STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER: Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE: 2201 Glenn Hendren Dr Liberty, MO 64068	

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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 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44993

Based on observation, interview, and record review, the facility staff failed to provide complete perineal care, (cleaning the private area of the resident's anatomy), for two dependent residents (Resident #2 and #3). This deficient practice affected two of three sampled residents. The facility census was 118.

Review of the facility policy titled Perineal Care, dated 9/1/21, showed:

- Perineal care is to be provided to all incontinent residents as needed to promote cleanliness and prevent infection;

- Cleanse front to back;

- Separate the vaginal folds with one hand and cleanse with the other hand and a wipe, wiping front to back;

- Use a separate wipe with each swipe.

1. Review of Resident #2's Quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility), dated 11/19/24, showed:

- The resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive deficit;

- Diagnoses included: Paraplegia (the resident can not voluntarily move his/her lower half of body), bladder incontinence, and anxiety;

- The resident was dependent on staff to provide personal hygiene, getting dressed, and urinary catheter care;

- The resident had an indwelling urinary catheter.

Review of the resident's activities of daily living (ADLs) care plan, dated 5/25/23, showed the resident had an ADL self-care deficit. Interventions showed the resident was dependent on staff for bed mobility and toileting.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/3/25 at 7:43 A.M., the resident said: - He/She had a chronic Urinary Tract Infection (UTI); - He/She had a burning sensation when he/she urinated. Observation on 3/3/25 at 10:00 A.M., showed: - The resident was lying on his/her back in bed; - Certified Nurse Aide (CNA) A and Nurse Aide (NA) A entered the resident's room; - Both staff put on gloves and did not perform hand hygiene; - CNA A turned the water on at the sink and laid a hand towel in the sink bowl to wet it; - CNA A removed the wet hand towel from the sink bowl, saturated it with peri-wash (cleanser used to clean the perineal area); - CNA A used the wet hand towel, wrapped it around his/her hand, cleansed the perineal area by wiping front to back in a scrubbing motion multiple times using the same area of the towel; - CNA A did not separate resident's perineal area folds and clean the area; - NA A turned the resident to his/her side; - CNA A wiped the resident back to front with a different area of the same hand towel. During an interview on 3/3/25 at 10:15 A.M., CNA A said: - He/She should have used wipes to clean the resident; - He/She should not have laid the hand towel in the sink bowl; - He/She should have separated the resident's perineal folds and cleaned the area; - He/She should have used one swipe, then obtained a clean cloth or wipe and swiped again when cleaning the resident; - He she should have cleaned the resident's back side front to back and should not have cleaned with a back and forth scrubbing motion. During an interview on 3/3/25 at 10:39 A.M., Licensed Practical Nurse (LPN) C said: - He/She expected staff to use wipes when providing perineal care and not hand towels; - He/She expected staff to hold the cloth under the water and not lay it in the sink bowl; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- He/She expected staff to provide perineal care by swiping front to back one time per wipe; - He/She did not expect staff to scrub back and forth using the same area of the hand towel. During an interview on 3/3/25 at 2:47 P.M., the Director of Nursing (DON) said: - She expected staff to provide perineal care for Resident #2, by cleaning front to back and separating the perineal folds and cleaning; - Staff are not suppose to scrub back and forth when providing perineal care; - Staff should not have placed a hand towel directly in the sink bowl, they should have held the towel under the water. 2. Review of Resident #3's quarterly MDS, dated [DATE], showed: - He/She had a BIMS score of 13, indicating minimal cognitive deficit; - Diagnoses included: Need for assistance with personal cares and reduced mobility; - The resident was dependent on staff to use the toilet, shower, and provide incontinent care; - The resident was incontinent of bowel and bladder at all times. Review of the resident's ADL care plan, dated 8/12/24, showed the resident was dependent on two staff to provide bathing and toilet use. Observation on 3/3/25 at 9:23 A.M., showed: - The resident was lying in bed; - CNA B and CNA C entered the resident's room; - Both staff put on gloves; - CNA B pulled the resident's blanket away from the resident; - CNA B removed a wipe from the package and wiped down one side of the groin, wiped down the other side of the groin with the same area of the wipe, then wiped down the center of the perineal area with a different part of the same wipe; - CNA C turned the resident to his/her side; - CNA B wiped the resident back to front back and forth with the same wipe. During an interview on 3/3/25 at 9:30 A.M., CNA B said: - He/She was taught to one wipe, one swipe when providing perineal care; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- He/She should have used a clean wipe with each swipe front to back; - He/She should have separated the resident's perineal folds to clean; - He/She should not have wiped back to front back and forth when cleaning the resident's bottom. During an interview on 3/3/25 at 10:39 A.M., LPN C said: - He/She expected staff to use a clean wipe with each swipe when providing Resident #3 perineal care; - He/She expected staff to wipe front to back and separate the resident's perineal folds to clean. During an interview on 3/3/25 at 2:47 P.M., the DON said: - She expected staff to use a clean wipe with each swipe when they provided perineal care for Resident #3; - She expected the staff to separate the resident's perineal folds and clean the area; - She expected staff to wipe front to back. MO250276

