurs; encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; ensure commonly used items are within reach of resident prior to leaving the room; ensure that the resident is wearing appropriate footwear; follow facility fall protocol, low bed, physical therapy (PT) evaluate and treat as ordered or as need. The resident needs a safe environment; a working and reachable call light; the bed in low position at night; personal items within reach. -Discussion was held among the IDT. The following intervention is recommended to assist in reduction of recurrence; staff to ensure wheelchair is positioned properly prior to transferring. -This intervention has been reviewed with the resident. They agree with this intervention. During an interview on 1/24/25 at 11:49 A.M., the resident said: -On 12/19/24, the shower aide had just completed his/her shower, placed him/her in bed and dressed him/her. The shower aide did not use a gait belt, but placed his/her arms around him/her and lifted him/her up to transfer the him/her into his/her electric wheelchair. -At the time, the resident was able to stand and pivot. -The shower aide was not able to transfer him/her into the electric wheelchair and tried to lower him/her to the floor easily. -The shower aide left to get assistance from another staff member to get the resident up from the floor, the resident did not remember the name of the staff member that came in to help. -Another aide came back into the resident's room, and they did not use a gait belt or a mechanical lift to get him/her off the floor. The aides grabbed the resident's arms and legs and lifted him/her up into the electric wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health and Wellness	2201 Glenn Hendren Dr Liberty, MO 64068

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-The nurse came in and moved the resident's foot around and the resident complained of pain. -The nurse gave him/her a Tramadol for the pain. The resident stated it hurt really bad and the ankle was starting to swell. -The facility sent the resident out to the local hospital the next day. The resident fractured his/her right ankle and must wear a boot for 30 days to determine if he/she will require surgery. -The resident missed Christmas with his/her family because he/she was non weight bearing status and he/she was very upset about not being able to spend time with them. During an interview on 1/24/25 at 3:05 P.M., CNA B said: -He/she started working at the facility in December 2024. He/she routinely gave showers to residents on the top 100 hall. -On 12/19/24, after he/she gave the resident a shower, he/she transferred the resident back to bed to get the resident dressed. CNA B said he/she put the gait belt around the resident to transfer the resident into the electric wheelchair. -During that transfer CNA B had to lower the resident to the ground because the electric wheelchair was not close enough to guide the resident into the wheelchair. -He/she tried to lower the resident down easily, but the resident's right foot was under him/her. -He/she had the nurse and another CNA assist him/her to pick up the resident from the floor and put him/her into the electric wheelchair. -They grabbed the resident's arms and legs and lifted him/her up into the electric wheelchair. -The charge nurse came in and did an assessment on the resident. - He/she gave his/her statement to the DON on the same day. During an interview on 1/24/25 at 3:32 P.M., RN A said: -He/she could not remember what day the resident was on the floor. -RN A was in the hallway when CNA B informed him/her that he/she had lowered the resident to the floor and needed assistance to get the resident up from the floor. -He/she entered the resident's room with CNA A and CNA B. -The resident's bed was in the low position and the resident was right next to the bed with his/her legs out in front of him/her. The resident did not have a gait belt on him/her when he/she entered the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-RN A said he/she placed a gait belt around the resident's waist and all three of them lifted the resident up and placed him/her back in the electric wheelchair. -The resident did not complain of any pain until about 30 - 40 minutes afterwards and he/she gave the resident a Tramadol for pain. -He/she should have documented the incident on the date it occurred and notified the DON the resident was transferred without a gait belt. During an interview on 1/24/25 at 2:08 P.M., CNA A said: -They have a Kardex on the computer and it tells them how a resident is supposed to be transferred and can look at the residents' care plan. During an interview on 1/24/25 at 2:40 P.M., LPN C said he/she would look at the resident's care plan to see how they were supposed to transferred. During an interview on 1/24/25 at 4:19 A.M., the Administrator and the DON said: -The resident was lowered to the floor on the evening of 12/19/24. -RN A should have entered the information as a late entry. -RN A thought since the resident was lowered to the floor, it was not an actual fall. -The DON did an in-service with all the staff the next day and went over it with them when it was reported to her the resident was having swelling and pain in the right foot. -The resident and CNA B told the Administrator and the DON the staff had used a gait belt. -RN A should have notified the DON about the resident being lowered to the floor and the resident not being transferred with a gait belt. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the G level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO246757 MO248417