

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265867	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Norterre		STREET ADDRESS, CITY, STATE, ZIP CODE 2555 Norterre Circle 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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on interview and record review, the facility failed to provide personal conveyance of personal funds within thirty days of discharge. This affected three of fifteen of sampled residents (Resident #205, #206, and #207). The facility census was 58. Review of facility policy, Resident trust policy, dated [DATE], showed: -If resident has personal funds deposited expires, the facility shall refund the resident's account balance within thirty days and provide a full accounting of these funds to the individual, probate jurisdiction administering the resident's estate, or other entity as required by state law or regulation. 1. Review of the facility's interim aging report, dated [DATE], showed: -Resident #205 discharged on [DATE], with a balance of \$3,250.00; -Resident #206 discharged on [DATE], with a balance of \$6,490.00; -Resident #207 discharged on [DATE], with a balance of \$325.00. Review of outstanding account record showed: -Resident #205: -[DATE] a new vendor account was requested by Business Office Manager (BOM); -[DATE] a refund invoice was entered by BOM, with note waiting on check from corporate in amount of \$3,250.00; -Resident #206: -[DATE] a new vendor account was requested by BOM; -[DATE] a refund invoice was entered by BOM, with note waiting on check from corporate in amount of \$6490.00; (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 265867	Facility ID: 265867 If continuation sheet Page 1 of 63

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #207: -facility did not provide account record for resident. During an interview on [DATE] at 10:35 A.M., BOM said: -He/She had to put in a vendor request with corporate office prior to issuing a refund request if resident had not received funds from the facility in the past; -Once vendor request was submitted corporate would create a new account in accounting system so that a check could be issued to resident or responsible party; -He/She then submitted a refund request after the new vendor account was established; -Refunds were paid out of the corporate office; -The facility had thirty days to return funds to resident or their responsible party upon discharge; -Once corporate issued check the check was sent via courier to him/her so he/she could close out the amount owed in the electronic medical record; -Responsible party or resident would pick up check directly from him/her or he/she would mail it to them directly; -Refunds were attempted to be completed within thirty days but was dependent on how quickly it went through the referral process; -They requested a vendor account for resident #205 on [DATE], he/she discharged from facility on , d+[DATE], and he/she was waiting on the refund check from corporate office for resident; -Resident #206 discharged due to death on [DATE], they entered refund on [DATE] and he/she had not received a refund check from corporate office on resident; -Resident #207 discharged on [DATE]. The resident had been in facility for a planned two day respite but the responsible party took resident back home after only one day. He/She delayed the refund request due to responsible party asking to wait to issue refund in case they used additional respite. He/She did request refund on [DATE] During an interview on [DATE] at 1:04 P.M., Administrator said he/she expected personal funds to be conveyed upon discharge of residents within thirty days.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for three of fifteen sampled residents (Resident #10, #203, and #33) by not addressing use of side rails. The facility census was 58. Facility did not provide requested policy regarding comprehensive care plans. Review of facility policy, restraint use, dated 12/2024, showed: -Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot easily remove a device in the same manner in which staff applied it even that resident's physical condition, and this restricts their ability to change position or place, that device is considered a restraint. -Practices that utilize equipment to prevent resident mobility are considered restraints, include: using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed. -Restraints may be used only when the resident had specific medical symptoms that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medical symptom, protect the resident's safety, and help the resident attain the highest level of their physical or psychological well-being. -Care plans for residents in restraints will reflect interventions that address the medical symptom. 1. Review of Resident #10's admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 12/10/24, showed: -They had moderate cognitive impairment; -They had clear speech and was able to make self-understood and understand others; -They had impairment on one side of upper extremities and both sides of lower extremities; -They were dependent on a wheelchair; -Bed rail was not used; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included stroke (condition where blood flow to part of the brain is disrupted, causing brain cells to die due to lack of oxygen or nutrients), high blood pressure, diabetes (too much sugar in the blood), hemiplegia (a condition that causes paralysis or weakness on one side of the body). Review of care plan, dated 1/16/24, showed: -He/She required assist of one to reposition and turn in bed. -He/She required assist of two for transfers; -There was no side rail use care planned. Review of physician's orders, dated 1/14/25, showed no physician's orders for side rails were found. Review of physician's orders, dated 1/16/25, showed an order dated 1/14/24, review of bilateral assist rails to bed to promote bed mobility and assistance During an interview on 1/16/25 at 10:44 A.M., Resident said he/she used side rails to pull themselves up since having a stroke. Review of building management system record showed side rails were installed in resident room on 12/10/24 at 2:12 P.M. During an interview on 1/14/25 at 3:00 P.M., CNA E said: -Resident used side rails when they turned over to pull themselves over -They also used the bars to get up on the side of their bed. 2. Review of Resident #203's Admission MDS, dated [DATE], showed: -They were severely cognitively impaired; -They had clear speech and was able to make self-understood and understand others; -They did not use a bed rail; -They were dependent on a wheelchair; -They required substantial or maximal assistance with rolling left and right, sit to lying, lying to sitting on side of bed, chair to bed transfers, mobility; -Diagnoses included stroke, dementia (a decline in mental ability that affects memory, thinking, and behavior), urinary tract infection (an infection of the urinary system), and anxiety (a feeling of fear, dread, or uneasiness that can be a normal reaction to stress). Review of care plan, revised 1/9/25, showed: (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident required 1 staff participating to reposition and turn in bed; -Resident required the assistance of one staff with 4 wheeled walker with transfers; Review of physician's orders, dated 1/14/24, showed an order on 1/10/25, to start bilateral assist rails to bed to promote bed mobility and independence. Review of building management system record showed side rails were installed in resident room on 12/19/24 at 11:19 A.M. During an interview on 1/14/25 at 3:00 P.M., CNA E said the Resident used side rails to get up and turn themselves when they ask resident to turn 3. Review of Resident #33's admission MDS, dated [DATE], showed: -They were cognitively intact; -They had clear speech, able to make self-understood and understand others; -They were dependent for all mobility; -Bed rail was not used; Diagnoses included Parkinson's disease without dyskinesia (a progressive neurodegenerative disorder that cause movement problems), dementia (a general term for decline in mental ability that affects memory, thinking, and behavior), asthma (a chronic lung disease that causes inflammation in the airways, making it difficult to breathe), muscle weakness, diplopia (condition that causes double vision Review of care plan, dated 12/23/24, showed: -Avoid shearing while repositioning in bed; -Monitor for risk of falls; -Bed Mobility: requires assist of one to reposition and turn in bed -Transfer: Requires assist of two with sit to stand for transfers; -Use of side rails were not care planned. Review of physician's orders, dated 1/13/25, showed there was no orders for side rails. Observation on 1/13/25 at 11:29 A.M. showed bed had u-shaped rails on both sides of head of the bed in resident room. During an interview on 1/16/25 at 8:32 A.M., Resident said: -Side rails helped him get up and turn over in bed as they worked themselves around; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not use the side rails to get up; -Side rails were installed right after he/she first got to facility. Review of building management system record showed: -Bed rails were installed on 1/2/25 at 1:05 P.M. on resident's bed. During an interview on 1/14/25 at 3:00 P.M., CNA E said the resident had side rails because when he/she first entered facility he/she could not do anything on their own. 4. During an interview on 1/16/25 at 8:29 A.M. Licensed Practical Nurse (LPN) E said the side rails had to be documented in the care plan. During an interview on 1/16/25 at 10:04 A.M., Administrator said: -Care plans were written by multiple staff members; -Facility had two employees who worked remotely as out sourced staff to write care plans; -MDS Coordinator wrote some of care plans; -Activities Director wrote activity section of care plans. During an interview on 1/16/25 at 10:01 A.M., Assistant Director of Nursing said: -MDS coordinator did all the care plan writing; -He/She would help write new interventions on care plans. During an interview on 1/16/25 at 10:32 A.M., MDS Coordinator said: -He/She did not do separate care plans for side rails for residents; -He/she personalized resident's care plans within fourteen days from admission; During an interview on 1/16/25 at 1:04 P.M., Administrator said he/she expected residents who had side rails on their bed to have them care planned.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44993 Based on observation, interviews and record review, the facility failed to meet professional standards of quality care when Licensed Practical Nurse (LPN) B, prepared medications in advance and placed them in the second drawer of the medication cart for five residents (Resident #6, #32, #31, #105, and #106) out of 24 sampled resident's. The facility census was 58. Review of the Drug Administration General Guidelines policy, dated 5/2019 showed medications that are prepared by the nurse are given to the resident at the time they are prepared. 1. During an observation on 1/14/25 at 8:47 A.M. showed LPN C administered the resident his/her medications in a cup that was labeled with his/her room number. Review of Resident #6's admission Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/19/24 showed: - Diagnoses included: Pulmonary edema (fluid in and around the lungs) Chronic Kidney disease (CKD), and atherosclerotic heart disease (a disease that affects the way the heart pumps), high blood pressure, indigestion; - The resident had a brief interview for mental status score (BIMS) of 15, indicating no cognitive impairment; - The resident required some assistance from staff for hygiene and showering. The resident's comprehensive care plan dated 12/17/24 showed: - The resident had pain and the staff were supposed to provide medication as needed per physicians orders; - The resident had high blood pressure; - The resident had indigestion. Review of the residents Physician Order Sheet (POS) showed the following: - 12/16/24 Calcium 600 milligram (mg) plus vitamin D 400 units, give 2 tablets by mouth one time daily for a supplement; - 12/16/24 Protonix Delayed Release 40 mg by mouth one time daily, to treat indigestion; - 12/16/24 Vitamin D3 400 units by mouth one time daily for supplement; -12/16/24 Carvedilol 12.5 mg by mouth two times daily to treat high blood pressure; -12/16/24 Eliquis 2.5 mg by mouth two times daily to prevent blood clots; (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12/16/24 Hydralazine 25 mg one by mouth tree times per day to treat high blood pressure; - 12/16/24 Tylenol extra strength 500 MG give two tablets by mouth, three times per day for pain. During an interview on 1/14/25 at 8:47 A.M. LPN C and LPN B said: - LPN C said LPN B prepared the 8:00 A.M. medications for Resident #6 because LPN B did not think LPN C would be working that day; - LPN B said she prepared Resident #6's medications, but did not Adminster them to the resident; - LPN C said he/she was taught he/she was not supposed to give the resident medication he/she did not prepare; - LPN C said she should not have administered Resident #6's medications to him/her because LPN C did not prepare them; - LPN C said he/she should have destroyed the medications and prepared the resident's medications him/herself. LPN C said the medications he/she administered to Resident #6 was calcium with vitamin d, Protonix, Vitamin D3, Carvedilol, Eliquis, Tylenol and hydralazine. Review of the resident's MAR dated 1/14/25 showed: - LPN C documented he/she administered the resident's Calcium with D, Carvedilol, Eliquis, Protonix, and Vitamin D3; - LPN B documented he/she administered the resident's Hydralazine. 2. Observation of the 2nd floor medication cart on 1/14/25 at 11:47 A.M. showed the second drawer from the top of the cart had medications prepared in medication cups with resident room numbers written on the side of the cups. During an interview on 1/14/25 at 11:47 A.M. LPN B verified the medications in the medication cups were prepared for the 8:00 A.M. medication pass for Residents #32, #31, #105, and #106. 