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 44939 Based on observation, interview, and record review, the facility failed to provide adequate supervision, identify an elopement risk, implement safety measures, and prevent one resident (Resident #1), who had recently been deemed incapacitated, from leaving the facility unsupervised. The resident informed staff he/she was going out to smoke, left the facility and was observed by facility staff sitting outside the hospital next to the facility. The facility failed to follow their policy and procedure for elopements. Eight hours later the resident was found at a hospital approximately 18 miles away from the facility. The facility census was 118. The Administrator was notified on 3/3/25 at 4:33 P.M. of the Immediate Jeopardy (IJ) which began on 2/25/25. The IJ was removed on 3/3/25 as confirmed by surveyor onsite verification. Review of the facility's Elopements and Wandering Residents policy, dated 9/1/2022, showed: -This facility ensures that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk; -Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. -The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary; Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering - Residents shall be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. - Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. - Adequate supervision will be provided to help prevent accidents or elopements. Procedure for Locating Missing Resident -Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g. internal alert code). -The designated facility staff will look for the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-If the resident is not located in the building on or around the grounds, Administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. The administrator or designee should also notify the company's corporate office; -Director of Nursing (DON) or designee shall notify the physician and family member or legal representative. -Police will be given a description and information about the resident; include any photos. -All parties will be notified of the outcome once the resident is located. -Appropriate reporting requirements to the State Survey agency shall be conducted. Procedure Post-Elopement -When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility. -Documentation in the medical record shall include: findings from nursing and social service assessments, physician/family notification, care plan discussion, and consultant notes as applicable. Review of the facility's Therapeutic Leave policy, dated 3/21/24, showed: -The facility will inform the resident/resident representation of the therapeutic leave policy. -Therapeutic leave is defined as an absence for purposes other than required hospitalization . -Residents and/or resident representatives will be informed of the facility's bed hold and therapeutic leave policy on admission, at time of transfer to another facility, when the resident goes on therapeutic leave and with any change to the policy. -Residents may participate in therapeutic leave as approved by the physician/practitioner. -When taking therapeutic leave, the resident will notify the facility team of when they are leaving and of the anticipated return and where they plan to visit. -Upon admission/readmission from hospital and with quarterly assessment, the resident should be screened before leaving the facility independently. -The facility should determine if any medication need to be packaged and sent with the resident. -The facility should determine if any safety items need to be provided to the resident, such as information on facility location/address/phone number, etc. -The facility will not treat situations where a resident goes on therapeutic leave and returns later than agreed upon, as a resident-initiated discharged . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident will be permitted to return and be appropriately assessed for any ill effects from being away from the facility longer than expected. -Physician will be contacted to determine if an what medication can be resumed based on assessment upon return. -If a resident has not returned from therapeutic leave as expected the medical record will show evidence that the facility attempted to contact the resident and/or resident representative within 4 hours of expected return time in consideration of missed medications and treatment. 1. Review of Resident #1's annual Minimum Data Set (MDS, a federally mandated assessment conducted by staff), dated 12/19/24, showed: -The resident had diagnoses of malignant neoplasm of brain (a cancerous growth that originates in the brain or central nervous system), senile degeneration (a neurological disorder that causes a gradual decline in mental function), nicotine dependence, weakness, unsteady on feet, encephalopathy (a change in how the brain functions), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), insomnia; -He/She had adequate hearing, clear speech, was able to make self understood and understands others; -He/She scored 15 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). This score indicates intact cognition; -The resident was able to walk, but was unsteady and walked behind his/her wheelchair for steadiness; -He/She has displayed no behaviors. Review of the resident's wandering assessment completed as a part of quarterly assessments on 5/22/24, showed: - The wandering assessment included information to assess for elopement; - The resident scored a one, indicating he/she was at low risk for wandering. Further review of the resident's medical record showed the facility staff did not complete any further wandering assessments after 5/22/24. Review of the resident's comprehensive care plan, dated 2/28/25, showed: -He/She was an elopement risk with impaired safety awareness. Interventions were added to the care plan on 2/11/25. Staff are to assess the resident for fall risk, monitor the resident for exit seeking behaviors, monitor the resident's location as necessary and document behavior. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physicians Order Sheet (POS), dated February 2025, showed: -2/22/24 Levetiracetum oral tablet 500 milligram (MG), give 1 tablet by mouth two times daily to treat seizures in morning and evening; - 12/2/24 Levothyroxine sodium oral tablet 25 micrograms (MCG), give 1 tablet by mouth every morning to treat thyroid function. Review of the resident's progress notes showed: -1/15/25: Social Services Designee (SSD) noted the resident is showing physical and cognitive declines due to brain cancer; -1/22/25: SSD noted during morning clinical meeting, the team decided the resident needed to be a supervised smoker due to his/her physical and cognitive decline. SSD met with the resident, who became upset when SSD explained he/she would now be a supervised smoker, stating he/she did not care and was going to go out anyway. The resident went up to the front and began pushing on the door, sounding the alarm. SSD attempted to speak with the resident and the resident said he/she was going out anyway and would find a door. The resident went to the side door and pushed the door until it opened and went out. The SSD went outside with the resident. The Director of Nursing (DON) came to assist and was able to get the resident to come back inside. Once inside, the DON and the resident came to a compromise that the resident could go out to smoke unsupervised if he/she took a wheelchair to assist with mobility; - The facility staff did not complete a smoking assessment after the clinical team made the decision the resident needed to be supervised while smoking; -2/8/25 10:11 A.M.: Registered Nurse (RN A) noted the nurse was called to the front desk because the resident said he/she was going out to smoke and then going to take a taxi to go out to shop. The nurse notified the DON, who stated the resident was not safe to go out alone and to get the resident back in the building. The resident was brought back inside and sat next to the nurses station. Later, the front desk staff called the nurses station again stating the resident was out smoking. The nurse advised the front desk staff to monitor the resident closely. A few minutes later, the front desk staff notified the nurse the resident was observed going up the hill to the main road. The DON and physician were notified. Staff left the facility to bring the resident back to the facility. The resident was brought back into the building at 10:40 A.M. The resident stated he/she would sign out Against Medical Advice (AMA). The nurse educated the resident on AMA. The resident agreed to wait at the facility for the SSD to arrive to speak with him/her. SSD arrived at the facility at 11:05 A.M. The resident told the SSD he/she was going to walk to the casino to make more money. The SSD discussed with the resident the weather and distance to the casino. The resident became more upset and stated that staff should just stick a knife into him/her and let him/her bleed and die. The resident then stood up, walked to the door, and pushed on the door until it opened. The resident walked outside and started to walk up the drive to the main road. When he/she reached the flower garden in the parking lot, he/she sat down and started smoking. The SSD reminded the resident of the appropriate smoking area and the resident said he/she said I don't care, I want to die anyway. Maybe I will fall and hit my head and die. Administrator was notified and Emergency Medical Services (EMS) was contacted. The resident was taken by EMS to the local hospital for evaluation; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-2/9/25 5:26 P.M.: The resident returned to the facility from the hospital. He/She was alert with intermittent confusion noted. Review of the resident's care plan showed the facility did not implement any new interventions after the resident's was noted to attempt to leave the facility during the smoke time on 2/8/25. Review of the resident's progress notes showed: -2/10/25 8:41 A.M.: The Administrator noted that he/she spoke with the resident's Durable Power of Attorney (DPOA) and explained the resident's physical and cognitive decline and confirmed the DPOA was still willing to make medical decisions for the resident when he/she was no longer able to do so. The DPOA agreed he/she was still willing. The Administrator explained the resident's recent behaviors and informed the DPOA the facility would be discussing the situation with the physician; -2/11/25 10:11 A.M.: The SSD noted the resident was upset and anxious and wanting to go out to run errands and wanted to walk and do them. The SSD explained to the resident that it was not safe to walk and assisted the resident in running errands. Review of the resident's care plan, updated 2/11/25, showed facility staff updated the resident's care plan to include the resident was an elopement and wandering risk. Interventions included: Do 15 minute checks on the resident for 72 hours, monitor for exit seeking behaviors and document, document wandering behavior and attempted diversional interventions in the behavior log. Review of the resident's electronic medical record showed the resident's physician signed a letter of incapacity on 2/14/25 with the rationale of senile dementia (a condition that causes a progressive decline in cognitive abilities, such as memory, thinking, and reasoning). The resident had a DPOA. Review of the resident's progress notes showed: -2/25/25 11:32 A.M.: The DON noted the resident was found to have cigarettes on his/her person. The DON approached the resident in the hall and asked him/her for the cigarettes and educated on having the smoking materials at the nurses station. The resident was agreeable and gave the DON the cigarettes. A few minutes later the resident was noted to be upset and wanted to go outside to smoke and to walk around. The DON gave the resident two cigarettes and a lighter. The resident signed him/herself out on the smoking log. -2/25/25 2:15 P.M.: The Administrator noted the resident signed him/herself out on the smoking log and to take a walk. Facility staff checked the outside of the facility and surrounding area, such as the gas station, casino and other shopping areas the resident likes to go. Per conversations with the DPOA, the DPOA was ok with the resident going out on walks, to the store, and other areas. Message was left for the DPOA regarding the resident leaving the facility and the physician was notified. -2/25/25 8:30 P.M.: The Administrator noted that an area hospital notified the facility the resident was brought into the emergency room by EMS due to experiencing confusion at a nearby store. The Administrator informed the emergency room staff the resident would be accepted back at the facility. A message was left for the resident's DPOA regarding the resident's location. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility log sheet form Smoking only showed: -The resident signed out on the smoking log on 2/25/25 at 11:11 A.M. Review of the Medication Administration Record, dated February 2025, showed: -The resident's did not receive ordered Levetiracetum oral tablet 500 milligram (MG), give 1 tablet by mouth two times daily to treat seizures in morning and evening on 2/25/25. - The resident's did not receive ordered Levothyroxine sodium oral tablet 25 micrograms (MCG), give 1 tablet by mouth every morning to treat thyroid function on 2/25/25. During an interview on 2/28/25 at 11:44 A.M., the resident's DPOA said: -He/She spoke with the facility Administrator regarding the resident's decline physically and cognitively; -About a month ago, he/she spoke to the SSD about the resident needing to be supervised when smoking; -The DPOA was in agreement with the resident going outside to smoke and on a walk on the grounds unsupervised, but was working on the understanding that the resident would not leave the property unsupervised. During an interview on 3/3/25 at 9:19 A.M., Licensed Practical Nurse (LPN) A said: -He/She was aware Resident #1 had a letter of incapacity signed by the physician on file; -The resident's cognition varied from day to day. On the days he/she was experiencing more confusion, his/her risk of elopement increased; -LPN A had received instructions to keep an eye on the resident, but not that the resident could not go outside unsupervised. During an interview on 3/3/25 at 9:27 A.M., the Receptionist said: -He/She was unaware the resident had a letter of incapacity signed by the physician on file; -Being incapacitated means that a person cannot make safe decisions for themselves; -The Certified Nurses Assistants (CNAs) would call up and let the Receptionist know when the resident was headed to the front door to go out and smoke. The resident would sign out on the smoking log before going outside; -If a resident signs out on the smoking log, it means they are going out to smoke, staying on the property, and then will be coming back in the building; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-When Resident #1 was out smoking, the Receptionist would check on him/her every 10-15 minutes. He/She would usually be outside smoking 30-60 minutes at a time; - The DON told the Receptionist to keep an eye on the resident when outside smoking; - The resident had left the property before and had to be brought back to the facility. He/She could not remember a specific date; -On February 25, the Receptionist checked on the resident while he/she was out smoking and didn't see him/her. The receptionist spoke to other residents out smoking and they did not know where the resident was. A housekeeping staff member, who had been outside, told the Receptionist he/she thought he/she had seen the resident sitting in front of the hospital next door to the facility. The Receptionist called security at the hospital and asked if anyone had seen the resident and provided a description. Security at the hospital checked the grounds and informed the Receptionist the resident was not at the hospital. The Receptionist then informed the Administrator the resident could not be located; -After the resident attended an oncology appointment in February, the resident has been speaking more of leaving the facility and going home. The receptionist notified the Administrator and DON of this; -The Receptionist has observed the resident attempting to exit the facility through the front door. When the front door would not open, the resident would attempt to exit through other exit doors. The resident would also tell the staff a different resident needed help and when the staff would be busy assisting that resident, Resident #1 would attempt to leave the building. During an interview on 3/3/25 at 11:16 A.M., Certified Medication Technician (CMT) A said: -He/She has witnessed Resident #1 attempting to leave the facility. The resident has also exited the facility and staff had to bring him/her back inside; -He/She was instructed to 'keep an eye on the resident', when the resident was outside smoking; -The resident had been on 15 minute checks supervision a few times to monitor his/her location; -CMT A was aware the resident had a letter of incapacity signed by a physician on file. CMT A said this means the resident was not able to make his/her own decisions; -If a resident signs out to smoke, this means the resident is going outside to smoke, not leave the property and will come back inside when the resident is done smoking. During an interview on 3/3/25 at 1:54 P.M., the SSD said: -The resident has had a decline in his/her cognition in the past two weeks. Sometimes it was difficult to determine if the confusion was due to decline in cognition or increased anxiety; -Sometimes the resident would want to go outside to clear his/her head; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 Glenn Hendren Dr Liberty, MO 64068	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The SSD noted that when he/she would take the resident out of the facility and tell him/her it was time to go back, the resident would display increased confusion; -When the clinical team determined the resident needed to be supervised while smoking due to mobility issues, it was upsetting and traumatizing for the resident. The clinical team and the resident came up with a compromise that the resident could go outside to smoke independently if he/she took a wheelchair with him/her. Independence is very important to the resident; -The