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	04/23/2024

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 0602 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46863 Based on interviews, record review, and facility document and policy review, the facility failed to protect a resident from misappropriation of property for one (Resident #99) of six sampled residents reviewed for abuse. The facility's previous Social Services Director was reported by Resident #99 to have sold some of his/her possessions, including a 2011 Mercedez-[NAME] and did not provide the resident the money received from the sales. Resident #99 had terminal cancer and stated he/she was devastated and asked how do you steal from someone that is gonna die?. Resident #99 stated this was the first car that he/she bought for themselves, they were very proud of the car, and had worked hard for their car. The facility census was 105. On 3/12/24, the Administrator was notified of the Past Non-Compliance situation. At that time, the facility notified the police, conducted an investigation, and inserviced staff on the facility's Abuse, Neglect, and Misappropriation policy. The deficiency was corrected on 3/12/24. A review of a facility policy titled Abuse, Neglect, and Exploitation, revised 08/22/2022, revealed that the definition of Exploitation meant taking advantage of a resident for a personal gain through the use of manipulation, intimidation, threats, or coercion. The policy revealed that the definition of Misappropriation of Resident Property meant the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. The policy revealed, Policy explanation and compliance guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Further review revealed, 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The policy revealed under the section titled III. Prevention of Abuse, Neglect, and Exploitation that The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. Building B. Wing	04/23/2024

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 0602 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	B. Identifying, correcting, and interviewing in situations in which abuse, neglect, exploitation, and/or misappropriation of residents property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the resident, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. The policy revealed under the section titled IV. Identification of Abuse, Neglect, and Exploitation that A. The facility will have written procedures to assist staff in identifying the different types of abuse- mental verbal abuse, sexual abuse, physical abuse and deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. B. Possible indicators of abuse include, but are not limited to: 4. Resident reports of theft of property, or missing property. A review of a facility policy titled Resident Personal Belongings, revised 09/01/2022, revealed, It is the policy of this facility to protect the resident's right to possess personal belongings such as clothing and furnishings for their use while in the facility and assure the personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative in the event of the resident's death or discharge from the facility. The policy revealed Policy Explanation and Compliance Guidelines: 7. The facility will exercise reasonable care for the protection of the resident's property from loss or theft. A review of a facility policy titled Transactions Involving Resident Funds or Property, revised 03/12/2024, revealed, Policy: It is the practice of this facility that anytime there is a transaction involving resident funds, the resident must be provided with a receipt of such transaction. Copies of each transaction are filed in the business office. The policy revealed Policy Explanation and Compliance Guidelines: 2. The facility will ensure resident funds are not comingled with the facility funds or funds of someone other than a resident such as a staff member managing the resident's personal funds. Further review revealed, 14. No facility employee shall knowingly exploit resident property. A review of Resident #99's Admission Record revealed the facility admitted the resident on 02/22/2024 with diagnoses that included malignant neoplasm (cancerous tumor) of the brain, encephalopathy (brain disease that alters brain function or structure, can be caused by infection, tumor, and stroke and symptoms include declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching are common symptoms), unsteadiness on feet, muscle weakness, and unspecified lack of coordination. A review of Resident #99's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/29/2024, revealed Resident #99 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed that it was very important for Resident #99 to have a place to lock their things to keep them safe. A review of Resident #99's care plan revealed a Focus area initiated on 03/07/2024 that indicated Resident #99's rights were guaranteed by the Federal 1987 Nursing Home Reform Law. Further review revealed the laws required skilled nursing facilities to promote and protect the rights of each resident, placing emphasis on individual preferences, dignity, and self-determination. Interventions included the resident's right to be treated with consideration, respect, and dignity and to be free from mental and physical abuse, corporal punishment, involuntary seclusion, and to be free from restraint (physical or chemical). (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	04/23/2024