3. Review of of Resident #32's admission MDS, dated 1 2/13/24 showed: -Diagnoses included: Benign Prostate Hyperplasia (BPH, and enlargement of the prostate making it difficult to urinate), depression, and impaired cognitive function; -BIMS score of 12, indicating moderate cognitive deficit; -He/She was independent with his her activities of daily living (ADL's). Review of the resident's comprehensive care plan dated 1/13/25 showed: (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident was receiving an antibiotic for a urinary tract infection; - Re resident was receiving medication to treat, BPH and depression Review of the resident's POS dated 1/25 showed: - 1/13/25 Flomax Capsule 0.4 mg by mouth one time daily to treat BPH; - 1/13/25 Multiple vitamin give one tablet by mouth daily for a supplement; - 1/13/25 Sertraline 25 MG by mouth one time daily; - 1/13/25 Cefpodoxime Proxetil 200 mg, give one tablet by mouth two times daily to treat UTI; - 1/13/25 Memantine 5 mg, give one tablet by mouth two times daily to treat memory loss. 4. Review of Resident #31's Admission MDS, dated [DATE] showed: - Diagnoses included: Encephalopathy (impaired brain function), dysphagia (difficulty swallowing), aphasia (difficulty forming words), dementia (a disease that impact the brain affecting memory and reasoning); - BIMS score of 15, indicating the resident did not have cognitive impairment; - The resident required some assistance with showering and using the toilet. Review of the resident's comprehensive care plan dated 12/9/24: - The resident was prescribed medication to treat his/her dementia; - The resident had pain and received pain medications;\ - The resident had medication to treat high blood pressure. Review of the resident's POS dated 1/25 showed the following medications scheduled to be given at 8:00 A. M.: - 12/4/24 Aspirin 81 mg by mouth one time daily to thin the resident's blood; - 12/4/24 Losartan 50 mg by mouth one time daily to treat high blood pressure; - 12/24/24 Omeprazole delayed release 20 mg, give one capsule two times daily to treat indigestion; - 12/31/24 Reglan 5 mg, give two tablets by mouth two times daily for nausea; - 12/13/24 Lactase Enzyme, give two tablets by mouth before meals for stomach upset; - 12/4/24 Tramadol 50 mg, give one tablet by mouth three times per day for severe pain. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #105's record showed the following: - The resident did not have an MDS completed; - Diagnoses included: Lung cancer, high cholesterol, anticoagulant (prevent blood clots) therapy, and pain; - BIMS score of 15, indicating no cognitive deficit; - He/She required some assistance with toileting and showering; Review of the comprehensive e care plan dated /9/25 showed: - The resident was receiving medication to prevent blood clots; - The resident was receiving medication to treat pain; Review of the POS dated 1/25 showed the following 8:00 A.M. medication orders: - 1/16/25 Rivaroxaban 20 mg by mouth one time daily to prevent blood clots; - 1/9/25 Tylenol 325 mg, give two tablets by mouth four times daily to treat pain; -1/13/25 Gabapentin 100 mg, give one capsule by mouth four times daily to treat nerve pain. 6. Review of Resident #106's record showed the following: - No MDS; - Diagnoses Included: Mild stroke, atrial fibrillation (a disorder in which the heart does not pump properly and can cause a blood clot), high blood pressure, diabetes (a disease in which the body does not process blood sugar properly), heart failure, and tremors. Review of the comprehensive care plan, dated 1/2/25, showed the resident received medication to treat his/her diabetes, high blood pressure and BPH. Review of the resident's POS date 1/25 showed the resident received the following ordered medication for 8:00 A.M.: - 1/11/25 Aspirin 81 mg by mouth one time daily; - 1/11/25 Celecoxib 200 mg, one by mouth one time daily to treat pain; - 1/11/25 Dapagliflozin Propanediol 10 mg by mouth, one time daily to treat heart failure; - 1/11/25 Lisinopril 40 mg by mouth one time daily to treat high blood pressure; - 1/11/25 Montelukast sodium 10 mg by mouth one time daily to treat asthma; (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/11/25 Pantoprazole 40 mg by mouth, one time daily to treat indigestion; - 1/11/25 Tamsulosin 0.4 mg by mouth one time daily to treat BPH; - 1/11/25 Coreg 3.125 mg by mouth two times daily to treat high blood pressure; - 1/11/25 Glimepiride 1 mg by mouth two times daily to treat diabetes; - 1/11/25 Primidone 50 mg by mouth two times daily to treat tremors. 7. During an interview on 1/14/25 at 8:47 A.M. LPN B said: - LPN B said he/she prepared the resident's medications in advance because he/she did not have access to a computer when he/she went down the hall to pass medications. - LPN B said he/she know he/she was not supposed to prepare resident medications, then place the room number on the side of the medication cup and then place the cup in the 2nd drawer of the medication cart; - LPN B said he/she was trained to prepare the resident's medication and then give the medications immediately. During an interview on 1/14/25 at 2:06 P.M., the Director of Nursing said she would not expect resident medications to be prepared in advance and placed in the 2nd drawer of the medication cart; During an interview on 1/16/25 at 8:36 A.M. the Administrator said: - It was not acceptable for the nurses to prepare residents medications in advance, label the medication cup with the resident's room number, and place the medication cup in the medication cart; - Her expectation was the qualified staff prepare residents medications and administer them immediately to the resident.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46706 Based on observation, interview and record review the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADL's) received the necessary services to maintain good personal hygiene when the facility failed to provide perineal care every two hours for three residents (Resident #22 #24, and #2) and when facility failed to provide regular showers for one resident (Resident #28) of 15 sampled residents. The facility census was 58. Review of the facility's policy titled, Activities of Daily Living, undated, showed: -This facility provides the resident with care according to the resident's care plan; -Staff will assist residents in bathing, grooming and toileting. 1. Review of Resident #22's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/31/24, showed: -Severe cognitive impairment; -Dependent in toileting; -Dependent in showering; -Dependent in transfers; -Incontinent of urine and bowel; -Diagnoses included, dementia, kidney failure and high blood pressure. Review of the resident's care plan, dated 04/08/24, showed: -ADL self care deficit related to dementia; -Bladder and bowel incontinence; -Check frequently and as required for incontinence; -Assistance of two in toileting. Continuous observation beginning on 01/15/25 at 06:49 A.M., showed: -06:49 A.M., the resident is setting in the living room area in a wheelchair; -07:23 A.M., the resident is still setting at the dining room table in a wheelchair, no staff are in the dining room; (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-07:42 A.M., the resident is yelling for help; -07:48 A.M., Licensed Practical Nurse (LPN) A gave the resident a drink of water; -07:49 A.M., LPN A did not check the resident for incontinence or offer perineal care; -08:10 A.M., Certified Nurses Aide (CNA) A and CNA B walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; - 08:48 A.M., CNA A walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -08:51 A.M., LPN A walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -09:07 A.M., and CNA B walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -09:50 A.M., the resident setting in a wheelchair in the living room; -10:12 A.M., CNA A and CNA B walking by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -10:48 A.M., the resident setting in the living room area in the wheelchair with his/her eyes closed; -10:51 A.M., Certified Medication Technician (CMT) A propelled the resident to his/her room; -11:00 A.M., CMT A and CNA B transferred the resident to the bed and removed his/her brief; -The resident's brief was saturated with urine and had a strong foul odor. During an interview on 01/15/25 at 11:14 A.M., CMT A said: -The resident should be checked for incontinence at least every two hours; -He/she said perineal care should be given before 4 hours; -The nursing staff is responsible for making sure the residents are checked for incontinence and changed. During an interview on 01/15/25 at 11:24 A.M., CNA B said: -The resident should be checked for incontinence at least every two hours; -The staff were behind on providing care today. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #24's significant change MDS, dated [DATE], showed: -Severe cognitive impairment; -Substantial assist in toileting; -Dependent in showering; -Dependent in transfers; -Incontinent of urine and bowel; -Diagnoses included, Alzheimer's disease, thyroid disorder, and Gastroesophageal reflux disease (GERD, a digestive disorder that occurs when stomach acid flows into the esophagus). Review of the resident's care plan, dated 07/01/24, showed: -ADL self care deficit related to dementia; -Bladder and bowel incontinence; -Check frequently and as required for incontinence; -Assist of one in toileting. Continuous observation beginning on 01/15/25 at 06:55 A.M., showed: -06:55 A.M., the resident sat at the table in the dining room in his/her wheelchair; -07:28 A.M., the resident sat at the table in the dining room in his/her wheelchair; -08:08 A.M., LPN A propelled the resident to the living room area in his/her wheelchair. LPN A did not offer to toilet the resident; -08:10 A.M., CNA A and CNA B walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; - 08:48 A.M., CNA A walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -08:59 A.M. the resident sat in his/her wheelchair in the living room with his/her eyes closed; -09:03 A.M., LPN A propelled the resident into the den in his/her wheelchair and rubbed lotion on his/her legs. LPN A did not provide incontinent care for the resident; (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-09:06 A.M., LPN A propelled the resident back to the living room. LPN A did not provide incontinent care for the resident; -09:07 A.M., and CNA B walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -09:50 A.M., the resident setting in a wheelchair in the living room; -10:12 A.M., CNA and CNA B walking by the resident setting in his/her wheelchair in the living room; -CNA A and CNA B did not check the resident for incontinence or offer perineal care to the resident; -10:48 A.M., the resident setting in the living room in the wheelchair with his/her eyes closed. -During an interview on 01/15/25 at 11:18 A.M., CNA A said: -The resident should be checked for incontinence at least every two hours; -Perineal care should be provided at least every two hours; -The CNA's are responsible for making sure the residents are checked for incontinence and changed. During an interview on 01/15/25 at 11:24 A.M., CNA B said: -The resident should be checked for incontinence at least every two hours; -He/she said perineal care should be given before 4 hours; -The CNA's were responsible for making sure the residents were checked for incontinence and changed. 3. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent in toileting; -Dependent in showering; -Dependent in transfers; -Incontinent of urine and bowel; -Diagnoses included, Alzheimer's disease (a progressive brain disorder that causes memory loss and a decline in thinking skills), Diabetes mellitus (chronic disease that causes high blood sugar levels) and high blood pressure. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 08/01/24, showed: -ADL self care deficit related to dementia; -Bladder and bowel incontinence; -Check frequently and as required for incontinence; -Assist of two for toileting. Continuous observation beginning on 01/15/25 at 06:49 A.M., showed: -06:49 A.M., the resident setting at the dining room table in a wheelchair; -07:23 A.M., the resident still setting at the dining room table in a wheelchair -08:21 A.M., LPN A propelled the resident to the living room; -08:21 A.M., LPN A did not check the resident for incontinence or offer perineal care; -08:40 A.M., CNA A and CNA B walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; - 08:48 A.M., CNA A walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -08:51 A.M., LPN A walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -09:07 A.M., and CNA B walked by the resident setting in his/her wheelchair in the living room and did not check the resident for incontinence or offer perineal care to the resident; -09:36 A.M., LPN A propelled the resident in his/her wheelchair to resident's room; -09:38 A.M., LPN A did not check the resident for incontinence or offer perineal care to the resident; -09:50 A.M., The resident setting the wheelchair in his/her room; -10:12 A.M., CNA A and CNA B walking by the resident's room and did not check the resident for incontinence or offer perineal care to the resident; -10:14 A.M., Resident setting in his/her room in the wheelchair with his/her eyes closed; -10:47 A.M., Resident setting in his/her room in the wheelchair with his/her eyes closed; -10:55 A.M., No staff have checked the resident for incontinence or offered perineal care to the resident. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-During an interview on 01/15/25 at 11:18 A.M., CNA A said: -The resident should be checked for incontinence at least every two hours; -Perineal care should be provided at least every two hours; -The CNA's are responsible for making sure the residents are checked for incontinence and changed. During an interview on 01/15/25 at 11:27 at A.M., LPN A said: -Resident's should be checked for incontinence at least every two hours; -Perineal care should be provided at least every two hours; -He/she did not realize the resident had been setting for over 2 hours without being checked for incontinence; -He/she said 4 hours was too long for the resident to go without perineal care; -It is the responsibility of all nursing staff to ensure the residents are given perineal care at least every 2 hours. During an interview on 01/16/25 at 11:56 at A.M., the Director of Nursing (DON) said: -He/she expects perineal care to be provided residents at least every 2 hours and as needed; -Residents should not go for 4 hours with no perineal care. During an interview on 01/16/25 at 12:07 P.M., the Administrator said: -He/she expects perineal care to be provided residents at least every 2 hours and as needed; -Residents should not go for 4 hours with no perineal care; -He/she expects the nursing staff to ensure this gets done. 47195 4. Review of Resident #28's Admission MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech, was able to make self understood and understand others; -He/She needed set up or clean up assistance with toileting, bathing, upper and lower body dressing, eating, oral hygiene; -He/She was dependent for all mobility; (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was dependent on a wheelchair; -Diagnoses included: heart failure (a condition where the heart can't pump enough blood to meet the body needs), hypertension, renal failure (a condition when the kidneys are unable to filter waste products and toxins from the body), septicemia (a life threatening complication from an infection), arthritis (a condition that causes joint pain, swelling, stiffness, and limited movement), and muscle weakness (feeling of decreased strength or weakness in most of your muscles) Review of care plan, created 12/17/24, showed: -Bathing: required assist of one with bathing; -He/She did not have shower preferences care planned. During an observation and interview on 1/14/25 at 7:44 A.M., resident said: -When facility staff are super busy his/her shower got skipped; -He/She had not had a shower in two weeks; -The resident appeared unkempt; -It was hard for facility to maintain his/her showers as he/she was gone out of facility for dialysis three days a week from 10 A.M.-5:00 P.M.; -In order to get his/her rehabilitation therapy in he/she did it prior to leaving for dialysis in the mornings. Review of shower schedule posted at nurses station showed he/she was scheduled to receive showers on Mondays and Thursdays. Review of resident's shower task log in the electronic medical record, dated 12/16/24 to 1/14/25, showed: -He/She had only received three of nine scheduled showers in last thirty days on 12/19/24, 12/26/25, and 1/2/25. -He/She refused showers on 12/30 (a day he/she was out of facility for dialysis), 1/6 (a day he/she was out of facility for dialysis), and on 1/9. -He/She was unavailable for a shower on 1/13 (a day he/she was out of facility for dialysis) During an interview on 1/14/25 at 3:00 P.M., CNA E said: -He/She documented showers in the electronic medical record under the shower task log; -When resident refused shower then he/she will offer the shower again two additional times during his/her shift; (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The charge nurse will document if a resident refused showers in their progress notes; -Resident will refuse his/her shower at times especially if shower was scheduled on his/her day she went out for dialysis treatments. During an interview on 1/16/25 at 10:06 A.M., CNA C said: -Shower schedules are posted on the wall by nurses station; -The nurse writes down his/her shower assignments on his/her shift. During an interview on 1/16/25 at 10:11 A.M., DON said: -He/She expected residents to be offered two showers per week; -He/She expected residents to be offered more than three showers in thirty days; -When residents refuse showers staff marked refused and check more times during the shift; -CNA was expected to notify the nurse of the shower refusal and nurse documented refusal in progress notes; -Facility did get a lot of shower refusals due to residents being tired from their rehabilitation therapy or dialysis treatments; -He/She would expect staff to offer changing shower days if resident was too tired on their scheduled days.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observation, interview and record review, the facility failed to provide an ongoing program to support residents in their choice of activities designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident when residents were not offered convenient access to activities, informed when activities would occur, or encouraged to attend activities. This affected 6 residents (Residents #1, #28, #33, #37, #42 and #250) out of 15 sampled. The facility census was 58. Review of the facility's Life Enrichment Philosophy, undated, showed: - The Life Enrichment programming is rooted in person-centered care philosophy and honoring the choices of our residents; - To provide a multidisciplinary, team oriented approach to life enrichment in which all team members are responsible for the enrichment of the lives of the residents; - We recognize that participation and enjoyment are the defining elements of a successful program and modified programming for distanced enrichment when needed; - Residents in the Lotus program are focused on short-term rehabilitation and return to home and programming should focus on building skills for adapting to new needs at home such as wellness classes, technology classes, cooking and nutrition courses which can be repeated on a regular basis since the residents are short term; - Long-Term care residents programming should focus on fostering feelings of belonging, purpose, and friendship with adaptations for any level of physical and cognitive functioning; 1. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/22/24, showed: - No speech, hearing or vision deficits; - Understands others and can make themselves understood; - Cognitively intact with no behaviors; - Activity preferences of having books, newspapers and magazines are very important; - Activity preferences for music, animals, going outside, and religious services are very important; - Mobility for rolling, sit to lying, and lying to sitting requires partial/moderate assistance from a help for half the work; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Sit to stand, Chair to bed transfer, toilet transfer requires supervision or touching assistance from a staff member; - Resident uses a walker for ambulation; - Active diagnosis: Hip and knee replacement, heart failure, hypertension (high blood pressure), orthostatic hypotension (drop in blood pressure when standing), peripheral vascular disease (reduced blood flow to the body), GERD (acid reflux), ulcerative colitis (ulcers in colon and rectum), diabetes, hyperlipidemia (high cholesterol), anxiety disorder, depression; Review of Resident Care Plan revised 12/19/24 showed: - Resident enjoys Christian music, doing activities by themselves, being around children, cats, and dogs, doing crafts, going outside for fresh air, watching news on the TV, playing card or board games; During an interview on 1/13/25 at 1:51 P.M., resident said: - They have been here since 12/18/24 and only one time in 26 days has anyone come by to ask them if they wanted to go to an activity which are held on the 4th floor; - Resident resides on the 3rd floor and needs a staff member to take them to the 4th floor via elevator in order to participate in an activity since they are unable to walk due to hip and knee surgery; - Today on 1/13/24 the resident received the activity calendar for January and did not have one for December 2024; - Resident enjoys doing activities in a group; During an interview on 1/16/25 at 9:25 A.M., resident said they have not been offered any in room activities; 2. Review of Resident #250's admission record, dated 1/16/25, showed: - admitted [DATE]; - Diagnosis: cerebral ischemia (brain deprived of oxygen), cerebral infarction (stroke), spondylosis (arthritis), osteoarthritis left hip (cartilage and bone breakdown); Review of resident's care plan, dated 1/6/25, showed: - Resident likes to watch Kansas City Chiefs on TV, to be alone and do things by myself, to be around children, fish, go outside and get fresh air, participate in psychomotor activities since he/she played sports in the past; During an interview on 1/13/25 at 2:40 P.M., resident said: (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- They have been here for two weeks and today they received an activity calendar for January; - Resident did not know they had activities and would have attended if he/she knew about them; - Resident requires a staff member to take them to the 4th floor via elevator if they are going to leave the room for activities; 3. Review of Resident #37's Admission MDS, dated [DATE], showed: - Brief Interview of Mental Status (BIMS) of 11, indicated moderate cognitive impairment; - No behaviors; - Activities that are somewhat important to resident are music, animals, going outside and participating in religious services; -Diagnosis: hypertension (high blood pressure), renal insufficiency (kidney impairment), urinary tract infection, diabetes (chronic disease when body can't produce insulin), and Alzheimer's disease (progressive brain disorder); Review of resident's comprehensive care plan dated 12/16/24 showed: - Resident likes to be around children for an activity; - Resident has impaired cognitive function/dementia or impaired thought processes; During an interview on 1/14/25 at 9:33 A.M., family member said: - They are here most everyday with resident during the morning till late afternoon and they do not recall a staff member ever coming to see the resident to do one on one activities; During an interview on 1/15/25 at 9:15 A.M., CNA D said: - The activities director is responsible for getting residents to activities but for big events the CNAs help get people to the fourth floor; - Not many residents go to activities on the fourth floor from floors two and three and each of them would need an escort to get to the fourth floor due to the elevator trip; - There is one CNA and one Nurse during the day per 10 residents on each floor; During an interview on 1/16/25 at 10:30 A.M., the Activities Director said: - They canceled the 2:30 P.M. Bingo event yesterday because four residents were in a meeting, two from the third floor and two from the fourth floor. Missing those four residents out of a census of 58 was too many missing to conduct the event; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The room that the resident council interviews were being conducted at that time did not take up any space that the Bingo event would have utilized; 47195 Review of activity calendars showed: -November calendar: -All weekends showed activities with care staff; -Thanksgiving 11/28/24 and 11/29/24 showed activities with care staff; -Bottom of calendar showed 'join us on fourth floor for all activities; -December calendar: -All weekends showed activities with care staff; -Christmas day 12/25/24 showed activities with care staff; -Bottom of calendar showed join us on fourth floor for all activities; -January calendar: -All weekends showed activities with care staff; -New Years Day 1/1/25 showed activities with care staff; -Bottom of calendar showed join us on fourth floor for all activities; -1/13/25: 8:30 A.M. Coffee n chronicles, 10:00 Daily Prayer, 11:00 Telephone/Puzzle; 1:30 P.M. Fancy nails, and 2:30 P.M. Bingo; -1/14/25: 8:30 A.M. Coffee n chronicles, 10:00 Daily Prayer, 10:30 A.M. Music with [NAME], 1:30 P.M. EZ Snowbirds Painting, 2:30 P.M. Winter Reminisce; -1/15/25: 8:30 A.M. Coffee n chronicles, 10:00 Bible study with chaplain, 11:00 P.M. Sit and Be fit, 1:30 P.M. Let's talk NFL, 2:30 P.M. Bingo; -1/16/25: 8:30 A.M. Coffee n Chronicles, 10:00 Daily Prayer, 11:00 A.M. Balloon toss, 1:30 P.M., Sundance film of choice, 2:30 P.M. Utah word search. 4. Review of Resident #28's Admission MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech, was able to make self understood and understand others; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not socially isolate; -Customary routines and activities: Very import to choose what clothes to wear, take care of personal belongings or things, choose own bed time, have books, newspapers, and magazines to read, listen to music, favorite activities, get fresh air when weather is good, participate in religious services or practices, It was somewhat important to do things with groups of people. -He/She needed set up or clean up assistance with toileting, bathing, upper and lower body dressing, eating, oral hygiene, -He/She was dependent for all mobility and used a wheelchair; --Diagnoses included: renal failure (a condition when the kidneys are unable to filter waste products and toxins from the body), septicemia (a life threatening complication from an infection), diabetes (a condition of too much sugar in the blood), arthritis (a condition that causes joint pain, swelling, stiffness, and limited movement), and muscle weakness (feeling of decreased strength or weakness in most of your muscles). Review of care plan, dated 12/17/24, showed the following: activity preferences included -doing things with groups of people; -following all kinds of music; -enjoyment of being alone and do things independently; -Being around children; -Completing word games; -Going outside; -Watching television; -Playing card games or board games: spades, scrabble, and bingo; -Using the computer; -Watching nature; -Reading the bible. Review of activity and preferences comprehensive evaluation, dated 12/17/24, showed: -They served in the military via the navy; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident participated in resident preference interview; -It was very important for resident to have books, newspapers, and magazines to read; -It was very important to listen to all kinds of music; -It was very important to keep up with the news; -They liked doing things with groups of people when they were physically capable to do so; -Favorite activities included word games, card games such as spades, board games such as scrabble and bingo, using the computer, and watching nature; -It was very important to go outside and get fresh air; -It was very important to participate in religious services and preferences included Christian services; -In the past they would participate in bingo. -Resident was independently capable of choosing and attending activities; -Activity program summary showed passive activities resident would like to participate in included word games, listening to music, computer use, spiritual, and reading and active activities they would like to participate in included card playing and bingo. Review of life enrichment group participation log, dated 12/13/24-1/14/25, showed: -No activities were offered on Saturday 12/14/24, Sunday 12/15/24, Saturday 12/21/24, Sunday 12/22/24, Saturday 12/28/24, Sunday 12/29/24, Saturday 1/4/25, Sunday 1/5/25, Saturday 1/11/25, and Sunday 1/12/25; -Resident refused 8 social activities, was out of facility on for 10 days of social activities, and was in bed for 3 social activities; -Resident refused 9 emotional activities, was out of facility on 10 days of emotional activities, and was in bed for 2 days of emotional activities; -Resident refused 10 physical activities, was out of facility on 10 days of physical activities, and was in bed for two days of physical activities; -Resident refused 1 intellectual activity, and actively participated 22 days of intellectual activities; -Resident refused 1 spiritual activity and actively participated in 22 days of spiritual activities; -Resident participated in 23 independent activities. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Norterre		STREET ADDRESS, CITY, STATE, ZIP CODE 2555 Norterre Circle Liberty, MO 64068	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The log did not indicate what activities the resident participated in. During an interview on 1/14/25 at 7:56 A.M., Resident said: -They had seen one activity, a cookie decorating event around Christmas, and that event was canceled by staff; -They had waited with multiple other residents on the floor around the table waiting for the cookie decorating activity to start and nobody showed up; -One of the staff members had felt bad about the cancellation so located leftover cookies and brought them to the couple of residents who were still out in common area so they could decorate one cookie; -A new activity calendar must have been hung in his/her room on 1/13/25, because he/she had no January activity calendar until then; -They had only been invited to the cookie decorating class in the facility; -They were not aware of other activities available in the facility; -They were only around on Tuesday, Thursday, Saturdays, and Sundays all day as the other days he/she was out of facility for dialysis most of the day; -He/she did not see any activities happening on Tuesdays, Thursdays, Saturdays, or Sundays. -He/She had asked other residents and had been told that they could either watch television in the common area or hang out in his/her bedroom. During a continuous observation on 1/14/25 from 12:47 P.M. to 3:14 P.M. showed no activities were offered to the resident. During an interview on 1/15/25 at 8:54 A.M., resident said: -Yesterday was the first time he/she had been was offered an activity; -They was offered to attend a painting class; -They indicated they would go to class but later changed their mind; -The only other time that they were offered to participate in an activity was the cookie class in December; -They were informed yesterday for the first time that activities were offered on the fourth floor; -They did not know that activities were available on the fourth floor until 1/14/25; -They had never refused activities until the painting class that was offered yesterday; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-They would love social interaction and was desperate to socialize; -Their activity log for December and January was not accurate because they had not refused any activities until 1/14/25. During an observation on 1/16/25 at 8:51 A.M. showed Activity Director entered resident's room and left daily chronicle. Activity Director did not say anything about activities that were going on but handed resident the piece of paper and left the room. During an interview on 1/15/24 at 4:50 P.M., Activity Director said: -They did not remember what activities Resident #28 liked doing; -They invited resident #28 to activities all the time; -There was only two activities that Resident #28 said yes to attending. 5. Review of Resident #33's admission MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech, able to make self-understood and understand others; -He/She had no impairment of upper and lower extremities; -He/She was dependent on a wheelchair; -Preferences for customary routine and activities showed it was very important to have books, newspapers, and magazines to read, keep up with news, go outside and get fresh air when weather is good, and participate in religious services or practices; Diagnoses included Parkinson's disease without dyskinesia (a progressive neurodegenerative disorder that causes movement problems), dementia (a general tem for decline in mental ability that affects memory, thinking, and behavior), anxiety (feeling of fear, dread, or uneasiness that can be normal reaction to stress), depression (a mental disorder that can impact a person's mood, thoughts, and ability to function), asthma (a chronic lung disease that causes inflammation in the airways, making it difficult to breathe), chronic venous insufficiency (condition where veins in the legs become damaged preventing blood from flowing effectively back to the heart), muscle weakness, diplopia (condition that causes double vision). Review of care plan, dated 12/24/24, showed: -Activity preferences included -Enjoyed of doing things with small groups of people; -Liked following sports teams: the chiefs. They liked watching chiefs on television; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enjoyed being around animals and liked dogs; -Liked to be around children; -Liked to go outside and get fresh air when weather was good; -Enjoyed keep up on the news by watching television; -Liked to read. Review of activity and preferences comprehensive evaluation, dated 12/23/24, showed: -Resident interview was completed by the resident; -It was very important to have books, newspapers, and magazines to read; -They liked being around animals specifically dogs; -They liked following sports teams, specifically the chiefs; -They enjoyed going outside; -It was very important to participate in religious services or practices and they preferred Christian services; -They enjoyed doing things with small groups of people; -In the past they enjoyed doing puzzles; -They were independently capable of choosing and attending activities Review of life enrichment group participation log, dated 12/21/24-1/14/25, showed: -No activities were offered on Saturday 12/21/24, Sunday 12/22/24, Saturday 12/28/24, Sunday 12/29/24, Saturday 1/4/25, Sunday 1/5/25, Saturday 1/11/25, and Sunday 1/12/25; -Resident refused all social, emotional, and physical group activities; -Resident participated in 7 intellectual activities; -Resident participated in six spiritual activities; -Resident participated in 17 independent activities; -The log did not indicate what activities the resident participated in. During an interview on 1/13/25 at 11:29 A.M., Resident said: (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Therapy was the only activity that he/she had seen while living in facility; -They could either watch the big television in the lounge or in their room; -They socialized at breakfast table but their was no other social activities offered by facility staff; -They knew the activity director had been off work for three weeks; -The activity director just came in to their room and put up a January activity calendar today; -They reviewed activity calendar that was just hung and had never seen any of the activities listed; -They did not know where bingo was at; -The calendar did not direct them where to go to participate in the activities; -They had not seen any daily prayer occurring; -They had observed puzzles on the calendar but had saw no puzzles laying around for them to do. During a continuous observation on 1/14/25 from 12:47 P.M. to 3:14 P.M. showed no activities were offered to the resident. During an interview on 1/15/25 and 2:29 P.M., Resident said: -They had no idea any activities were going on until they had looked at calendar. During an observation on 1/16/25 at 8:51 A.M. showed Activity Director entered resident's room and handed resident daily chronicle. Activity Director did not say anything about activities that were going on but handed resident the piece of paper and left the room. During an interview on 1/15/24 at 4:50 P.M., Activity Director said: -Resident #33 did not come to any activities; -They had a hard time convincing resident #33 to participate in activities; -They did not remember any activities that the resident #33 enjoyed doing from the initial assessment she did with resident upon admission. 6. Review of Resident #42's admission MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech, ability to make self understood and clear comprehension of others; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It was very important to have family or close friend involved in discussions about care; -It was somewhat important to listen to music, keep up with the news, do things with groups of people, to do favorite activities, go outside and get fresh air when the weather was good; -He/She had limited range of motion on both sides of lower extremities; -He/She was dependent on wheelchair and walker; -He/She required substantial/maximal assistance with mobility of rolling left and right, sit to lying, and lying to sitting; -He/She was dependent for sitting to stand transfers, chair to chair/bed transfers, toilet transfers -Diagnoses included: hip fracture, enterocolitis caused by clostridium difficile (a bacterial infection that results in inflammation of the colon and diarrhea), muscle weakness, pulmonary hypertension (condition where blood pressure in arteries of the lungs is abnormally high, causing the right side of the heart to work harder to pump blood through the lungs, leading to symptoms like shortness of breath and chest pain), lymphedema (condition that causes swelling in the body due to buildup of lymph fluid). Review of care plan, dated 11/27/24, showed: -Activity preferences included liked being around children. Review of activity and preferences comprehensive evaluation, dated 11/25/24, showed: -He/She served in military in the navy; -Resident interview showed the resident was not interviewed; -Staff interviewed showed it was important for family or significant other involved in care; -Activity history showed resident wanted to focus on therapy. not interested in doing activities; -Assistance required showed resident was independently capable of choosing and attending activities. Review of life enrichment group participation log, dated 11/23/24-1/14/25, showed: -No activities were offered on Saturday 11/23/24, Sunday 11/24/24, Saturday 11/30/24, Sunday 12/1/24, Saturday 12/14/24, Sunday 12/15/24, Saturday 12/21/24, Sunday 12/22/24, Saturday 12/28/24, Sunday 12/29/24, Saturday 1/4/25, Sunday 1/5/25, Saturday 1/11/25, and Sunday 1/12/25; -Resident was out of facility from 12/3/24-12/9/24; -Resident refused social, emotional, physical activities on 32 days; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident actively participated in intellectual, spiritual, and independent activities on 32 days; -The log did not indicate what activities the resident participated in. During an interview on 1/13/25 at 11:15 A.M., Resident said: -They did not know about activities offered; -Nobody came around to invite them to participate in activities; Observation showed on 1/13/25 at 11:16 A.M. that Activity Director entered resident room during interview and brought a January activity calendar. Activity Director was observed asking resident where they wanted the calendar hung. Activity Director also observed handing resident a piece of paper titled the daily chronicle. During an interview on 1/13/25 at 11:17 A.M., Resident said that was about as much activity as they received on activities. During a continuous observation on 1/14/25 from 12:47 P.M. to 3:14 P.M. showed no activities were offered to the resident. During an observation on 1/16/25 at 8:51 A.M. showed Activity Director entered resident's room and handed resident daily chronicle. Activity Director did not say anything about activities that were going on but handed resident the piece of paper and left the room. During an interview on 1/15/25 at 4:45 P.M., Activity Director said: -Resident #42 did not participate in group activities; -Resident #42 only participated in their rehabilitation therapy; -They did not know what resident #42 liked or disliked since completing the residents admission assessment; -Resident #42 never came to their activities. During a group meeting held 1/15/25 at 2:29 P.M., 2 of 4 residents said they had no idea any activities were going on in the facility. During an interview on 1/14/25 at 3:00 P.M., Certified Nurse Aide (CNA) E said: -There were no activities offered to residents on the third floor; -Residents had to be taken up to the fourth floor for activities; -They had observed Activity Director occasionally come down to third floor and ask residents if they wanted to go to fourth floor for activities; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Facility used to offer activities on the third floor but had not in a long time; During an interview on 1/15/25 at 11:13 A.M., Director of Nursing (DON) said: -Activities were offered on every floor of facility; -Depending on number of residents interested in an activity the facility would combine groups from different floors; -Residents on fourth floor were really passionate about playing bingo; -Activities Director will go in and complete an activity assessment with all residents within 48 hours of admission; -Activities Director ensures residents all have an activity calendar in their room; -Activity Director will go around and ask residents if they want to participate in available groups; -There are residents who will say that they are in facility for rehabilitation and they did not care about facility activities; -Activity Director got to know each residents likes and dislikes in regards to activities; -Activity Director will come down to other floors and take residents up to fourth floor for activities. During an interview on 1/15/25 at 11:42 A.M., Licensed Practical Nurse (LPN) D said: -Most activities were offered off the floor on the fourth floor; -The fourth floor was where the long term care residents mostly resided; -It was very rare for activity staff member to come to the floor to initiate activities; -Most residents on second and third floors were kept busy with rehabilitation therapy. During an interview on 1/15/25 at 4:45 P.M., Activity Director said: -They completed activity assessments with residents when they first admitted to the facility and then updated them quarterly and annually; -They did not participate in care planning process for residents; -They learned residents likes and dislikes based on the assessments she completed; -Residents were informed of daily activities by calendars in their rooms; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents were also provided a piece of paper titled the daily chronicle to read every morning; -The daily chronicle had a prayer attached to it every day; -The daily chronicle informed residents what was happening throughout the day; -They saw every resident every day because they went to every residents room to pass out the daily chronicle; -They offered a physical activity every day; -Physical activities included a class titled sit and be fit, a balloon toss, and chair yoga, -Social activities were offered daily to include bingo, food, crafts; -Bingo was held Monday, Wednesday, and Friday but they only had a couple of residents that attended regularly; -Intellectual and spiritual activities were counted by handing out the daily chronicle piece of paper; -Activities were held on the fourth floor; -Residents were notified of activities by the calendar hanging in the he wall in every resident room; -They had not done the January calendar until 1/13/25 due to being off work the past three weeks; -1/13/25 was their first week back to work; -Facility aides and nurses occasionally assisted them with activities; -The facility CNA's and nurses are aware to bring residents up to the fourth floor for activities; -The residents that are in the facility for rehabilitation did not care to do anything with them unless it was a fun food or craft activity; -Activity participation from residents not residing on the fourth floor was poor, they were lucky to get any residents to attend activities from the second or third floors of facility; -There was no reason that they did not schedule activities on second and third floors; -Activities previously were scheduled on various floors but did not engage much participation; -They were currently lucky to get one person from each floor to come to the fourth floor to participate in activities were scheduled; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The largest participation they had included eight residents for an outside led hospice activity and the reason they had so many was because he/she went room to room and got residents not cognitively aware to sit in on the group. -It was more reasonable to offer activities on the fourth floor; -Their office was on the fourth floor; -They did not write care plans; -They obtained information from residents upon admission for the MDS assessments; -They tried to plan activities that would accommodate residents physical abilities such as offering items the one handed residents could complete; -They did not document anything in residents electronic medical record on activities and they did not document in progress notes any of residents participation. During an interview on 1/16/25 at 10:11 A.M., DON said: -Activities are ran on fourth floor because residents are good friends and want to sit at same table; -Activity director completes the care plan section on activities for all residents; -Activities staff will take residents to fourth floor to participate in activities; -Activities staff goes around and informs residents of activities throughout the day; -If activity director is off the Administrator in Training fills in for them or facility had transportation staff fill in for activity staff; -They expected residents to be informed of what activities were going on in the facility throughout the day; -Facility would not commingle residents from different floors for activities if they were dealing with an outbreak; -If respiratory infection was going around on one of the floors the residents residing on that floor would not be taken to another floor for an activity so that the outbreak could be contained. During an interview on 1/16/25 at 1:04 P.M., Administrator said: -They expected residents to be informed of activities available in the facility; -They expected meaningful activities to be offered to all residents; -They expected activities to be offered on the resident's floors that they resided on; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-They expected staff to notify residents of activities being offered within the facility.		

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. 47195 Based on observation, interview, and record review the facility failed to employ a qualified activity professional to oversee the activity program of the facility. The facility employees a full time activity director but he/she has not completed an approved activity professional training program. The facility census was 58. The facility did not provide a policy regarding activity professional training and requirements. Review of facility policy, life enrichment, undated, showed: -It was responsibility of all team members under the guidance of the Activity Director to ensure implementation of minimum standards for life enrichment programming; -Life enrichment program was built on five dimensions of wellness: Physical, social, emotional, spiritual, and Intellectual and should be informed by resident references, expressed interests, and goals. -Residents in long-term care group should focus on fostering feelings of belonging, purpose, and friendship with adaptations available for any level of physical and cognitive functioning; -Program goals: to provide support to our staff through continued education and stress management programs. During an interview on 1/15/25 at 5:02 P.M., Activity Director said: -He/She has been activity director since October 2024; -He/She had not had formal job specific training for being the activity director but picked up on things well; -He/She had received emails from corporate staff on scheduled monthly calls for activity training's but when he/she tried to participate in call there was nobody on the call to lead the meeting; -He/She had been working in long term care for last ten years in nursing aide positions. During an interview on 1/16/25 at 1:04 P.M., Administrator said: -He/She expected activity director to be qualified by having state training or certification; -He/She was in process of getting Activity Director into a training program; -He/She was aware that activity director had not been state trained or certified.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on interview and record review the facility failed to recognize, treat and notify the primary physician of severe/significant weight loss for two of the 15 sampled residents (Resident #37 and #251). The facility census was 47. Review of facility policy Nutrition Impaired/Unplanned Weight Loss, undated, showed: - The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time; - 1 month 5% weight loss is significant, greater than 5% is severe; - 3 months 7.5% weight loss is significant, greater than 7.5% is severe; - The Physician will review possible causes of anorexia or weight loss with the nursing staff and/or Dietitian before ordering interventions; - The Dietitian will estimate calorie, nutrient and fluid needs and, with the Physician, will identify whether the resident's current intake is adequate to meet his or her nutritional needs; - The staff and Physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis and treatment wishes; 1. Review of Resident #37 Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 12/18/24 showed: - Brief Interview of Mental Status (BIMS) of 11, indicated moderate cognitive impairment; - No behaviors; -Set up assistance of staff for meals; -Diagnosis: hypertension (high blood pressure), renal insufficiency (kidney impairment), urinary tract infection, diabetes (chronic disease when body can't produce insulin), and Alzheimer's disease (progressive brain disorder); Review of resident's comprehensive care plan dated 12/16/24 showed: - Resident has potential for impairment to skin integrity due to impaired mobility. Encourage good nutrition and hydration in order to promote healthier skin; - Resident prefers snacks between meals and would like an apple with peanut butter, popcorn or anything for a snack; - Resident has diabetes. Conduct dietary consult for nutritional regimen and ongoing monitoring; (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Monitor/document/report to Medical Doctor (MD) weight loss; - Offer substitutes for foods not eaten; - Monitor/record/report to nurse loss of appetite, refusal to eat and weight loss; - Resident has potential for nutritional problems. Monitor/record/report to MD significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months; - Registered Dietician (RD) to evaluate and make diet change recommendations; - Resident has an ADL self care performance deficit. Requires meal setup to eat, may need cues; - Resident is on psychotropic medication, monitor for weight loss and poor appetite. During an interview on 1/13/25 at 4:24 P.M., family member said the resident is visibly losing weight and they have asked staff for the resident's weight and total loss but have not received a response. Observation on 1/14/25 at 3:37 P.M. showed the residents legs, hands and arms appeared to be thin and the resident looked frail. During an interview on 1/14/25 at 3:44 P.M., RD said: - She monitors monthly for weight changes and is not normally contacted by staff when there is a significant weight loss; - She looks at each case individually and looks at key factors such as intake, medications and will normally make sure there are dietary supplements like Boost available for resident; Observation on 1/15/25 at 7:20 A.M., showed the resident sitting at the dining room table with nothing on the table in front of them waiting for breakfast to be served at 8:00 A.M. Observation on 1/15/25 at 8:56 A.M. showed CNA D collecting room trays from multiple residents without recording any information about food intake. Observation on 1/15/25 at 9:15 A.M. showed the resident sitting at same position in dining room with food in front of them completely untouched. One can of boost was sitting at the table in front of resident and the resident was not alert to his/her surroundings. During an interview on 1/15/25 at 9:20 A.M., CNA D said: - He/she learns about her residents through personal interactions with them but does not review any documents regarding their care. Information is passed down from the nurses about residents; - He/she uses eating habit history and memory to record how much each resident intakes for meals and might not get the information from breakfast entered until lunchtime; (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Norterre		STREET ADDRESS, CITY, STATE, ZIP CODE 2555 Norterre Circle 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident's weight record showed: - 12/16/24 weight of 139.8 Lbs, (admission weight); - 1/6/25 weight of 128.8 Lbs, (-7.87%, < 1 month, significant weight loss); - 1/13/25 weight of 126.6 Lbs, (-9.44%, < 1 month, significant weight loss); Review of resident's meal intake percentage showed an average oral intake of 50% of their meals completed from 1/1/25 through 1/14/25. Review of resident progress notes from 12/16/24 through 1/14/25 showed no dietary notes or notification to the physician regarding a severe weight loss. 2. Review of Resident #251 MDS, dated [DATE], showed the record was not completed by staff and no other MDS information was available. Review of resident's admission record, dated 12/28/24, showed: Diagnosis: Hemiplegia and hemiparesis (weakness left side of body) following cerebral infarction (stroke), pneumonia, acute respiratory failure (a life-threatening condition that occurs when the lungs are unable to exchange gases properly with the blood), cognitive communication deficit (difficulty with communication caused by a cognitive impairment), diabetes (chronic disease when body can't produce insulin), hyperlipidemia (high cholesterol), chronic heart failure, dysphagia (swallowing difficulties); Review of resident's comprehensive care plan dated 12/16/24 showed: - Resident requires tube feeding due to Dysphagia (swallowing problem, 12/30/24); - RD to evaluate quarterly and as needed, monitor caloric intake, estimate needs, make recommendations for changes to tube feeding; - Resident has diabetes. Monitor/document/report to physician as needed for weight loss; - Resident has nutritional problem and requires G-tube (small tube that's surgically inserted into the stomach through the abdomen) for nutrition and hydration. RD to evaluate and make diet recommendations as needed; - Resident has potential for fluid deficits due to diuretic use. Monitor/document/report to physician of weight loss; Review of resident's weight record showed: - 12/28/24 weight of 140.5 Lbs, (admission weight); - 1/8/25 weight of 129.8 Lbs, (-7.62%, < 1 month, significant weight loss); (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident's progress notes from 12/28 through 1/15/24 showed: - No dietary notes regarding a severe weight loss or notification to the physician; - Note dated 1/8/25 at 2:57 P.M. showed < 5% and < 7.5% change in weight for resident without any time reference attached; During an interview on 1/15/25 at 10:00 A.M., LPN B said: - Residents with significant or severe weight losses will be normally identified by nursing staff; - Weights are normally charted by the nurses and sometimes the CNA and staff are looking for weekly trends in weight loss; - Weight loss calculations are done with a computer program which will alert them if there is a significant or severe weight loss; - If a significant or severe weight loss is identified then staff will immediately notify the physician and family and start developing a plan of action and that should be found in the residents chart; - Currently there are no residents that identify as having a significant or severe weight loss that they are aware of; During an interview on 1/16/24 at 1:30 P.M., DON said: - Weekly weights are reviewed by nursing staff and the dietician and believes that the severe weight loss for resident #37 is due to a scale error while using a wheelchair but that has not been verified; - Staff should reach out to the physician or dietician when a significant or severe weight loss is discovered so the next steps or interventions can be taken. Weights should be done on a consistent basis using the same weight method; - A progress note contacting the doctor and dietician will be in the record identifying a significant or severe weight loss condition.