STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265888	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raintree Village	1501 S W Arborwalk Blvd Lees Summit, MO 64082

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure one sampled resident (Resident #1) was free from significant medication errors when Licensed Practical Nurse (LPN) A failed to administer medications via gastrostomy tube (G-tube/feeding tube - a tube surgically inserted into the stomach to provide hydration, nutrition, and medications) in accordance with standards and the facility policy which resulted in the resident's G tube to clog (blockage) requiring him/her to transfer to an acute care hospital out of three sampled residents. The facility census was 18 residents.The Administrator was notified on 5/19/26 of the past noncompliance which began on 2/19/26. The facility immediately completed education for all licensed nurses regarding correct medication administration via G-tube. The deficiency was corrected on 2/28/26. Review of the Enteral Tube (medication via feeding tube) Administration policy, undated showed:-Flush the tube with approximately 30 milliliters (ml) of water before administering medication, unless otherwise ordered by the physician.-Administer medications separately using a syringe.-Medications can be diluted with water, administered and then flushed with 5-10 ml of water.-Per Centers for Medicare and Medicaid Services (CMS - the Federal agency that establishes quality standards for long-term care facilities) guidelines crushed medications should not be combined and given all at once via feeding tube as this may result in incompatibilities leading to an altered therapeutic response or cause feeding tube occlusions (blockage) when medications are combined and administered via feeding tube.-After having given medications, flush the tube with approximately 30 ml of water. 1. Review of Resident #1's admission Record dated 2/19/26 showed the following:-A diagnosis of gastrostomy status.-He/she was admitted to the facility from an acute care hospital on 2/29/26.-He/she was transferred back to an acute care hospital on 2/29/26, the same day as his/her facility admission. Review of the resident's Order Summary Report (physicians orders) dated 2/19/26 showed the following:-To check Medication Administration Record (MAR) if these medications were administered.-Amoxicillin (antibiotic) Oral Capsule 500 milligrams (mg), give one capsule via G-tube two times a day for prophylaxis (to prevent a disease or condition from occurring).-Bumetanide (diuretic/ water pill) oral tablet 1 mg via G-tube two times a day for fluid in the lungs.-Eliquis (blood thinner) oral tablet 5 mg, give one tablet via G-tube two times a day for blood clot prevention.-Esomeprazole Magnesium (medication that decreases acid in the stomach) 40 mg via G-tube two times daily for acid reflux (flow of contents from the stomach upwards into the food pipe).-Gabapentin (seizure medication used to treat some types of persistent pain) oral capsule 300 mg, give one capsule via G-tube two times a day for neuropathic (nerve) pain.-Ropinirole hydrochloride (HCL) (medication used to treat involuntary movements) oral tablet 1 mg, give 1 tablet via G-tube in the evening for tremors.-Ropinirole hydrochloride oral tablet 2mg, give 1 tablet via G-tube in the evening for tremors.-Jevity (tube feeding formula) 1.5 calories per milliliter (ml), give 237 ml or one carton four times a day with 90 ml water flush before and after. Review of the resident's February 2026 MAR showed the following medications were given at bedtime on 2/19/2026:- Ropinirole hydrochloride HCL 1 mg tablet via G-tube.- Amoxicillin 500 mg capsule via G-tube.- Eliquis oral tablet 5 mg via G-tube.- Esomeprazole Magnesium 40 mg via G-tube.- Ropinirole hydrochloride HCL 2 mg tablet via G-tube was not documented as given. Review of the facility photographs of the resident's (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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication bubble packs dated 2/19/26 showed one dose of the following medications had been punched out:-Ropinirole hydrochloride HCL 2 mg tablet via G-tube with a written comment popped and given, but not on MAR.--Ropinirole hydrochloride HCL 1 mg.-Gabapentin oral capsule 300 mg. via G-tube with a written comment popped and given, but not on MAR.- Amoxicillin 500 mg capsule via G-tube.- Bumetanide 1 mg tablet via G-tube.- Esomeprazole Magnesium 40 mg. via G-tube with instruction on the label do not crush.-Eliquis 5 mg. Review of the residents' progress note late entry dated 2/19/26 at 11:30 P.M. showed:-He/she was transported to an acute care hospital via ambulance due to his/her clogged G-tube.-Three unsuccessful attempts were made to flush his/her G-tube. Review of the resident's hospital records dated 2/20/26 showed:-His/her G-tube was obstructed and after several attempts could not be flushed.