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 0602 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #99's initial Care Conference Summary, dated 02/23/2024, revealed Resident #99 stated that their doctor gave them six months to a year to live. The summary revealed that Resident #99 indicated they had a vehicle at the hospital with personal items inside. A review of a facility document titled Follow-up Investigation Report dated 03/12/2024 indicated Resident #99 stated that a former employee, the previous Social Services Director (PSSD), was assisting them with selling their car and personal belongings. The report revealed that Resident #99 reported their items were gone and that they did not receive money for them. The report revealed the local police department was notified on 03/12/2024. A review of a police case report revealed fraud was reported by the facility on 03/12/2024 at 2:04 PM by the facility Administrator, naming Resident #99 as the victim of financial exploitation of an elderly/disabled person. The report revealed the PSSD was named as the suspect. The report revealed an Initial Narrative that indicated the Administrator reported to the police that Resident #99 had only five to seven months to live and was potentially a victim of fraud or being financially coerced by the PSSD. The narrative revealed an officer confirmed that Resident #99 owned a white 2011 Mercedez-[NAME]. The narrative revealed that on 03/15/2024 at 10:32 AM, Resident #99 was interviewed by the police, and Resident #99 stated that they had a few months to live. The narrative revealed Resident #99 stated that the PSSD offered to sell their car and that they had signed over their car title to the PSSD with intentions that they would get $500-$1000. The narrative revealed Resident #99 stated, I thought she was there to help me since she was a Social Services worker knowing my health condition. The narrative revealed Resident #99's car was last seen in the facility parking lot on 03/08/2024. The narrative revealed that an officer had attempted to contact the PSSD over the phone on 03/15/2024 at 11:58 PM, but was unsuccessful. A review of a facility document titled Corrective Action Memo dated 03/11/2024 indicated the PSSD was terminated on 03/11/2024 for failing to meet expectations of job duties. A review of a facility document titled [Resident #99's] Report, dated 03/12/2024 at 11:20 AM, revealed that Resident #99 had reported to the Admissions Director the PSSD had been helping them sell their car, and the car was now missing. A review of a facility document titled Summary of Investigation involving [Resident #99] and misappropriation of resident property revealed that on 03/12/2024 at 11:20 AM, the Administrator had been made aware that Resident # 99's car and other items were missing. The summary revealed that on 03/15/2024, around 9:00 AM, the PSSD returned Resident #99's microwave and coffee maker to the facility. The summary revealed that on 03/15/2024, around 10:30 AM to 11:00 AM, two officers arrived at the facility and spoke with the Administrator and Resident #99. The summary revealed Resident #99 indicated they wanted to press charges against the PSSD. The summary revealed the PSSD had been terminated from their position at the facility on 03/11/2024 for unrelated reasons. (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	04/23/2024

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 0602 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #99's statement dated 03/12/2024 at 11:25 AM, documented by the Administrator, revealed that Resident #99 reported that a short white-haired lady (the PSSD) had been helping them sell their car, and the car was no longer outside. Resident #99 reported missing five to six boxes of items. Resident #99 reported the PSSD had picked up five to six boxes of their belongings from Resident #99's previous employer, and the PSSD instructed the resident to place items he/she wanted the PSSD to sell for them under the sink in PSSD's office. Resident #99 stated they had put a microwave, DVD player, movies, dishes, knife set, and other random things under the sink. Resident #99 reported the PSSD had picked up the resident's car from the hospital, drove it to the facility, and parked it. Resident #99 stated they realized the car was missing last week. Resident #99 stated the PSSD called their bank and spoke to the Banker (BK) multiple times. Resident #99 stated the PSSD had paid off the $4,700.00 they owed on the car and that the PSSD showed them where to sign on the car title. Resident #99 stated the PSSD had told them they had to sign the title so they could find a buyer. Resident #99 stated he/she did not receive money for the car or other items. A review of the Business Office Manager's (BOM) statement dated 03/12/2024 at 11:58 AM revealed the BOM assisted Resident #99 with calling their bank. The statement revealed the BK stated that the PSSD paid off Resident #99's car loan in full out of their personal bank account. A review of a typed interview with the PSSD dated 03/12/2024 completed by the Director of Nursing (DON) revealed the DON interviewed the PSSD, who stated they loaded Resident #99's belongings into their vehicle and had brought them back to the facility. The PSSD stated they did not know where the car was. The PSSD stated that Resident #99's bank bought the car back for what was owed. A review of a typed interview with the Social Services Aide (SSA) dated 03/12/2024 at 3:10 PM completed by the Administrator revealed the SSA stated the PSSD had reported to her that she was going to ask the BK how to get Resident #99's car. The SSA stated that she was aware the PSSD had asked Resident #99 to sell their belongings and that 10 of Resident #99's items were sold by the PSSD. The SSA reported the PSSD took Resident #99's microwave and refrigerator on 03/11/2024 when she left the facility. The SSA stated they had thought it was strange that the PSSD was getting the car. A review of a typed interview with the PSSD dated 03/12/2024 at 3:55 PM completed by the DON via phone revealed the PSSD stated they had received a call from the hospital indicating that Resident #99's car needed to be moved out of their parking lot. The PSSD stated the