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation, record review, and interview, the facility failed to assess residents for risk of entrapment from bed rails prior to installation, failed to obtain informed consent of risks and benefits of side rails prior to installation, failed to obtain physician's orders for side rails prior to installation, and failed to ensure the bed's dimensions were appropriate to the resident's size and weight, and failed to have a system in place to check bed rails regularly to make sure they were installed correctly for three of fifteen sampled residents (Resident #10, #203, and #33). The facility census was 58. Review of facility policy, restraint use, dated 12/2024, showed: -Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot easily remove a device in the same manner in which staff applied it even that resident's physical condition, and this restricts their ability to change position or place, that device is considered a restraint. -Practices that utilize equipment to prevent resident mobility are considered restraints, include: using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed. -Restraints may be used only when the resident had specific medical symptoms that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medical symptom, protect the resident's safety, and help the resident attain the highest level of their physical or psychological well-being. -Prior to placing a resident in restraints, there shall be an assessment and review to determine the need for the restraints. Review of resident record to determine alternative interventions to the restraint were attempted and documented. -Emergency use of restraints is permitted if their use is immediately necessary to prevent the resident from injuring themselves or others or to prevent the resident from interfering with life-sustaining treatment, and no other less-restrictive interventions are feasible. -The Director of Nursing (DON) has the authority to order the use of emergency restraints. The attending physician must be notified of such use and the reason for the order. -Orders for emergency restraints may be received by telephone, and shall be signed by the physician within 48 hours; (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. the order shall include the following: -The specific reason for the restraint (as it relates to the resident's medical symptoms) -The type of restraint, and period of time for the use of the restraint. -Residents and/or representative shall be informed about the potential risks and benefits and consent shall be obtained. -Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive method of restraints, and total restraint elimination. -Care plans for residents in restraints will reflect interventions that address the medical symptom. Review of manufacturers guidelines, bed system measurement device, undated, showed: -Test when a modification was made to assist devices and side rails. -Test according to manufacturers requirements 1. Review of Resident #10's admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 12/10/24, showed: -They had moderate cognitive impairment; -They had clear speech and was able to make self-understood and understand others; -They had impairment on one side of upper extremities and both sides of lower extremities; -They were dependent on a wheelchair; -Bed rail was not used; -Diagnoses included stroke (condition where blood flow to part of the brain is disrupted, causing brain cells to die due to lack of oxygen or nutrients), high blood pressure, diabetes (too much sugar in the blood), hemiplegia (a condition that causes paralysis or weakness on one side of the body). Review of care plan, dated 1/16/24, showed: -He/She required assist of one to reposition and turn in bed. -He/She required assist of two for transfers; -There was no side rail use care planned. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician's orders, dated 1/14/25, showed no physician's orders for side rails were found. During an interview on 1/16/25 at 10:44 A.M., Resident said he/she used side rails to pull themselves up since having a stroke. Review of building management system record showed side rails were installed in resident room on 12/10/24 at 2:12 P.M. Review of electronic medical record on 1/13/24 showed: -12/9/24, Resident risk evaluation showed restraints were being reviewed but no side rails or grab bars were needed; -1/1/25 showed verbal consent was obtained from resident to install side rails. -No device or restraint evaluation was found. Review of device restraint evaluation, dated 1/1/25, showed: -Resident used or requested use of side rails to assist with positioning -Alternatives were attempted to include a low bed; -Used to prevent injuries, reduce fall potential, and functional enhancement; -Physician order was obtained, consent was signed, and had been signed in last year; -Signed by Assistant Director of Nursing (ADON) on 1/14/25. Review of bed system measurement device test results showed: -1/1/25 showed bed make: zenith, model 17EL1213, mattress sizewize, model NPT3 was tested in zones 1-3 on both sides of the rail and the bed passed the assessment. -Measurements shown Zone 1: 4 inches and 16lbs, Zone 2: 4 inches, and Zone 3: 4 inches on both sides of the bed. During an interview on 1/14/25 at 3:00 P.M., CNA E said: -Resident used side rails when they turned over to pull themselves over -They also used the bars to get up on the side of their bed. 2. Review of Resident #203's Admission MDS, dated [DATE], showed: -They were severely cognitively impaired; -They had clear speech and was able to make self-understood and understand others; (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-They did not use a bed rail; -They were dependent on a wheelchair; -They required substantial or maximal assistance with rolling left and right, sit to lying, lying to sitting on side of bed, chair to bed transfers, mobility; -Diagnoses included stroke, dementia (a decline in mental ability that affects memory, thinking, and behavior), urinary tract infection (an infection of the urinary system), and anxiety (a feeling of fear, dread, or uneasiness that can be a normal reaction to stress). Review of care plan, revised 1/9/25, showed: -Resident required 1 staff participating to reposition and turn in bed; -Resident required the assistance of one staff with 4 wheeled walker with transfers; Review of physician's orders, dated 1/14/24, showed: -Order started 1/10/25, bilateral assist rails to bed to promote bed mobility and independence. -Side rails were installed on 12/19/24, prior to obtainment of physician's orders. Review of building management system record showed side rails were installed in resident room on 12/19/24 at 11:19 A.M. Review of electronic medical record on 1/13/24 showed: -1/7/25 a resident bed rail/enabler consent was obtained. -1/7/25 a device restraint evaluation was completed for unsafe mobility, bed positioning or transfers, and benefit was noted for prevention of injuries. The restraint consent had not been marked on form, physician order had been obtained. A lesser restrictive device had not been marked as attempted Review of bed system measurement device test results showed: -1/1/25 showed bed make: zenith, model 17EL1213, mattress sizewize, model NPT3 was tested in zones 1-4 on both sides of the rail and the bed passed the assessment. -Measurements showed Zone 1: 4 inches, Zone 2: 4 Inches 16lbs, Zone 3: 4 inches on both sides of the bed. During an interview on 1/14/25 at 3:00 P.M., CNA E said the resident used side rails to get up and turn themselves when they ask resident to turn. 3. Review of Resident #33's admission MDS, dated [DATE], showed: -They were cognitively intact; (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-They had clear speech, able to make self-understood and understand others; -They were dependent for all mobility; -Bed rail was not used; Diagnoses included parkinson's disease without dyskinesia (a progressive neurodegenerative disorder that cause movement problems), dementia (a general term for decline in mental ability that affects memory, thinking, and behavior), asthma (a chronic lung disease that causes inflammation in the airways, making it difficult to breathe), muscle weakness, diplopia (condition that causes double vision Review of care plan, dated 12/23/24, showed: -Avoid shearing while repositioning in bed; -Monitor for risk of falls; -Bed Mobility: requires assist of one to reposition and turn in bed -Transfer: Requires assist of two with sit to stand for transfers; -Use of side rails were not care planned. Review of physician's orders, dated 1/13/25, showed there was no orders for side rails. Observation on 1/13/25 at 11:29 A.M. showed bed had u-shaped rails on both sides of head of the bed in resident room. Observation on 1/14/25 at 2:29 P.M. showed resident had two u-shaped side rails at the head of their bed. Observation on 1/15/25 at 8:03 A.M. showed resident had two u-shaped side rails at the head of their bed. During an interview on 1/16/25 at 8:32 A.M., Resident said: -Side rails helped him get up and turn over in bed as they worked themselves around; -He/She did not use the side rails to get up; -Side rails were installed right after he/she first got to facility. Review of building management system record showed bed rails were installed on 1/2/25 at 1:05 P.M. on resident's bed. Review of electronic medical record on 1/13/24 showed: -No device restraint evaluation found; (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No consent for side rail found. Review of device restraint evaluation, dated 1/1/25, showed: -Resident requested use of side rails; -Resident used side rails to assist with positioning; -Alternatives attempted included a low bed prior to install; -Benefits of device/restraint use included prevention of injuries, reduced fall potential, and functional enhancement; -Physician order was marked that it was obtained; -Restraint consent was marked that it was obtained. Review of bed system measurement device test results showed there was no bed system measurement results provided for this resident. During an interview on 1/14/25 at 3:00 P.M., CNA E said the resident had side rails because when they first entered facility they could not do anything on their own. During an interview on 1/16/25 at 9:10 P.M., CNA C said the resident used side rails to help them up for support in getting up and out of their bed. 4. During an interview on 1/16/25 at 8:29 A.M. Licensed Practical Nurse (LPN) E said: -Residents have to be evaluated by therapy for side rails; -Therapy gives the okay; -Facility has to obtain a physician's order for the side rails; -The physician had to be contacted; -Maintenance was contacted to install the side rail; -The side rail must be added to the resident's care plan; -Nursing completed a device assessment; -If nursing missed completing the device assessment then the DON was supposed to see if it was done. During an interview on 1/16/25 at 8:45 A.M., Maintenance staff said: -They learned about work orders through the building management system; (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-They received orders to install side rails via the building management system; -Maintenance Supervisor completes the bed checks; -He/She did not do any measurements of beds or mattresses; -The mattresses in the facility were all the same; -He/She did not know how often bed checks were completed. During an interview on 1/16/25 at 9:03 A.M., Maintenance Director said: -Therapy staff or nursing staff determine if resident requires side rails; -That information was then escalated to the ADON; -They only installed bed rails on resident beds after getting word from the ADON; -A work order was placed in the building management system in regards to putting on or taking off side rails; -Maintenance was always the staff responsible for installing or taking off side rails; -Facility had a test kit that measures four or six inches to ensure proper measurements of the side rails to the bed; -The