-His/her G-tube bulb was deflated, his/her existing G-tube was removed and replaced with a new G-tube and the bulb on the new G-tube was inflated.-The resident was then discharged home with his/her family. Review of the Director on Nursing's (DON) written document dated 2/23/26 showed:-On 2/23/26 he/she contacted LPN A to discuss the incident on 2/19/26 involving the administration of medications through a resident's feeding tube.-He/she explained to LPN A that the manner in which the medications were administered resulted in obstruction of the resident's feeding tube, requiring hospital transfer; the hospital was unable to unclog the tube, and the tube required replacement.-LPN A stated that he/she had administered the residents medication as it was ordered in the facility electronic medical record (EMR).-He/she explained to LPN A that the medications dispensed were not appropriate for crushing and enteral (directly into the stomach or small intestine through a tube) administration in the manner given and when a medication formulation (dosage form) appears inconsistent with enteral administration, the appropriate protocol was to stop and seek clarification from the physician, pharmacy, or on-call nurse prior to administering the medication.-He/she said that based on the investigation findings and the outcome of the incident, the next step was termination of employment due to failure to follow medication administration protocol, which resulted in feeding tube obstruction requiring hospital transfer and replacement of the residents feeding tube; the resident's feeding tube obstruction was a result of the medication administration method.-At that time LPN A disconnected the call before further details of the investigation findings could be discussed.-Post-termination expanded investigation included review of the resident's MAR compared to medication cards which identified that gabapentin 300 mg and ropinirole 2 mg were not scheduled at that time and photographs taken of medication cards showed medications were removed from the cards.-Camera footage review showed only one medication was carried into the resident's room; administration occurred just before 11:00 P.M. Review of Certified Nursing Assistant (CNA) A's statement dated 2/26/26 showed:-He/she was in the resident's room when LPN A entered with one medication cup with crushed medications.-He/she did not observe multiple separate medication cups for individual medications.-He/she observed LPN A mix the crushed medication with liquid in the cup.-There was also a small container or jug of water present in the resident's room.-He/she observed LPN A administer the medication mixture through the feeding tube through the syringe connected to the tube.-He/she observed water being used during the process but could not state the exact sequence of water and medication administration.-LPN A poured the medication mixture into the resident's feeding tube through a syringe connected to the residents feeding tube. Review of LPN B's undated statement showed:-On 2/29/26 LPN A took report from him/her for the oncoming night shift.-After report, he/she and Registered Nure (RN) A spoke with LPN A about the newly admitted resident with a G-tube.-He/she told LPN A to do the G-tube feeding and meds exactly as directed and to flush the tube as directed and LPN A stated understanding. He/she left the facility at approximately 9:15 P.M.-He/she received a call from LPN A at 10:00 P.M., stating the resident's tube was clogged and that he/she thought the esomeprazole had clogged the tube.-He/she instructed LPN A to use a declogging tool that was in his/her office in a desk drawer that he/she could access.-LPN A again called him/her at 10:15 P.M. and told him/her that he/she was unable to declog the resident's tube (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but that the on call [physician] had given him/her an order for a different esomeprazole and the resident was going to be sent to the emergency room. During an interview on 5/22/26 at 1:32 P.M., CNA A said:-He/she was a facility employee and worked the night shift on 2/19/26.-He/she was in the resident's room at around 11:00 P.M. when LPN A entered the room with a Styrofoam cup with water and a small clear plastic cup with crushed medications.-While LPN A gave the resident his/her medication into his/her feeding tube something went wrong and the resident's tube stopped working.-LPN A sent the resident to the hospital because the resident's tube stopped working. During an interview on 5/19/26 at 12:56 P.M. LPN B said:-On 2/29/26, he/she gave shift report to the night shift licensed nurse, to LPN A.-After report he/she was with RN A when RN A told LPN A to do everything right with the resident's tube feeding, give the meds exactly as directed, and to flush the resident's tube as directed. During an interview on 5/22/26 at 5:03 P.M., LPN A said:-He/she worked the night shift on 2/19/26.