resident had intermittent confusion. When he/she first came to the facility, he/she would make big trips independently, such as to the store or other shopping centers. A few weeks ago, the resident was upset and wanted to get out of the facility. The SSD took the resident to the casino. The SSD kept his/her distance from the resident but continued to monitor the resident's location while in the casino. The resident did not like change in routine, and it caused agitation in the resident; -Signing out on the smoking log shows the resident is outside smoking. Staff are to keep an eye on the residents while out smoking; -Since the resident signed out on the smoking log, the SSD would not expect the resident to be gone from the facility for over nine hours. The reason people were out looking for the resident was because he/she was upset about smoking; -The SSD does not complete elopement assessments. Nursing is responsible for completing these assessments. During an interview on 3/3/25 at 2:47 P.M., the DON said: -Leave of Absence is when a resident signs themselves out of the facility, leave the premises and comes back later. The resident and staff make preparations for the leave of absence for medications/meals, the physician and responsible party are notified, an order is put in for the resident to go on a leave of absence, the resident is taken out of the census, a progress note is put in the chart when the resident leaves and when the resident returns to the facility; -An elopement is when a resident leaves the facility without notifying staff or someone seeing them; -When a resident signs out on the smoking log, they are going out the front doors to smoke; -The resident said he/she wanted to go on a walk 2/25/25. The resident had a history of being upset and saying he/she wants to leave to go shopping or the casino; -On February 25, a staff member saw the resident at the front of the hospital next to the facility. When facility staff came to the hospital, the resident had gotten on the bus and left the hospital grounds; -Elopement assessments are completed by nursing quarterly in the electronic medical record. During an interview on 3/3/25 at 3:17 P.M., the Administrator said: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Therapeutic leave or leave of absence is when a resident signs out and says he/she is going out. Prior arrangement can be made for a leave of absence; -An elopement is if the resident does not sign out or is trying to leave and sneaks out of the facility; -Signing out on the smoking log is for both going out to smoke and leaving for therapeutic leave. Typically, a resident will sign out in the leave of absence book when leaving on therapeutic leave; -The resident had declining cognition and the physician signed a letter of incapacity. The administrator had spoken with the resident's DPOA about possibly transferring the resident a secure memory care unit on 2/11/25. The DPOA wanted the resident to be able to go out shopping and the casino and go out on walks; -On February 25, the resident signed out on the smoking log at 11:11 A.M. The administrator saw the resident outside smoking at 11:40 A.M. At approximately 11:50 A.M., a member of the housekeeping staff said the resident was seen sitting outside the hospital next to the facility. Staff began searching the surrounding areas and places the resident liked to go; -The resident did not say he/she was going to leave the property; -She called the police on 2/25/25 at approximately 1:30 P.M. to see if they have seen the resident or had any reports of the resident being spotted; -She was unable to provide the name of the officer or a police report number; -This was a leave of absence because the resident was not fully incapacitated and could make the decision to leave the facility without supervision. -A local hospital, approximately 18 miles south of the facility, contacted the facility at approximately 8:30 P.M. on 2/25/25. The administrator spoke to the emergency room physician and confirmed the resident would be accepted back at the facility. The resident went to a local store and called the ambulance from the store. The resident did not want to go to the nearest hospital and was taken to the hospital the physician was calling from; -The resident returned to the facility on [DATE] around 11:30 A.M. The hospital set up transportation for the resident, so the facility did not send a staff member to pick up the resident; - There were no noted injuries. During an interview on 3/3/25 at 1:30 P.M.,the police dispatcher said there was no record of any calls involving the facility or resident on 2/25/25 or 2/26/25. During an interview on 3/3/25 at 1:30 P.M. the police records clerk said there was no record of any calls on 2/25/25 or 2/26/25 regarding the facility or the resident. If a call had been made, there would be a record of it, even if there was no official report taken. During an interview on 3/3/25 at 2:52 P.M., the physician said: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She signed the letter of incapacity on 2/14/25 due to the resident's decline in cognition; -He/She was aware the resident left the faciity on [DATE] without notifying anyone; -The resident was unsafe to leave the facility without supervision due to his/her declining cognition. During an interview on 3/6/25 at 10:35 A.M., Resident #1 said: -On the day he/she left the facility, he/she was upset about not being able to have his/her cigarettes on his/her person; -He/She was not sure how, but he/she ended up at a truck stop off of the Interstate. He/She was familiar with truck stops due to history of being an over the road truck driver; -He/She wanted to get back to the facility, but was not sure how. He/She got on a bus at the truck stop and rode it for about two full trips. He/She then got off at a store. He/She was not sure who called the ambulance or why the ambulance took him/her to the hospital far from the facility. 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. At the time of exit, the severity of the deficiency was lowered to the D 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). MO250250 MO250271