hospital had called again three to four days later and stated they needed to pick up Resident #99's car by 5:00 PM that same day. The PSSD stated she and one of her family members had picked up Resident #99's car. The PSSD reported they had talked to Resident #99's bank, but did not assist in selling the car. The PSSD reported that she was approached by Resident #99, who had a buyer. The PSSD stated the buyer handed her cash. The PSSD stated that she and the resident called the bank and were told the resident could debit or credit the money to the bank for the car. The PSSD stated the resident did not have enough money, so she paid the remaining balance on Resident #99's loan to Resident #99's bank using her personal account. The PSSD stated she had Resident #99's coffee maker. A review of Resident #99's Social Services Note dated 03/12/2024 at 4:10 PM, written by the Social Services Director (SSD), revealed the SSD attempted to talk to Resident #99 about a situation surrounding their vehicle. The note revealed Resident #99 indicated they were too upset to talk about the incident that day. (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	04/23/2024

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 0602 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #99's nursing Behavior Note dated 03/17/2024 at 12:59 PM revealed that Resident #99 got very upset in the dining room. Resident #99 took their plate and slammed it down on the dining room table, breaking the plate. During an interview on 04/02/2024 at 12:03 PM, Resident #99 stated that a facility staff member, the PSSD, stole their car. Resident #99 indicated they pressed charges, and a police report had been filed. Resident #99 stated they had gotten their microwave back from the PSSD, but their car was still missing. Resident #99 was observed to become upset when talking about their car that was stolen and slapped their right leg with their right arm. Resident #99 stated that the facility did not provide a resolution regarding their car. During a follow-up interview on 04/04/2024 at 3:49 PM, Resident #99 stated she/he had been affected by the missing car, stating that it tore him/her up and they just wanted to return the car to the bank. Resident #99 stated that he/she was Devastated. and How do you steal from someone that is gonna die? Resident #99 was observed fidgeting his/her fingers and hands. Resident #99 stated he/she internalized the situation and felt like breaking stuff. Resident #99 stated he/she was trying to make the best of their time, but it was devastating. Resident #99 stated this was the first car that he/she bought for themselves, they were very proud of the car, and had worked hard for their car. Resident #99 stated they were dealing with terminal cancer and should not have had to deal with the theft of their car, too. During an interview on 04/05/2024 at 1:19 PM, Resident #99 indicated that after the police came, they had not received updates from the facility. Resident #99 stated the facility washed their hands clean and pushed it all back on them. Resident #99 clapped their hands, making a loud noise, and swept their hands together, making the wiping hands gesture. Resident #99 then clenched their hands, stood up from their bed, and began pacing and fussing with belongings. Resident #99 stated that they wanted staff to keep them updated. Resident #99's eyes were observed to be watery. Resident #99 stated that they were being ripped off, and the resident became visibly upset, shifting their body weight on their bed. Resident #99's eyes continued to be watery. Resident #99's voice tone changed and became shaky. Resident #99 stated, I am extremely stressed out; I am not going to let it show. Resident #99 stated, I have been told I have six months to live. I shouldn't have to deal with this. I came here for help. During an interview on 04/04/2024 at 1:39 PM, the Detective with the local police department indicated they were investigating the report of Resident #99's stolen car. The Detective indicated the vehicle had not been re-registered. During an interview on 04/05/2024 at 11:32 AM, the PSSD stated that she assisted Resident #99 with locating their car and picking up belongings from their previous employer. The PSSD stated that she had taken home Resident #99's belongings to sell. The PSSD stated that she asked Resident #99 if they wanted to sell their car so it would not get repossessed. The PSSD indicated that Resident #99 had [NAME] who came to the facility to buy the car. The PSSD stated they had taken the cash from the [NAME] and made the payoff payment using their personal banking card to Resident #99's bank. The PSSD indicated the amount of cash received from the [NAME] was the same amount that was charged to her card. The PPSD stated, I reimbursed myself; I am not a charity. The PSSD indicated she had accessed her online banking portal but could not provide the date of the charge. The PSSD stated, I am very confused; I did nothing illegal; they should be thanking me. (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	04/23/2024