device measures gaps between the side rail and bed frame; -Maintenance staff complete a full audit on all beds; -Facility used the exact same bed facility wide -Facility did not have any document of testing room [ROOM NUMBER]; -They had documentation when the side rail was put on the resident's bed via the building management system; -After a side rail was installed and once a resident exits the facility the housekeeper will notify maintenance via the building maintenance system of a need to remove bed rails prior to a new resident moving into facility; -They only installed side rails if ADON put the order in; -Maintenance did not have system of regular checking bed measurements after initial bed testing and measurements were taken; -Maintenance completed bed checks semi-annually; (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/16/25 at 9:08 A.M. showed facility had a box containing bed measurement system. During an interview on 1/16/25 at 9:09 A.M., Maintenance Director said: -The bed measurement system was used after the side rail was installed; -If the device falls through then they were aware that the bed rail had not been installed correctly During an interview on 1/16/25 at 9:24 A.M., Physical Therapist said: -The Director of Rehabilitation (DOR) will contact the ADON about the need for side rails; -The ADON has to put in the orders for the side rails to be installed. During an interview on 1/16/25 at 9:27 A.M., Director of Rehabilitation said: -When new residents admit to the facility the evaluating therapist will notify him/her on whether a resident would benefit from use of a right or left assist bar; -He/She then sends an email to the ADON so they can write an order; -The ADON then obtains the order and will then notify maintenance to get the assist bar installed on the bed. During an interview on 1/16/25 at 10:08 A.M., ADON said: -Therapy evaluates residents for need of side rails and then notifies him/her; -He/She then provides assessment orders; -Maintenance staff will get an order to install the side rails; -They have to obtain a physician's order prior to installing the side rails on resident's bed; -Maintenance was responsible for entrapment assessments and bed measurements. During an interview on 1/16/25 at 10:11 A.M., Director of Nursing (DON) said: -Therapy screens residents first for side rails; -Therapy then goes to nursing with recommendations; -Nursing notifies maintenance; -He/She expected therapy to put in the orders and that would be placed on physician's orders; During an interview on 1/16/25 at 1:04 P.M., Administrator said: (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Therapy was expected to evaluate residents for side rails; -Only reason side rails are added was for bed mobility or per request; -Therapy notified ADON and DON of requests for the side rails; -ADON or DON would put in a work order for maintenance to install the rail after an evaluation had been completed; -He/She expected a physician's order to be obtained for side rails; -He/She expected the physician's order to be obtained prior to the installation of the side rails; -He/She expected a device risk assessments or side rail assessment to be completed initially and then annually thereafter; -He/She expected residents or their responsible parties to be educated on the risk of side rails; -Facility provided education on side rails via a form; -He/She expected consents to be obtained and signed prior to the installation of the side rails; -He/She expected zones of entrapment to be assessed and measured; -The facility only measured the top zones because facility did not use four rails and only used the cane rails; -He/She expected zone measurements to be obtained with any change when they are taken off or put back on resident beds.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 44993 Based on observation, record review and interview The facility failed to maintain a medication error rate less than five percent when Licensed Practical Nurse (LPN) B prepared the 8:00 A.M. medications for Resident #6 and LPN C administered the medications LPN B prepared to the resident. The facility staff had seven medication errors out of 25 opportunities resulting in a 28% medication error rate. This deficient practice affected one of 24 residents sampled. The facility census was 58. Review of the Drug Administration General Guidelines policy, dated 5/2019 showed: - Only the licensed personnel who prepare the resident's medication may administer it; - The medication is to be recorded in the residents medication administration record (MAR) at the time the medication is administered. 1. Review of Resident #6's admission Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/19/24 showed: - Diagnoses included: Pulmonary edema (fluid in and around the lungs) Chronic Kidney disease (CKD), and atherosclerotic heart disease (a disease that affects the way the heart pumps), high blood pressure, indigestion; - The resident had a brief interview for mental status score (BIMS) of 15, indicating no cognitive impairment; - The resident required some assistance from staff for hygiene and showering. The resident's comprehensive care plan dated 12/17/24 showed: - The resident had pain and the staff were supposed to provide medication as needed per physicians orders; - The resident had high blood pressure; - The resident had indigestion. Observation on 1/14/25 at 8:45 A. M. showed LPN C walked to Resident #6 in the dining room and gave the resident his/her morning medications. The cup had the resident's room number written on the side of it. LPN C handed the cup to the resident who took the medications one at a time. Once the resident took the medications, LPN C threw the empty labeled medication cup in the trash and returned to the medication cart. Review of the residents Physician Order Sheet (POS) showed the following: - 12/16/24 Calcium 600 milligram (mg) plus vitamin D 400 units, give 2 tablets by mouth one time daily for a supplement; (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Norterre		STREET ADDRESS, CITY, STATE, ZIP CODE 2555 Norterre Circle Liberty, MO 64068	
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12/16/24 Protonix Delayed Release 40 mg by mouth one time daily, to treat indigestion; - 12/16/24 Vitamin D3 400 units by mouth one time daily for supplement; -12/16/24 Carvedilol 12.5 mg by mouth two times daily to treat high blood pressure; -12/16/24 Eliquis 2.5 mg by mouth two times daily to prevent blood clots; - 12/16/24 Hydralazine 25 mg one by mouth tree times per day to treat high blood pressure; - 12/16/24 Tylenol extra strength 500 MG give two tablets by mouth, three times per day for pain. During an interview on 1/14/25 at 8:47 A.M. LPN C and LPN B said: - LPN C said LPN B prepared the 8:00 A.M. medications for Resident #6 because LPN B did not think LPN C would be working that day; - LPN B said he/she prepared the resident's medications in advance because he/she did not have access to a computer when he/she went down the hall to pass medications. - LPN B said he/she know he/she was not supposed to prepare resident medications, then place the room number on the side of the medication cup and then place the cup in the 2nd drawer of the medication cart; - LPN B said she prepared Resident #6's medications, but did not Adminster them to the resident; - LPN B said he/she was trained to prepare the resident's medication and then give the medications immediately; - LPN C said he/she was taught he/she was not supposed to give the resident medication he/she did not prepare; - LPN C said she should not have administered Resident #6's medications to him/her because LPN C did not prepare them; - LPN C said he/she should have destroyed the medications and prepared the resident's medications him/herself. LPN C said the medications he/she administered to Resident #6 was calcium with vitamin d, Protonix, Vitamin D3, Carvedilol, Eliquis, Tylenol and hydralazine. Review of the resident's MAR dated 1/14/25 showed: - LPN C documented he/she administered the resident's Calcium with D, Carvedilol, Eliquis, Protonix, and Vitamin D3; - LPN B documented he/she administered the resident's Hydralazine. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/14/25 at 2:06 P.M., the Director of Nursing said: - She would not expect Resident #6's medications to be prepared in advance and placed in the 2nd drawer of the medication cart; - It would no be acceptable for a nurse to prepare the resident's medications and another nurse give the medications he/she did not prepare, the the resident; - She would expect the medications that were prepared by another nurse to be destroyed, and the nurse administering the medications to prepare the residents medications. During an interview on 1/16/25 at 8:36 A.M. the Administrator said: - She would expect staff to prepare Resident #6's medication themselves and Adminster the residents medications immediately; - It was not acceptable for one nurse to prepare Resident #6's medications and a different nurse Adminster the medications because that would be considered a medication error.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observation, record review, and interviews, the facility failed to store, prepare and serve food in accordance with professional standards of food service safety when staff failed to date the receipt of incoming products, label, seal, and date used products, store food items off of the floor of the dry storeroom, and properly dispose of expired products, leftovers, and dented cans. This affected all residents by putting them at risk for a food borne illness. The facility census was 58. Review of facility policy Food Storage (Dry, Refrigerated, and Frozen), undated, showed: - Guideline: Food shall be stored on shelves in a clean, dry area, free from contaminants; - All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded; - Rotate products so the oldest are used first (Observation: This can only be done, based on current observed facility storage practices, if a product has a received date annotated on the container or case since there is no systematic way to tell what order items have been received in the storeroom); - Discard food that has passed the expiration date; - Store deliveries as soon as they have been inspected; - Leftover contents of cans and prepared food will be stored in covered, labeled and dated containers in refrigerators and/or freezers; - When freezing food that has been prepared on site, ensure clear labeling of the item; - Store dry food on shelves; - Discard damaged cans; - Dented cans are set aside in a separate labeled area; Review of facility policy Handling Leftover Food, undated, showed: - Leftover foods stored in the refrigerator shall be wrapped, dated, labeled with a use by date that is no more than 72 hours from the time of first use; - Refrigerated leftovers stored beyond 72 hours shall be discarded; - Opened canned food items shall be transferred to a clean, closed container for storage; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Leftover foods stored in the freezer shall be wrapped air-tight and moisture proof, dated, and labeled. The date, item, and amount shall be clearly posed; Observation at 9:57 A.M on [DATE] in the dry storeroom main kitchen showed: - No dates (six) #10 cans (Volume of 3 quarts approx.) sliced peaches; - No dates (six) #10 cans mandarin oranges; - No dates (six) #10 can Cherry Pie Filling; - No dates (one) bag corn meal; - No dates (three) #10 cans sliced apples; - 2 medium sized dents in (one) #10 can sliced apples stored on shelf with other cans that had no dents; - No dates on (26) boxes of cake mix of various flavors; - One container of chocolate pudding mix used, improperly sealed, leaking contents, opened [DATE], use by [DATE] (expired) and not disposed of; - No dates (nine) #10 cans great northern beans; - (One) large bag of croutons opened [DATE] with no use by date annotated; - No dates (five) bags of nacho cheese sauce - No dates (one) bag flour tortillas opened and resealed; - No dates (four) pasta bags 10lb each; - No dates (one) 10lb bag macaroni pasta opened and resealed; - (One) bucket of kosher pickle chips, improperly sealed and stored on floor of storeroom; - No dates (one) bag wild rice opened and resealed; - No dates (four) loose cups of vanilla pudding; - (One) case 100% orange Juice, individual servings, stored on the floor; Observation at 10:17 A.M on [DATE] in refrigerator #1 showed: - [NAME] Farms vacuum packed lettuce case with (four) 5lb bags best used by [DATE] and received [DATE] expired 11 days and not disposed; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- No date (one) real lemon juice bottle opened and resealed; Observation at 10:20 A.M on [DATE] in refrigerator #2 showed: - Yellow onions diced best used by [DATE] and received [DATE] expired 7 days and not disposed; - Leftover gravy sealed and dated ,d+[DATE] and leftover beef gravy sealed and dated ,d+[DATE] both expired 1 day and not disposed; - Large container leftover red rice mixture unlabeled ,d+[DATE]; - Leftover hash dated ,d+[DATE] expired 3 days and not disposed; Observation at 10:23 A.M on [DATE] in the freezer showed: - (One) bag of curly fries opened, unlabeled and undated; - No dates (one) bag of frozen hot dog rolls; - (One) bag of unknown item unlabeled, undated, opened and resealed; - (Two) bags of loose meat patties, opened, resealed, and unlabeled; Observation on [DATE] at 1:45 P.M. in the main kitchen showed: - One of four large containers of cereal dated and labeled, all others had no label of contents or dates; During an interview on [DATE] at 2:09 P.M., the Dietary Manager (DM) said: - Large containers that hold cereals and grains should be dated and labeled; - Leftover policy is seven days for everything, leftovers in satellite kitchens in the main building go straight to the trash; - Dry storage receipt policy is to date incoming items for FIFO (First in, First out) stock rotation. Staff follow the expiration date for all items that are unopened; Observation on [DATE] at 3:15 P.M. in the 2nd floor satellite kitchen showed: - No received dates on individual servings of PB/Jelly packages loose; - No received dates on various cans of soup unopened; During an interview on [DATE] at 3:30 P.M., the Dietician said: - She conducts a monthly walkthrough of the kitchen to make sure items are stored off the floor in the dry storeroom; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Monitors storeroom items once they are opened then she expects a date to be placed on the container with a seven-day limit before disposing of item; - All items should be labeled as to their contents; - Expiration dates dictate how long an unopened container can be kept in storage; During an interview on [DATE] at 1:45 P.M., the Administrator said: - She would you expect food shipments received to be stored off the floor of the storeroom; - She would expect a date on food product packaging showing when products have been opened or stored for leftovers;		