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44993 Based on observation, interview, and record review, the facility failed to provide urinary catheter care in a manner to prevent urinary tract infections (UTIs) for one resident (Resident #4). This deficient practice affected one of three sampled residents. The facility census was 118. Review of the facility policy titled Catheter Care, dated 9/1/21, showed: - With a clean wipe, starting at the body and moving away, wipe the catheter; - Ensure the urinary drainage bag is located below the level of the bladder to discourage back flow of urine. 1. Review of Resident #4's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 2/8/25, showed: - He/She had a Brief Interview for Mental Status (BIMS) score of 14, indicating little cognitive deficit; - Diagnoses included: Urinary Tract Infection (UTI), urine retention, and need for assistance with personal care; - He/She had an indwelling urinary catheter; - He/She required assistance with getting dressed, using the toilet, and bed mobility. Review of the resident's Physician Order Sheet (POS), dated 3/2025, showed: - 10/18/24 Check catheter anchor and placement to prevent excessive tension, keep tubing free of kinks and positioned below the level of the bladder; - 10/18/24 Irrigate catheter with 30-50 milliliter (ML) of sterile water as needed for blockage; - 10/22/24 Indwelling catheter 18 french, 30 ML balloon every four weeks and as needed, for urine retention. Review of the resident's indwelling urinary catheter care plan, dated 8/29/24, showed: - Cleanse urinary catheter with soap and water every shift; - Monitor for signs and symptoms of UTI. Observation on 2/28/25 at 1:20 P.M., showed: - Certified Nurse Aide (CNA) D entered the resident's room and put on gloves; (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident was lying in his/her bed; - CNA D pulled the resident's blanket back and the resident's catheter tubing was pulled tight; - CNA D removed the catheter tubing from the stat lock (a device stuck to the resident's thigh to prevent the catheter tubing from pulling); - CNA D held the catheter tubing below the area to be cleaned; - Dark brown discharge was seen on the catheter tubing; - CNA D took one wipe and rubbed it back and forth on the catheter tubing; - CNA D said he/she was trying to get the goo off of the tubing; - CNA D continued scrubbing the catheter tubing; - CNA D attempted to empty the urinary drainage bag and there was less than 50 ML in the bag; - CNA D laid the bag on the mattress beside the resident and left the resident's room. During an interview on 2/28/25 at 1:34 P.M., CNA D said: - He/She was not supposed swipe back and forth when providing catheter care for the resident; - He/She was supposed to swipe one time top to bottom; - He/She was not supposed to leave the drainage bag sitting on the resident's mattress; - He/She was supposed to replace the drainage bag on the side of the bed keeping it below the bladder. During an interview on 2/28/25 at 2:08 P.M., Licensed Practical Nurse (LPN) B said: - He/She expected staff to swipe with one wipe, top to bottom when catheter care was provided to Resident #4; - It was not ok for staff to place the resident's urinary drainage bag on the resident's mattress and leave the room; - He/She expected staff to ensure the resident's drainage bag was anchored below the level of his/her bladder. During an interview on 3/3/25 at 2:47 P.M., the Director of Nursing (DON) said: - She did not expect staff to wipe back and forth when providing catheter care for Resident #4; - She expected staff to wipe once top to bottom with one wipe and repeat with a new wipe if needed; (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	03/04/2025