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 0602 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/07/2024 at 8:49 AM, Restorative Aide (RA) #13 stated the day Resident #99 reported their car missing, Resident #99 was walking fast; their walk was different, and their mood changed. RA #13 stated Resident #99 was worried if they would be able to stay at the facility. RA #13 stated that Resident #99 seemed more secluded. RA #13 stated Resident #99 had an outburst since their car was stolen, Resident #99 went off in the dining room on some residents, and that this was not normal behavior for Resident #99. During an interview on 04/05/2024 at 12:44 PM, the SSA stated that she had not suspected, witnessed, or heard reports of possible abuse or abuse. The SSA indicated that she was aware of a situation where the PSSD had assisted Resident #99 with their car. The SSA stated the PSSD had reported that she had picked up Resident #99's car from the hospital. The SSA stated that at the beginning of March, she had unexpectedly returned to her office and observed Resident #99 sitting in the office with the PSSD. She stated that Resident #99 and the PSSD were on a call with Resident #99's bank, discussing the amount of money left on Resident #99's car loan. The SSA indicated the PSSD was leading the conversation. The SSA stated that she had a planned absence from the facility on 03/05/2024 and was not at the facility. The SSA indicated that was when the PSSD made her move and that the PSSD was a very manipulative and sneaky person. The SSA stated the PSSD was aware that she would not be at the facility on 03/05/2024. During an interview on 04/05/2024 at 1:57 PM, the BOM stated the PSSD had dropped off Resident #99's coffee maker and microwave when she picked up her final stuff from the facility. The BOM stated the PSSD reported that she ran an estate business on the side. During an interview on 04/07/2024 at 10:58 AM, the Administrator stated she was the facility's abuse coordinator. The Administrator stated that she expected staff not to get involved in resident finances, indicating that she or the BOM should be involved. MO233090

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	04/23/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36105 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the environment for one (Resident #58) of five sampled residents remained free of accident hazards. Specifically, observation revealed medications were unsafely stored at Resident #58's bedside. The facility census was105. Findings included: A review of the facility's Medication Storage policy, implemented 09/01/2021, revealed, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The policy revealed, 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls and b. Only authorized personnel will have access to the keys to locked compartments (see attached listing). A review of Resident #58's Admission Record revealed the facility admitted the resident on 08/18/2022 with diagnoses that included encephalopathy, bipolar disorder, diabetes, chronic obstructive pulmonary disease, and osteoarthritis. A review of Resident #58's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/26/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #58 had intact cognition. The MDS revealed Resident #58 experienced shortness of breath when lying flat. The MDS also revealed the resident used ointments/medications (not to the feet) during the assessment period. A review of Resident #58's physician Order Recap Report, for the timeframe from 04/01/2024 through 04/30/2024, revealed an order started on 09/28/2023 for artificial tears ophthalmic solution (ophthalmic lubricant and irrigation agent), one drop in both eyes four times a day for dry eyes. In addition, there was an order started on 12/20/2023 for one percent (%) silver sulfadiazine cream (topical antibiotic), to be applied to the right ear topically every shift for skin care. A review of Resident #59's physician Order Summary Report for active orders as of 04/03/2024 revealed an order started on 08/26/2023 for Ventolin HFA inhalation aerosol solution (generic name albuterol; adrenergic bronchodilator), two puffs every six hours as needed for shortness of breath. The order revealed the medication could be kept at the resident's bedside. (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	04/23/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #58's care plan Focus area, initiated on 08/31/2022, revealed the resident was resistive to care and refused medications at times. Interventions directed staff to allow the resident to make decisions about their treatment regimen to provide a sense of control and to educate Resident #58 and family/caregivers of the possible outcomes of not complying with treatment or care. Another care plan Focus area, initiated on 08/18/2022, revealed Resident #58 had impaired cognitive function/dementia thought processes. Interventions directed staff to administer medications as ordered. A review of Resident #58's care plan revealed no documented evidence that self-administration of medications or safe storage of medications in the resident's room was addressed. During a concurrent observation and interview on 04/02/2024 at 1:51 PM, Resident #58 had an inhaler and sulfadiazine cream at the bedside. The resident indicated they had been self-administering their inhaler for six months up to two times a day when they were having a difficult time breathing. Resident #58 indicated they also used sulfadiazine cream on sores on their feet, chin, and pre-cancerous tissue on their ear. The resident stated staff did not assist them with applying the cream. The facility census was 105. During an interview on 04/02/2024 at 3:50 PM, Licensed Practical Nurse (LPN) #12 indicated Resident #58 had antifungal powder, artificial tears, 1% hydrocortisone cream, 1% silver sulfadiazine cream 50 grams, and an albuterol sulfate 90 mcg inhaler at the bedside. LPN #12 confirmed the resident had no physician order for antifungal powder or hydrocortisone cream. LPN #12 stated medications should not be left at bedside because another resident could wander into the resident's room and ingest the medications. An interview with Certified Medication Technician #37 on 04/05/2024 at 5:00 PM revealed medications were not supposed to be kept at the bedside. An interview with LPN #27 on 04/05/2024 at 5:11 PM revealed cream, eye drops, and inhalers should not be kept at the bedside. During an interview on 04/07/2024 at 9:48 AM, the Director of Nursing (DON) stated medications should not be kept at the bedside. The DON asserted Resident #58 was an online shopper and bought medication online.

