

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 06/07/2024
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45190</p> <p>Based on observation, interview, and record review, the facility failed to ensure a clean and homelike environment for all residents when staff failed to maintain the cleanliness of the the bathrooms of six residents (Resident's #51, #89, #32, #36, #39 and #102). The facility census was 108.</p> <p>Review showed the facility did not provide a policy that related to cleaning and maintain the bathrooms in residents' rooms.</p> <p>Review of the facility's cleaning sheet titled, Housekeeping 3 (300 hall), undated, showed the following:</p> <ul style="list-style-type: none"> -Five step procedure for rooms included pull trash/sanitize can/replace liner, horizontal surfaces, vertical surfaces, dust mop, and damp mop; -Seven step procedure for bathrooms included check/refill supplies, pull trash/sanitize can/replace liner, dust mop/sweep, clean sink area/tub, clean commode/base, clean walls/partitions, and damp mop; -At 8:15 A.M., begin regular day cleaning on resident rooms 301, 303, 305, and 307 using five step/seven step procedure; -At 10:00 A.M., continue regular day cleaning on resident rooms [ROOM NUMBER] using five step/seven step procedure; -At 10:45 A.M., continue regular day cleaning on resident rooms 302, 304, 306, 308, 310, 312, 314 and 316 using five step/seven step procedure; -Wednesdays focus cleaning schedule bath floors and focus on corners and edges. <p>1. Review of Resident #51's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included dementia, anxiety, and syncope (fainting). <p>(continued on next page)</p>

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #51's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 04/12/23, showed the following:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Dependent on staff with toileting hygiene. <p>Review of Resident #89's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included bradycardia (slower than normal heartbeat), syncope, dementia, anxiety, chronic kidney disease. <p>Review of Resident #89's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Dependent on staff with toileting hygiene. <p>Observation on 06/04/24, at 10:43 A.M., of Resident #51's and Resident #89's shared bathroom showed brown fecal-like substance smeared on the toilet seat.</p> <p>Observation on 06/05/24, at 9:20 A.M., of Resident #51's and Resident #89's shared bathroom showed brown fecal-like substance smeared on the toilet seat. The room had a strong urine-like odor when entering.</p> <p>2. Review of Resident #32's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included dementia, cognitive communication deficit, hypokalemia (low potassium), and schizophrenia (mental health condition that affects how people think, feel and behave). <p>Review of the Resident #32's quarterly MDS), dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Set-up and clean up assistance required for toileting hygiene. <p>Review of Resident #36's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included chronic kidney disease, dementia, anxiety, and depression. <p>Review of the Resident #36's quarterly MDS, dated [DATE], showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cognitively intact;</p> <p>-Independent with toileting hygiene.</p> <p>Observation on 06/04/24, at 9:59 A.M., of Resident #32's and Resident #36's shared bathroom showed the following:</p> <ul style="list-style-type: none"> -The walls were dirty with soap and grime dried dripping down the wall under the soap dispenser; -The wall behind a three-drawer dresser had several small brown spots; -The bottom quarter of the mirror was dirty with grime; -The room had a strong urine-like odor upon entering and was stronger in the bathroom; -The toilet had a brown fecal-like matter smeared down the front of the toilet, in between the toilet seats and all inside the toilet; -The bathroom floor was dirty and had debris. <p>Observation on 06/06/24, at 9:25 A.M., of Resident #32's and Resident #36's shared bathroom showed the following:</p> <ul style="list-style-type: none"> -The bathroom walls were dirty with soap and grime dried dripping down the wall under the soap dispenser; -The wall behind a three-drawer dresser had several small brown spots; -The bottom quarter of the mirror was dirty with grime; -The room had a strong urine-like odor upon entering and was stronger in the bathroom; -There was a large amount of brown fecal like matter splatter all over the inside of the toilet, all down the side of the toilet to the base of the toilet, on the floor next to the