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- She expected staff to place Resident #4's urinary drainage bag below the level of his/her bladder; - The staff should not have placed the resident's drainage bag on the bed mattress and left the room. During an interview on 3/3/25 at 3:17 P.M., the Administrator said she expected staff to provide catheter care, one swipe away from the body. MO250276

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
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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** 44993 Based on observation, interview, and record review, the facility failed to maintain infection control standards when staff did not perform hand hygiene with glove changes while performing perineal care for two residents (Resident #2 and #3) and did not perform glove changes when providing urinary catheter care for one resident (Resident #4) per facility policy. Additionally, the staff failed to wear gowns while providing catheter care and perineal care for three residents that were on Enhanced Barrier Precautions (EBP), (Resident #2, #3, and #4) and while emptying Resident #2 and #4's urinary catheter drainage bag. The staff failed to place dirty linens in bags per facility policy and instead placed dirty linens and used incontinence briefs directly on the floor. The deficient practice affected three of three residents sampled. The facility census was 118. Review of the facility policy titled Hand Hygiene, dated 9/1/21, showed: - Alcohol - based hand rub (ABHR) is preferred in most clinical instances: - Wash hands when visibly dirty; - The use of gloves does not replace hand hygiene, hand hygiene is supposed to be completed before putting on gloves and after removing gloves. Review of the facility policy titled, Infection Prevention and Control Program, dated 9/1/22, showed soiled linen should be collected at the bedside and placed in a linen bag. Review of the facility policy titled, Enhanced Barrier Precautions, dated 6/5/24 showed: - EBP refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employ targeted gown and glove use during high contact resident care activities; - An order will be obtained for EBP for residents that have indwelling urinary catheters and chronic wounds; - EBP should be followed when staff are changing linens and briefs and when providing urinary catheter care. 1. Review of Resident #2's Quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility), dated 11/19/24, showed: - The resident had a Brief Interview for Mental Status score of 15, indicating no cognitive deficit; - Diagnoses included: Paraplegia (the resident can not voluntarily move his/her lower half of body), bladder incontinence, and anxiety; (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident was dependent on staff to provide personal hygiene, getting dressed, and urinary catheter care; - The resident had an indwelling urinary catheter. Review of the resident's Physician Order Sheet (POS), dated March 2025, showed an order for EBP, dated 9/26/24. Review of the resident's activities of daily living (ADLs) care plan, dated 5/25/23, showed the resident had an ADL self-care deficit. Interventions showed the resident was dependent on staff for bed mobility and toileting. Review of the resident EBP care plan, dated 10/1/24, showed: - The resident was on EPB precautions due to an indwelling suprapubic urinary catheter; - The staff were supposed to wear gowns and gloves when providing incontinent care. Observation on 3/3/25 at 10:00 A.M., showed: - Certified Nurse Aide (CNA) A and Nurse Aide (NA) A entered the resident's room; - Neither staff washed their hands upon entering; - Neither staff put on a protective gown; - Both staff put on gloves; - CNA A started perineal care stopping midway to tend to the resident's roommate; - CNA A took his/her gloves off, did not perform hand hygiene, put new gloves on and tended to the residents' roommate; - CNA A took his/her gloves off after tending to the resident's roommate, did not perform hand hygiene, put new gloves on, and resumed to provide the resident with perineal care; - CNA A threw the used linens directly on the floor; - CNA A emptied the resident's urinary drainage bag in a urine container; - CNA A and NA A left the resident's rooms and did not perform hand hygiene. During an interview on 3/3/25 at 10:15 A.M., CNA A said: - He/She was trained to perform hand hygiene when entering a resident room, between glove changes, and when exiting a resident room; (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 knew they were not supposed to throw dirty linens directly on the floor. The linens were supposed to be placed in a bag and then in the dirty linen barrel; - He/She had not been trained in EBP and did not know he/she was supposed to wear a protective gown and gloves when providing care to the resident. During an interview on 3/3/25 at 10:39 A.M., Licensed Practical Nurse (LPN) C said: - He/She expected staff to wear a gown and gloves when they provided Resident #2 with perineal care and emptied the resident's urinary catheter; - He/She expected staff to perform hand hygiene when entering the resident's room, between glove changes, and exiting the resident's room; - Staff are not supposed to throw dirty linens directly on the floor. During an interview on 3/3/25 at 2:47 P.M., the Director of Nursing (DON) said: - Staff were trained in EPB when it began, upon hire, during skills fairs and as needed; - She was not aware some staff did not know what EBP was; - She expected staff to follow EBP when they provided incontinent care and emptied the urine bedside drainage bag for Resident #2; - She did not expect staff to throw the resident's used linens directly on the floor; - She expected hand hygiene to be performed when staff entered Resident #2's room and between each glove change; - Staff should have performed hand hygiene when they stopped cares for Resident #2 and assisted the resident's roommate and then finished care for Resident #2. During an interview on 3/3/25 at 3:17 P.M., the Administrator said: - She expected staff to follow the EBP policy when providing personal cares to Resident #2. - Staff were not to throw the resident's dirty linens directly on the floor; - She expected staff to place