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	04/23/2024

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 0745 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46863 Based on observations, interviews, record review, and facility document review, the facility failed to provide medically related social services for one (Resident #99) of six sampled residents. Resident #99 had recently been diagnosed with a terminal diagnosis, lost their job, and where they lived due to their health condition. The resident had a history of trauma, and showed signs of mental and psychosocial distress including signs of anxiousness and depression about losing their job, being homeless, as well as allegations of the previous social worker stealing from them. The facility census was 105. Findings included: A review of an undated facility job description for the facility social services director revealed, Position Description: Responsible for planning, developing, organizing, and evaluating and directing the overall operations of the Social Services department and accordance with the National Association of Social Workers (NASW) Code of Ethics and in compliance with Federal, State, and Local guidelines and regulations, company policies and procedures, and governing agencies. Responsible for fostering a climate, policies and routines that enable residents to maximize their individuality, independence, and dignity. This climate shall provide residents with the highest practical level of physical, mental, psychosocial well-being, and quality of life. Responsible for identifying psychosocial mental and emotional needs along with providing developing, and/or aiding in the access of services to meet those needs. A review of Resident #99's Admission Record revealed the facility admitted the resident on 02/22/2024 with diagnoses that included malignant neoplasm of the brain (cancerous tumor), encephalopathy (brain disease that alters brain function or structure, can be caused by infection, tumor, and stroke and symptoms include declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching are common symptoms), unsteadiness on feet, muscle weakness, and unspecified lack of coordination. A review of Resident #99's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/29/2024, revealed Resident #99 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that Resident #99 was cognitively intact. The MDS revealed that it was very important for Resident #99 to have a place to lock their things to keep them safe. The MDS revealed that Resident #99 indicated that it was somewhat important for them to participate in religious services or practices. The MDS revealed the resident received antidepressant medication during the seven-day lookback period. A review of Resident #99's care plan revealed a Focus area initiated on 03/12/2024 that indicated Resident #99 had a history of a traumatic event. The Focus area revealed the resident had been raped by multiple people when they were younger. Interventions directed staff to provide a psychiatric evaluation as needed and refer to the social services department as indicated. Further review of the interventions revealed Known triggers of potential abuse include: no triggers were documented as identified. (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	04/23/2024

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 0745 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #99's initial Care Conference Summary, dated 02/23/2024, revealed Resident #99 stated that their doctor gave them six months to a year to live. The summary revealed that Resident #99 worked as a truck driver for many years and had few friends they kept in contact with or family who were a support system to them. Resident #99 indicated they had a vehicle at the hospital with personal items inside. A review of a police case report revealed fraud was reported by the facility on 03/12/2024 at 2:04 PM by the facility Administrator, naming Resident #99 as the victim of financial exploitation of an elderly/disabled person. The report revealed that the previous Social Services Director (PSSD) was named as the suspect. The report revealed an Initial Narrative that indicated the Administrator reported to the police that Resident #99 had only five to seven months to live and was potentially a victim of fraud or being financially coerced by the PSSD. The narrative revealed an officer confirmed that Resident #99 owned a white 2011 Mercedez-[NAME]. The narrative revealed that on 03/15/2024 at 10:32 AM, Resident #99 was interviewed by the police, and Resident #99 indicated that they had a few months to live. The narrative revealed Resident #99 indicated that the PSSD offered to sell their car and that they had signed over their car title to the PSSD with intentions that they would get $500-$1000. The narrative revealed Resident #99 stated, I thought she was there to help me since she was a Social Services worker knowing my health condition. The narrative revealed Resident #99's car was last seen in the facility parking lot on 03/08/2024. The narrative revealed that an officer had attempted to contact the PSSD over the phone on 03/15/2024 at 11:58 PM but