toilet, and on the wall next to the toilet. <p>Observation on 06/06/24, at 1:42 P.M., of Resident #32's and Resident #36's shared bathroom showed the following:</p> <ul style="list-style-type: none"> -The bathroom walls were dirty with soap and grime dried dripping down the wall under the soap dispenser; -The wall behind a three-drawer dresser had several small brown spots; -The bottom quarter of the mirror was dirty with grime; -The room had a strong urine-like odor upon entering and was stronger in the bathroom; <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The side of the toilet had a large amount of brown fecal-like matter smeared from the top to the base of the toilet, on the floor next to the toilet, and on the wall next to the toilet.</p> <p>Observation on 06/07/24, at 9:40 A.M., of Resident #32's and Resident #36's shared bathroom showed the following:</p> <p>-The bathroom walls were dirty with soap and grime dried dripping down the wall under the soap dispenser;</p> <p>-The wall behind a three-drawer dresser had several small brown spots;</p> <p>-The bottom quarter of the mirror was dirty with grime;</p> <p>-The side of the toilet had a large amount of brown fecal-like matter smeared from the top to the base of the toilet, on the floor next to the toilet and on the wall next to the toilet.</p> <p>During an interview on 06/07/24, at 9:52 A.M., Certified Nurse Aide (CNA) B/Activities Director said the following:</p> <p>-The toilet and wall should not have smeared brown fecal-like substance on them;</p> <p>-He/she could smell the strong odor of urine when entering the room;</p> <p>3. Review of Resident #39's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), high blood pressure, major depressive disorder, chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs), and heart disease.</p> <p>Review of the Resident #39's quarterly MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Dependent on staff for toileting hygiene.</p> <p>Review of Resident #102's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included unspecified dementia, anxiety disorder, depression, cognitive communication disorder, COPD, and heart disease.</p> <p>Review of the Resident #102's admission MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Partial/moderate assistance required from staff for toileting hygiene.</p> <p>Observation on 06/06/24, at 9:22 A.M., of Resident #39's and Resident #102's shared bathroom showed the following:</p> <ul style="list-style-type: none"> -Brown fecal-like substance smeared on the back of the toilet seat; -The wall next to the toilet had small brown spots and dried substances; -The floor around the toilet area was dirty and had several small brown spots. <p>Observation on 06/06/24, at 1:30 P.M., of Resident #39's and Resident #102's shared bathroom showed the following:</p> <ul style="list-style-type: none"> -Brown fecal-like substance smeared on the back of the toilet seat; -The wall next to the toilet had small brown spots and dried substances; -The floor around the toilet area was dirty and had several small brown spots. <p>Observation on 06/07/24, at 9:40 A.M., of Resident #39's and Resident #102's shared bathroom showed the following:</p> <ul style="list-style-type: none"> -Brown fecal-like substance smeared on the back of the toilet seat; -The wall next to the toilet had small brown spots and dried substances. <p>4. During an interview on 06/06/24, at 1:42 P.M., CNA A said housekeeping cleans room daily. He/she notifies housekeeping of any cleanliness issues in a resident's bathroom.</p> <p>5. During an interview on 06/07/24, at 9:52 A.M., CNA B/Activities Director said housekeeping cleans rooms daily, including the bathrooms. Housekeeping is responsible for cleaning brown fecal-like matter on the toilets, walls and floors.</p> <p>6. During an interview on 06/07/24, at 10:30 A.M., Housekeeping C said staff should clean every room in the facility once per day, which includes sanitizing everything such as doorknobs and light switches, dust, dry mop and damp mop the room floor, take out the trash from the room and then clean the bathroom including sink, dresser, walls if dirty, mirror, and all of the toilet, including the floor around and sides. Housekeeping is responsible for cleaning smeared brown fecal-like matter, and there should be no smeared brown fecal-like matter in the bathroom. The walls should not have brown spots, dirt, or grime on them.