the dirty linens in a bag and place them in the appropriate receptacle; - She expected the staff to perform hand hygiene upon entering the resident's room, between glove changes and upon exit of the room. 2. Review of Resident #3's quarterly MDS, dated [DATE], showed: - He/She had a BIMS score of 13, indicating minimal cognitive deficit; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses included: need for assistance with personal cares and reduced mobility; - The resident was dependent on staff to use the toilet, shower, and provide incontinent care; - The resident was incontinent of bowel and bladder at all times. Review of the POS, dated March 2025, showed an order, dated 9/26/24, EPB required for a chronic wound, wear gowns and gloves for high contact resident care activities. Review of the resident's ADL care plan, dated 8/12/24, showed the resident had an ADL self- care deficit. Interventions included the resident was dependent on two staff to provide bathing and toilet use. Review of the resident's EBP care plan, dated 10/1/24, showed: - The resident had a chronic wound; - The staff were supposed to wear gowns and gloves during incontinent care. Observation on 3/3/25 at 9:23 A.M., showed: - CNA B and CNA C entered the resident's room; - Neither CNA preformed hand hygiene upon entering the room, nor put on a protective gown; - Both CNAs put on gloves and began perineal care; - CNA B dropped the package of wipes, open side to the floor, and picked the wipes up with his/her gloved hand; - CNA B's gloved fingers brushed against the floor; - CNA B threw the top wipe away and continued providing perineal care without getting a new package of wipes and did not change his/her gloves; - CNA C threw the resident's urine saturated incontinence brief and wet cloth incontinence pad directly on the floor; - The CNAs finished the resident's perineal care; - CNA C picked up the dirty linen and incontinence brief from the floor and placed them in a plastic bag. - Both CNAs removed their gloves and did not perform hand hygiene, left the resident's room and went directly into another resident's room, and did not perform hand hygiene. During an interview on 3/3/25 at 9:30 A.M., CNA B said: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- She expected the staff to remove the dirty gloves when they touched the floor, perform hand hygiene, and put on a clean pair of gloves; - She expected staff to throw the wipes away that was dropped on the floor and use a new package of wipes while providing perineal care. During an interview on 3/3/25 at 3:17 P.M., the Administrator said: - She expected staff to wear a protective gown when they provided perineal care for Resident#3; - Staff are not supposed to throw dirty linens and incontinence briefs directly on the floor; - She expected staff to perform hand hygiene between glove changes; - She expect staff to remove their dirty gloves, perform hand hygiene, and put on clean gloves if the staffs gloved fingers touched the floor, it was not appropriate for the staff to continue proving perineal care for Resident #3 with contaminated gloves. 3. Review of Resident #4's quarterly MDS, dated [DATE], showed: - He/She had a BIMS score of 14, indicating little cognitive deficit; - Diagnoses included: Urinary Tract Infection (UTI), urine retention, and need for assistance with personal care; - He/She had an indwelling urinary catheter; - He/She required assistance with getting dressed, using the toilet, and bed mobility. Review of the resident's POS, dated March 2025, showed an order, dated 10/18/24, for EBP precautions because the resident has an indwelling urinary catheter; gown and gloves are to be worn during catheter care. Review of the resident's indwelling urinary catheter care plan, dated 8/29/24, showed: - Cleanse urinary catheter with soap and water every shift; - Monitor for signs and symptoms of UTI. Review of the resident's EBP care plan, dated 10/1/24, showed: -The resident was on EBP because he/she had an indwelling urinary catheter; - Staff were supposed to wear a protective gown and gloves when providing catheter care. Observation on 2/28/25 at 1:20 P.M., showed: - There was a Personal Protective Equipment (PPE) cart with PPE outside of the resident's room; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 Glenn Hendren Dr Liberty, MO 64068	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was a sign taped to the resident's door indicating the resident was on EBP; - CNA D entered the resident's room; - He/She did not put on a protective gown or perform hand hygiene upon entering he resident's room; - CNA D provided catheter care for the resident; - The resident had a bowel movement, CNA D changed his/her gloves and did not perform hand hygiene; - CNA D removed his/her soiled gloves, did not perform hand hygiene and put on a clean pair of gloves; - CNA D completed catheter care a second time; - CNA D emptied the resident's urinary catheter drainage bag; - CNA D exited the resident's room, removed his/her soiled gloves, and did not perform hand hygiene. During an interview on 2/28/25 at 1:34 P.M., CNA D said: - He/She should have used hand sanitizer between glove changes, but there was no hand sanitizer dispenser in the resident's room; - He/She should have put on a protective gown before providing catheter care During an interview on 2/28/25 at 2:08 P.M., LPN B said: - He/She expected staff to perform hand hygiene when entering Resident #4's room and between glove changes; - He/She expected staff to put on a protective gown when providing perineal care and catheter care for Resident #4; - The DON provided EBP training for the staff recently, but could not recall the date. During an interview on 3/3/25 at 2:47 P.M., the DON said: - She expected staff to wear PPE when providing catheter care for Resident #4; - She expected staff to perform hand hygiene when entering the resident's room, with glove changes, and upon exiting the resident's room. During an interview on 3/3/25 at 3:17 P.M., the Administrator said: - She expected staff to perform hand hygiene upon entry of the resident's room, exit, and with glove changes; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- She expected staff to wear gowns and gloves when emptying Resident #4's catheter. MO250276