

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265877	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER Westgate		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 John Duffy Dr Joplin, MO 64804	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, observation, and interview the facility failed ensure all residents were treated with dignity and respect when one staff (Licensed Practical Nurse D) grabbed one resident's arm (Resident #1) and grabbed food out of the resident's hand. The facility's census was 109. Review of the facility's policy titled Dignity, revised February 2021, showed the following: -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem; -Residents are treated with dignity and respect at all times; -Demeaning practices and standards of care that compromise dignity are prohibited; -Staff are expected to promote dignity and assist residents; -Staff are expected to treat cognitively impaired residents with dignity and sensitivity, addressing underlying motives or root causes for a behavior. 1. Record review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admission date of 04/16/25; -Diagnoses included Alzheimer's (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest of tasks), high blood pressure, anxiety, depression, dementia with agitation, psychotic disturbance, mood disturbance, and anxiety. Review of the resident's care plan, revised 05/01/25, showed the following: -Risk for impaired communication; -Behavior management due to dementia, -Resident needs finger foods offered regularly because he/she does not sit still for meals; -Risk for visual impairment; -At risk for weight loss due to decreased appetite and dementia. Review of the resident's June 2025 Physician Orders showed the resident was on a regular textured diet. Review of the resident's progress notes showed on 06/12/25, staff noted the resident had behaviors that included this resident trying to take food off of other residents' plates. Review of the camera footage on 07/01/25, at 10:39 A.M., showed the following: -On 06/18/25, at 4:48 P.M., during the dinner meal, Licensed Practical Nurse (LPN) D stood at the kitchen window where meal trays were passed thorough. -The resident approached the area where LPN D was standing and grabbed food off a meal tray; -The resident then with his/her left hand attempted to put food into his/her mouth. LPN D grabbed the resident's right arm with his/her left hand and then with right hand grabbed the food away from the resident; -The residents face appeared distraught and two certified nurse aides (CNA) approached and re-directed the resident from this serve-out area. During an interview on 07/18/25, at 2:35 P.M., CNA E said the following: -The resident was not alert and oriented and was very confused; -The resident cannot express what he/she wants and gets agitated at times; -On the date in question he/she was in the Special Care Unit (SCU) dining room and LPN D was doing the serve out window. -The resident was at the serve-out window and reached over to a plate and tried to get food off the plate; -He/she was not sure if the resident had any food in his/her hand and if the resident did have food staff should have let the resident have the food and should not have taken the food away from the resident; -LPN D yelled out for someone to come and get the resident; -He/she and another CNA approached and redirected the resident away from the serve out area; -He/she would not have taken food away from the resident. He/she would have just given the resident that meal tray; -It was rude to take the sandwich from the resident; -The staff are always supposed to treat the residents with dignity and respect. During an interview on 07/01/25, at 3:27 P.M., CNA C said the following: -If a resident was attempting to take food off a tray, he/she would redirect the resident away from the area; -If the resident had already grabbed food from a tray he/she would let them have it and replace the tray; -He/she would not attempt to grab food from a resident's hands unless it was a safety or choking issue; -He/she thought grabbing food from a resident would be disrespectful. During an interview on 07/01/25, at 2:51 P.M., Registered Nurse (RN) A said the following: -Nurses typically check meal orders coming from kitchen for diet accuracy and the CNA's pass the trays to the residents; -If a resident came to the window and tried to grab food, he/she would redirect them from the area; -He/she would not grab food from the resident if they already had it; -He/she would let the resident have the food and order another tray from the kitchen. During an interview on 07/01/25, at 4:10 P.M., the Director of nursing (DON) said the following: -The resident was not alert and oriented. -LPN D should have let the resident eat the sandwich and ordered another plate; -LPN D should never have grabbed the sandwich or any food away from the resident or any resident; -The resident does not usually sit at the table and eat meals. He/she is usually up wandering; -The resident typically eats finger foods. During an interview on 07/01/25, at 4:10 P.M., the Administrator said the following: -The resident had dementia. -LPN D should never have taken food away from the resident. -LPN D should have let the resident eat the sandwich and order another plate. -All Residents should be treated with dignity and respect. MO000256099</p>		