</p> <p>7. During an interview on 06/07/24, at 10:47 A.M., the Housekeeping Supervisor said the following:</p> <ul style="list-style-type: none"> -Staff should clean every room in the facility one time per day, utilizing the five and seven step cleaning process on the cleaning sheet; <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48187</p> <p>Based on observation, interview, and record review, the facility failed to ensure all medications were stored per standards of practice when staff walked away and out of view of an unlocked medication cart containing resident medications. The facility census was 108.</p> <p>Review of the facility policy titled Administering Medications, revised 12/12, showed during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse</p> <p>1. Observation on 06/05/24, beginning at 2:45 P.M., showed Certified Medication Technician (CMT) D prepared medications for multiple residents and placed the cups containing the medication in the top drawer of the medication cart. The CMT then walked away from the medication cart without locking the cart. The CMT walked to dining room approximately twenty-five feet away and turned his/her back to medication cart to check a blood pressure of a resident. The CMT was in not in line of sight of the unlocked medication cart.</p> <p>During an interview on 06/06/24, at 9:00 A.M., CMT E said he/she always locks the medication cart before walking away from the cart.</p> <p>During an interview on 06/06/24, at 11:00 A.M., Licensed Practical Nurse (LPN) J said he/she always locks the medication cart before walking away from the cart.</p> <p>During an interview on 06/06/24, at 2:01 P.M., CMT G said he/she locks his/her cart before walking away from it.</p> <p>During an interview on 06/06/24, at 2:53 P.M., LPN K said he/she always locks the medication cart before walking away.</p> <p>During an interview on 06/06/24, at 3:09 P.M., CMT F said he/she would always lock his/her medication cart before walking away from it.</p> <p>During an interview on 06/07/24, at 8:30 A.M., CMT H said he/she always locks the medication cart before walking away.</p> <p>During an interview on 07/07/24, at 8:45 A.M., the Director of Nursing (DON) said that he/she expects staff to lock their medication cart prior to walking away from them.</p> <p>During an interview on 07/07/24, at 9:00 A.M., the Administrator said that he/she expects staff to always lock their medication carts prior to walking away from them.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48187</p> <p>Based on observation, interview, and record review, the facility failed to ensure all medical records were maintained in a confidential fashion when staff left the computer on medication cart unlocked, unattended, and visible to other for one resident (Resident #5). The facility census was 108.</p> <p>1. Review of Resident # 5's face sheet showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnosis included hypertension (high blood pressure), diabetes, and chronic kidney disease.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/06/24, showed the resident had moderate cognitive impairment.</p> <p>Observations on 06/05/24, starting at 2:45 P.M., showed Certified Medication Technician (CMT) D prepared medication for the resident. CMT D then walked away from the medication cart with the computer screen showing patient information, including medication orders. CMT D walked to dining room approximately twenty-five feet away and turned his/her back to medication cart to check the resident's blood pressure. The resident' medical information would be visible to any staff, residents, or visitors passing by.</p> <p>During an interview on 06/06/24, at 9:00 A.M., CMT E said he/she always locks his/her computer screen before walking away from the cart.</p> <p>During an interview on 06/06/24, at 11:00 A.M., Licensed Practical Nurse (LPN) J said he/she always locks the computer screen before walking away from the cart.</p> <p>During an interview on 06/06/24, at 2:01 P.M., CMT G said he/she locks computer before walking away from it.</p> <p>During an interview on 06/06/24, at 2:53 P.M., LPN K said he/she always locks the computer screen before walking away.</p> <p>During an interview on 06/06/24, at 3:09 P.M., CMT F said he/she would always lock computer screen before walking away from it.</p> <p>During an interview on 06/07/24, at 8:30 A.M., CMT H said he/she always locks the computer screen before walking away.</p> <p>During an interview on 07/07/24, at 8:45 A.M., the Director of Nursing (DON) said he/she expects staff to lock their computer screen prior to walking away from them.</p> <p>(continued on next page)</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/07/24, at 9:00 A.M., the Administrator said that he/she expects staff to always lock computer screens prior to walking away from them.		