was unsuccessful. A review of a facility document titled Follow-up Investigation Report dated 03/12/2024 at 1:05 PM revealed as a result of a verified finding of abuse, identified interventions included, Resident #99 had been scheduled a psychiatric follow-up as well as a new Trauma Informed Care (Assessment). On 04/07/2024 at 9:48 AM, documentation related to the psychiatric follow-up was requested from the facility, but the facility was unable to provide documentation. A review of an undated facility document titled Abuse Investigation Checklist revealed, A 'Trauma Informed Care' in [the electronic health record system] under assessments MUST be completed on admit and quarterly AND WHEN ANY ALLEGATION IS REPORTED. A review of Resident #99's Social Services Note dated 03/12/2024 at 4:10 PM, written by the Social Services Director (SSD), revealed the SSD attempted to talk to Resident #99 about a situation surrounding their vehicle. The note revealed Resident #99 indicated they were too upset to talk about the incident that day and was organizing their room to keep their mind off of things. The note revealed the resident said they would sit down and talk to the staff about the situation surrounding the vehicle and do a trauma-informed care assessment the following day. A review of Resident #99's Social Services Notes for the timeframe from 02/23/2024 to 04/07/2024 revealed no further follow-up with Resident #99 related to their stolen vehicle or services needed related to the issue. A review of Resident #99's nursing Behavior Note dated 03/17/2024 at 12:59 PM revealed that Resident #99 got very upset in the dining room. Resident #99 took their plate and slammed it down on the dining room table, breaking the plate. (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	04/23/2024

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 0745 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/02/2024 at 12:03 PM, Resident #99 stated they had lost their job and the fifth-[NAME] truck they lived out of due to their health condition. Resident #99 was observed to become upset, raise their voice, and become very animated with both arms while sharing their experience. Resident #99 stated that a facility staff member, the PSSD, stole their car. Resident #99 stated they pressed charges, and a police report had been filed. Resident #99 stated they had gotten their microwave back from the PSSD, but their car was still missing. Resident #99 was observed to become upset when talking about their car that was stolen and slapped their right leg with their right arm. Resident #99 stated the facility did not provide a resolution regarding their car. During an interview on 04/04/2024 at 3:49 PM, Resident #99 indicated they felt like they had been affected by their missing car, stating that it tore them up and they just wanted to return the car to the bank. Resident #99 stated that they were Devastated; how do you steal from someone that is gonna die? Resident #99 was observed fidgeting with their fingers and hands. Resident #99 stated that they internalized the situation and stated that they felt like breaking stuff. Resident #99 stated they were trying to make the best of their time, but it was devastating. Resident #99 stated that this was the first car that they bought for themselves, and they were very proud of the car. Resident #99 stated that they worked hard for their car. Resident #99 stated that they were dealing with terminal cancer and should not have had to deal with the theft of their car, too. Resident #99 stated that staff did not check in on them to see how they were or how they were dealing with their car being stolen. Resident #99 stated that they talked to other residents when they were frustrated about the situation. During an interview on 04/05/2024 at 1:19 PM, Resident #99 indicated that after the police came, they had not received updates from the facility. Resident #99 stated the facility washed their hands clean and pushed it all back on them. Resident #99 clapped their hands, making a loud noise, and swept their hands together, making the wiping hands gesture. Resident #99 then clenched their hands, stood up from their bed, and began pacing and fussing with belongings. Resident #99 stated that they wanted staff to keep them updated, that they had not been asked about their feeling or emotions, and that the staff were not interacting with them. Resident #99's eyes were observed to be watery. Resident #99 stated that they were being ripped off, and the resident became visibly upset, shifting their body weight on their bed. Resident #99's eyes continued to be watery. Resident #99's voice tone changed and became shaky. Resident #99 stated, I am extremely stressed out; I am not going to let it show. Resident #99 stated, I have been told I have six months to live. I shouldn't have to deal with this. I came here for help. During an interview on 04/05/2024 at 02:11 PM, the Social Services Director (SSD) stated that they were aware that Resident #99 was upset about their stolen car. The SSD stated that they identified that Resident #99 had psychological/social needs as a result of their stolen car. The SSD stated that the facility had not