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observation and interview, the facility failed to provide sufficient dining space to accommodate all residents for dining resulting in crowded dining room tables, lack of privacy for residents, and residents turned away from dining room service. This affected four of 15 residents (#34, #42, #201, #250) sampled. The facility census was 58. 1. Review of Resident #250's admission record, dated 1/16/25, showed: - admitted [DATE]; - Diagnosis: cerebral ischemia (brain deprived of oxygen), cerebral infarction (stroke), spondylosis (arthritis), osteoarthritis left hip (cartilage and bone breakdown); Review of resident's care plan, dated 1/6/25, showed: - Resident has potential nutritional problems, provide and serve diet as ordered; - Resident is able to eat independently after set-up; During an interview on 1/13/25 at 2:38 P.M, resident #250 said: - They don't like sitting in a group to eat when people are sick, coughing and hacking. They wish they had a choice to sit somewhere else if someone is sick at the table; 2. Review of Resident #34's Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 9/29/24 showed: - Brief Interview of Mental Status (BIMS) of 15, cognitively intact; - Independent eating with no assistance required; - Diagnosis: atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), GERD (acid reflux), benign prostatic hyperplasia (enlarged prostate), diabetes (chronic disease when body can't produce insulin), hyperlipidemia (high cholesterol), Parkinson's Disease (brain disorder that affects movement); Review of resident's care plan, dated 12/24/24, showed: - Resident has potential for nutritional problems, provide and serve diet as ordered; - Resident is able to feed themselves independently; During an interview on 1/14/25 at 8:59 A.M., resident said: (continued on next page)		

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The seating in the dining room does not encourage them to sit there and eat because there is no privacy, people are too close together and some people have bad eating habits and it's tough to watch; Observation on 1/13/25 at 11:52 A.M., showed: - 3rd floor dining area has a main dining room which can seat 8 residents in wheelchairs around one large wooden table and an alternate dining room off to the side which was closed for the survey period; - The 3rd floor has 20 resident capacity with a total of 8 seats available for lunch at this seating; - In front of all the other residents well within earshot a staff member asks a resident if they needed help cutting their meat which they declined needing help; - With everyone set up at one table at the same time there is a large time difference between the first person at the table being fed and the last person getting their meal (25 min); - Last resident served is given a special bowl to eat from to help them from making a mess; - There are no condiments or place settings or table settings to indicate this is a dining table; - One resident appears to be very sick with a wet cough that is very loud next to residents while they try to eat only 2 feet away at the same table; - Dirty dishes are collected from the table and dumped outside the kitchen door (2 feet from dining table) in plastic tubs which causes a lot of noise and makes it hard to hear in the room; Observation on 1/15/25 at 7:36 A.M. showed: - 3rd floor side dining room table seats 8 persons at one large wooden table which is slightly wobbly with a surface that is very worn with missing varnish throughout; - The dining room contains medical equipment and book shelves and does not resemble a dining room due to not having any items that would suggest residents eat at this location; Observation on 1/15/25 at 7:46 A.M. showed: - 4th floor dining room has same set up as 3rd and 2nd floors for eating; - Side overflow dining room is not set up for residents with any tableware or condiments and there are no chairs around the table. The blinds are closed so no sunlight enters the room and no one is sitting in there eating. The room does not appear inviting as a choice for residents to sit down and eat in privacy; - One resident observed making loud guttural noises at the main dining room table next to other residents; (continued on next page)		

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Residents entering the room are automatically wheeled to the main dining room table with choice offered; - All four table legs have deep gouges in the wood from wheelchairs trying to maneuver into place for meals; - One resident in an oversized wheelchair cannot fit under the table and is positioned at the corner two feet from the table's surface and uses a installed tray table onto their wheelchair to eat; During an interview on 1/15/25 9:00 A.M., LPN A said: - There are about 20 residents on the 4th floor but in the morning we do more hall trays than seating; - If they are a new resident they get a choice to sit where they want, not sure if they do that on every floor; - Overflow diners go to the additional dining room, residents get in the habit and sit where they always sit; - For breakfast if they have too many residents wanting to dine they rotate residents as one leaves another will take their place but for lunch and dinner they will utilize overflow seating mostly; Observation on 1/15/25 at 2:30 P.M. showed: - Resident on 4th floor eating alone in overflow dining room table with no condiments or anything on the table except for their plate and silverware indicating it's a dining room; - At 3:28 P.M. leftover food and plate still sitting on overflow dining table and not cleared or cleaned by kitchen staff; Observation on 1/16/25 at 8:32 A.M., showed: - 4th floor dining room table is full, two residents that can't fit at table are sitting with their backs to the table with table trays on their wheelchairs so they can eat while watching television; Observation on 1/16/25 at 11:17 A.M. showed: - Residents are crowded around the dining room table, resident sitting in the back is flanked by residents in wheelchairs with their back to the wall. They cannot exit swiftly out of the room unless residents move their chairs out of the way; During an interview on 1/15/25 at 2:30 P.M., resident council members said: - Residents #33 and #25 felt that the tables that they eat at are crowded and they need multiple smaller tables when dining. A large table does not promote a safe eating distance from other residents and sick people who are too close to them. (continued on next page)		

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/25 at 1:30 P.M., the Administrator said: - If the main dining room was full she would expect staff to put residents in the overflow conference room next to the dining room; 47195 3. Review of Resident #42's admission MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech, ability to make self understood and clear comprehension of others; -It was very important to do things with groups of people; -He/She was independent with eating; -He/She was on a therapeutic diet; -Nutritional status and dehydration and fluid maintenance were care areas triggered; -He/She was dependent for sitting to stand transfers, chair to chair/bed transfers, toilet transfers -Diagnoses included: high blood pressure, urinary tract infection, hip fracture, enterocolitis caused by clostridium difficile (a bacterial infection that results in inflammation of the colon and diarrhea), and muscle weakness. Review of care plan, dated 12/12/24, showed: -Resident had potential for nutritional problems; -Monitor, record, report to medical doctor any signs or symptoms of malnutrition, muscle wasting, significant weight loss, emaciation; -Provide and serve diet as ordered; -Registered dietician to evaluate and make diet change recommendations as needed. Review of physician's orders, dated 1/15/25, showed: -Order started 12/10/24, Cardiac diet, regular texture, regular liquid consistency. Observation on 1/13/25 at 12:09 P.M. showed resident was wheeled back to their room by therapy staff member after being wheeled to dining area. During an interview on 1/13/25 at 12:34 P.M., Resident said: (continued on next page)		

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Would have ate in dining room today; -When he/she was wheeled out to dining room he/she was told it was full and there was not room; -Staff told him that he had to eat in his/her bedroom. During an interview on 1/14/25 at 3:00 P.M., CNA E said: -He/She returned resident to their room when there was not sufficient space yesterday during lunch service; -Resident had to eat their meal in their room after wheeling out to dining area and finding the dining table was full. 4. Review of Resident #201's admission MDS, dated [DATE], showed: -He/She had moderate cognitive impairment; -He/She had clear speech and was able to make self-understood and understand others; -He/She was independent with eating; -He/she had coughing or choking during meals; -He/she was on a mechanically altered diet; -Nutritional status was a care area triggered; -Diagnoses included pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus), gastroesophageal reflux disease (a chronic condition that occurs when stomach acid flows back up into the esophagus), and renal failure (condition where the kidneys can no longer filter waste). Review of care plan, dated 1/9/25, showed: -Resident had nutritional problem or potential nutritional problem due to dysphagia; -Monitor, record, report to medical doctor any signs or symptoms of malnutrition, muscle wasting, significant weight loss, emaciation; -Provide and serve diet as ordered; -Registered dietician to evaluate and make diet change recommendations as needed. Review of physician's orders, dated 1/15/25, showed: -Order started 1/7/25, regular diet pureed texture, nectar thick fluids consistency, regular pureed diet with nectar thick liquids. (continued on next page)		

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/13/25 at 12:09 P.M. showed resident was wheeled back to their room by therapy staff member after being wheeled to dining area. During an interview on 1/13/25 at 12:19 P.M. resident said: -He/She was eating in room because they did not have space for them at the dining table; -He/She would have enjoyed eating with others; During an interview on 1/13/25 at 12:16 P.M., Occupational Therapist A said: -He/she wheeled resident back to their room due to spacing concerns; -Resident did not have an opinion either way in regards to eating in room or at table; -Resident would have gone out to eat at dining table if there had been enough space for him/her; -He/She had been working with resident on activities of daily living as a part of their therapy. Observation on 1/13/25 at 12:09 P.M. showed nine residents seated at table in dining room. The dining table is full with no additional space. Observation showed lotus nurse telling staff they were out of space and remaining residents would have to eat in their rooms. Census for third floor showed twenty residents resided on third floor. Observation on 1/14/25 at 8:28 A.M. showed nine residents at breakfast table this morning having breakfast. The dining table was observed to be full with no additional space. Census for third floor showed twenty residents resided on third floor. Observation on 1/15/25 at 8:30 A.M. showed seven residents at dining room table. Census for third floor showed twenty residents resided on third floor. During an interview on 1/14/25 at 3:00 P.M., CNA E said: -Residents had to eat in their rooms if there as not sufficient space at dining table; -Facility often used conference or private dining room on floor to accommodate additional eating spaces for residents. During an interview on 1/16/25 at 9:10 A.M., CNA C said: -Having sufficient space in dining room was dependent on how many residents wanted to eat in the dining room; -When he/she first started working at facility many residents chose to eat in their rooms; -Everyone currently residing in the facility on floor three seemed to like to come out to dining room for meals (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265867	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Norterre		STREET ADDRESS, CITY, STATE, ZIP CODE 2555 Norterre Circle 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 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When there was not sufficient spacing then residents had to be taken back to their rooms to eat their meals. During an interview on 1/16/25 at 10:11 A.M., Director of Nursing said: -Facility had two different dining spaces on each floor to include the main dining table and the private dining/conference room where additional dining could be accommodated on each floor; -Having sufficient dining space was dependent on residents in facility and their dining preferences; -Some residents preferred to eat in their rooms; -Facility regularly uses the private dining room space that was currently occupied to accommodate having sufficient space for diners.		