-He/she gave the resident his/her evening G-tube medications.- He/she crushed the pills, separated the capsules and placed all the resident's medications in one small plastic medication cup.-He/she put water in a Styrofoam cup and entered the resident's room with the water and the resident's medications.-He/she poured a small amount of water from the Styrofoam cup into the small plastic cup and mixed the resident's medications with the water.-He/she flushed the resident's G-tube with a small amount of water and then put all the medications in the resident's G-tube.-He/she noticed that some of the beads from the capsules had clumped and caused the resident's G-tube to clog.-He/she called RN A to notify her the resident's G-tube had clogged.-RN A told him/her that he/she had a declogging tool in his/her office in a desk drawer that he/she could use to try to unclog the resident's G-tube and if that did not work to call the resident's physician.-He/she tried to unclog the resident's G-tube with the declogging tool, but it did not work. -He/she then called the resident's physician on-call and was given an order to transfer the resident to the hospital to have the resident's G-tube replaced.-He/she knew that G-tube medications were to be placed in individual small cups before administration, the G-tube was to be flushed and then each medication was to be given separately with a water flush between each medication and then another water flush after all the medications were given.-He/she knew that the resident's medications should have been placed in individual small medication cups and that Esomeprazole was not to be crushed.-He/she had mixed the medications into one small medication cup because the resident's family was in a hurry for the resident's medications to be given. During an interview on 5/19/26 at 12:56 P.M. RN A said:-He/she was the nurse manager on call on 2/19/26.-He/she had completed the resident's bolus tube feeding around 5:45 P.M. on 2/19/26.-At that time the resident's tube was patent (open, unobstructed, allowed free passage).-Before leaving the facility, he/she spoke with LPN A and told her to be sure to complete all the residents care correctly - including to give the resident's tube medications correctly; he/she often reminded licensed nurses to follow correct procedures when providing care.-She left the facility at about 9:45 P.M.-Shortly after he/she arrived home at about 10:00 P.M., he/she received a call from LPN A.-LPN A said the resident's tube was clogged and that he/she thought the tube had clogged because of administration of esomeprazole.-He/she told LPN A that he/she could try using a G-tube declogger device that he/she had in her office and if that did not work to call the resident's physician.-LPN A again called him/her at 10:15 P.M. and told him/her that he/she was unable to unclog the resident's tube and that the resident was going to be sent to the emergency room for replacement of his/her G-tube. During an interview on 5/19/26 at 10:40 A.M., the Administrator said:-In February 2026 LPN A had incorrectly administered tube medications to the resident.-The DON who no longer worked at the facility did an investigation and LPN A's employment was terminated.-Immediately following the incident, all staff licensed nurses were retrained regarding medication administration which included administration of tube medications. During an interview on 5/22/26 at 1:54 P.M., Physician A said:-He/she was the resident's assigned physician but had not actually seen the resident as the resident was transferred to hospital the same day as his/her facility admission.-He/she did expect that facility nurses would (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow proper nursing procedure when administering medications.-He/she was familiar with the medication that it was not to be crushed and there was a hospital physician's transfer order to give that medication via the resident's gastrostomy tube.-He/she was familiar with that medication and in hospitals that medication for years had been given by separating the capsule and administering the medication by gastrostomy tube.-Had the LPN flushed the resident's tube with water first, administered each medication separately with a water flush between each medication and a final water flush after all the medications had been administered there would likely not have been a problem with any of the medications that were ordered being given through the resident's tube.-The issue was not flushing the resident's tube between each medication,not the formulation of the medications.-The resident was sent to hospital to have the tube replaced and that would not have caused harm to the resident beyond having the tube deflated, removed and replaced with a new tube. Complaint 2992846