put any other steps in place following Resident's #99's stolen car. The General Nurse Consultant (GNC) was observed entering the SSD's office. The GNC and SSD reviewed Resident #99's care plan and were unable to locate any care plan tasks and interventions related to Resident #99's stolen car. The SSD stated that they had not completed a trauma-informed assessment following Resident #99's stolen car. The SSD stated that on 03/12/2023, they had entered a social worker progress note as a result of Resident #99's stolen car. The SSD stated that they were aware Resident #99 was upset and indicated they identified that Resident #99 needed a trauma-informed care assessment. The SSD stated that they did not complete a trauma-informed assessment with Resident #99. (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	04/23/2024

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 0745 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #99's Progress Notes revealed that on 04/07/2024 at 12:04 PM, a late entry, Social Services Note, was entered by the SSD with an effective date of 03/13/2024 at 12:01 PM. The note revealed, This writer followed back up with resident concerning incident from previous day and to attempt to complete the Trauma informed care assessment. Resident #99 let this writer know that resident had already told this writer that they were not interested in completing this assessment as they did not feel trauma related to this situation. During an interview on 04/07/2024 at 12:43 PM, the SSD indicated that they were the author of the Late Entry Social Services Note entered on 04/07/2024 at 12:04 PM. The SSD indicated the facility administrator had asked them to write it earlier that day. The SSD stated that they had been approached by the Administrator regarding the lack of her follow-up of the trauma-informed care assessment referenced in the progress note for Resident #99 on 03/12/2024. The SSD stated that she remembered she had followed up with the resident but forgot about it. The SSD indicated that they should have documented the refusal right away and that she should have reapproached the resident to complete a trauma-informed care assessment at a later time. She stated that she did not approach the resident again. The SSD indicated that Resident #99 was working as a truck driver and lived in the truck, had terminal cancer, no longer had a job, had their car stolen, and Resident #99 did not consider the facility their home. The SSD stated that no referrals had been made for outside resources. During an interview on 04/07/2024 at 8:49 AM, Restorative Aide (RA) #13 stated that Resident #99 was anxious and depressed about losing their semi-truck where they live, being homeless, as well as the social worker stealing from them. RA #13 stated that the day Resident #99 reported their car missing, Resident #99 was walking fast; their walk was different, and their mood changed. RA #13 stated Resident #99 was worried if they would be able to stay at the facility. RA #13 stated that Resident #99 seemed more secluded. RA #13 stated that they have not been told about or instructed on any changes to Resident #99's care. RA #13 stated Resident #99 had an outburst since their car was stolen, Resident #99 went off in the dining room on some residents, and that this was not normal behavior for Resident #99. During an interview on 04/07/2024 at 9:13 AM, Resident #99 stated that the facility staff had not asked if they wanted to see a therapist, psychologist, or spiritual services. During an interview on 04/07/2024 at 9:48 AM, the Director of Nursing (DON) indicated that traumatic events were different for each person. The DON indicated that residents can still experience trauma from events they do not identify as traumatic events. The DON indicated that a diagnosis of terminal cancer was traumatic, depending on how the resident was taking it. The DON indicated that a stolen car was traumatic, depending on how the resident was taking it. The DON indicated that if a resident experienced a traumatic event while being a resident at the facility, the facility should conduct a trauma-informed assessment, update the care plan interventions, and refer the resident to see a psychologist or therapy. The DON indicated that the facility set up Resident #99 with a psychologist or therapy as a response to Resident #99 terminal cancer diagnosis but was unable to provide documentation this occurred. (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	04/23/2024

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 0745 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/07/2024 at 11:46 AM, the Administrator indicated that she expected residents who had experienced trauma to be offered a psychiatrist or other related services. The Administrator indicated that for residents who experienced trauma at the facility, she expected staff to ensure the residents felt safe, the residents were assessed, and care plans were updated. The Administrator indicated that she expected residents who had received a recent cancer diagnosis to be assessed and care planned. The Administrator stated social services should speak to the residents and address them appropriately. MO233090

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	04/23/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 19186 Based on record review, interview, and facility policy review, the facility failed to maintain a complete health record for one (Resident #35) of four residents reviewed for pressure ulcers. Specifically, the facility failed to ensure staff documented wound treatments on a treatment administration record (TAR). The facility census was 105. Findings included: A review of a facility policy titled, Wound Treatment Management, revised on 09/01/2022, revealed, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The policy also revealed, 7. Treatments will be documented on the Treatment Administration Record. A review of an Admission Record revealed the facility originally admitted Resident #35 on 09/21/2023 and readmitted the resident on 01/04/2024. The Admission Record revealed the resident had diagnoses that included type 2 diabetes mellitus, chronic combined congestive heart failure, end stage renal disease, and dependence on renal dialysis. A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/14/2024, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS identified the resident was at risk of pressure ulcer development, but noted the resident did not have any unhealed pressure ulcers. The MDS indicated the resident had one venous or arterial ulcer, and had moisture associated skin damage (MASD). A review of Resident #35's care plan revealed a focus area, with a revision date of 02/07/2024, that indicated the resident had an arterial ulcer to the posterior (back) of their heel. The care plan indicated the wound had improved and included staff instructions to continue treatment per physician orders. The care plan revealed a note, dated 02/02/2024, that indicated the resident had a wound to their right distal dorsal foot that was considered resolved. The care plan revealed a note, dated 02/07/2024, that indicated that the resident had a pressure ulcer in the middle of their left heel that was considered resolved. A review of Resident #35's January 2024 Treatment Administration Record revealed a transcription of an order for staff to cleanse wounds to the left and right heels and right distal dorsal foot with normal saline, pat dry, apply nickel thick Santyl (topical debriding agent) to the wounds, apply gentamicin cream (topical antibiotic) to the wounds, place wound-sized calcium alginate (algal biopolymer wound dressing) to wounds, cover with a dry dressing, and change daily and as needed. The TAR revealed staff did not document the treatment was completed on the following dates: 01/03/2024, 01/05/2024, 01/09/2024, 01/10/2024, 01/13/2024, 01/24/2024, 01/26/2024, or 01/27/2024. (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	04/23/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #35's February 2024 Treatment Administration Record revealed a transcription of an order for staff to cleanse the left medial heel wound with normal saline, pat dry, apply Skin-Prep (protective barrier wipe), and leave open to air daily during the day shift. The TAR revealed staff did not document the treatment was completed on the following dates: 02/15/2024, 02/22/2024, or 02/23/2024. A review of Resident #35's March 2024 Treatment Administration Record revealed a transcription of an order for staff to cleanse the left medial heal wound with normal saline, pat dry, apply Skin-Prep (protective barrier wipe), and leave open to air daily during the day shift. The TAR revealed staff did not document the treatment was completed on the following dates: 03/03/2024 or 03/12/2024. During an interview on 04/07/2024 at 2:49 PM, Registered Nurse (RN) #21 stated Resident #35 did not let staff forget to do their treatments. She stated a day shift nurse was unable to render the resident's treatment (date/s unknown), so RN #21 conducted the resident's wound treatments, but forgot to document the care she provided to Resident #35. During a phone interview on 04/07/2024 at 2:57 PM, Licensed Practical Nurse (LPN) #2 stated she worked on Mondays and Wednesdays, noting Resident #35 went to dialysis on those days. She stated that Resident #35 usually wanted their treatment completed just before dinner and sometimes did not want to be bothered. LPN #2 indicated that, when she provided wound treatment, she always documented the completion of that treatment. LPN #2 revealed that she could not remember if Resident #35 refused treatment altogether, but noted the resident may have wanted the treatment completed later. During an interview on 04/06/2024 at 8:05 AM, LPN #12 stated she sometimes got busy and may forget to document rendered treatment. She indicated that normal practice was to document after treatment was provided. During an interview on 04/07/2024 at 3:28 PM, the Director of Nursing (DON) indicated she expected all treatments and tasks to be documented after they were completed. She stated she was not aware that staff had not documented treatments for Resident #35 on some days. During an interview on 04/07/2024 at 3:09 PM, the Administrator indicated she expected staff to document on the TAR after a treatment was completed.