STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A293	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clara Manor Nursing Home	3621 Warwick Boulevard Kansas City, MO 64111

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on observation, interview and record review, the facility failed to ensure each resident was treated with dignity and respect by not maintaining and enhancing self-esteem, self-worth, and not incorporating individual preferences and choices during assisted feeding for one sampled resident (Resident #56) out of 18 sampled residents. The facility census was 89 residents. Review of the facility's Feeding - Helpless Patient guidelines, undated, showed: -The purpose was to ensure adequate nutrition for those residents who were unable to feed themselves. -Tell the resident they are going to be fed. -If the resident was blind, tell him/her what was being done to feed him/her. -Feed slowly to prevent choking. -Use a straw to give liquids. -When finished wipe the resident's face with a napkin or washcloth. Review of the facility's Feeding Patient-Assisting with Meals guidelines, undated, showed: -Whenever possible feed two to four residents at a time to allow more time for chewing while feeding the other resident. Review of the Resident Rights-Dignity and Privacy Policy, dated 2023, showed: -All residents had the right to: --Respect and dignity. --Competent care. -All staff must follow and respect the resident's 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26A293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #56's face sheet, undated, showed he/she was legally blind (severe vision loss). Review of the resident's Care Plan (a document created for a person that received healthcare, personal care, or other forms of support), dated 9/12/24, showed: -The resident had impaired vision related to blindness. -Set up meals as needed and assist with opening cartons, cutting up food, and tray orientation. -No other focus areas, goals or interventions were noted for feeding assistance. Review of the resident's quarterly Minimum Data Set (MDS-a standardized assessment tool that measured health status in nursing home residents), dated 9/13/24, showed: -The resident required substantial/maximal eating assistance (helper did more than half of the effort). -The resident was severely cognitively impaired. Observation on 11/19/24 at 5:20 P.M., showed: -The resident was sitting in his/her wheelchair in the dining room. -The resident was served a thick soup in a bowl, ham and cheese sandwich, chocolate milk and red gelatin and whipped cream in a side cup, all on a tray in front of the resident. -The resident ripped open the milk carton and drank it from the carton, spilling it on the floor, his/her socks, and clothing. -Certified Nursing Assistant (CNA) D stood next to the table and did not assist the resident. -CNA D said, wait and I will open for you. -The resident did not want to give the carton back. -CNA D took the carton out of the resident's hand poured the milk into a cup with a lid, which helped the resident drink it with less spilling. -The resident then took the lid off and drank it. -CNA D continued to stand over the resident. -CNA D put food on a spoon or fork, held in front of the resident, said Eat and put the food in the resident's mouth. -CNA D said, You want to eat? and the resident continued to drink the milk, still spilling on the floor and on his/her socks and not being offered a napkin. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA D asked the resident if he/she wanted to eat the sandwich. -The resident grabbed the sandwich and started eating it while hunched over in his/her wheelchair. -CNA D continued to put soup and dessert on a spoon or fork and hold in front of the resident saying eat. -CNA D tried taking the milk cup away from the resident. -The resident yanked it back spilling it on his/her clothing, not being offered help to clean it up. -CNA D continued hovering over the resident saying eat when trying to put food in front of the resident's mouth. During an interview on 11/19/24 at 6:13 P.M., CNA D said he/she had not received training from the facility regarding how to assist the resident with dining. During an interview on 11/20/24 at 5:42 A.M., CNA F said: -He/She received feeding assistance training when he/she was in CNA school. -He/She had been a CNA for [AGE] years. -No training since hired at the facility regarding feeding assistance. -He/She worked nights and was unaware of how residents were fed. -It was not appropriate to stand up while feeding the residents. -He/She would be patient and respectful while feeding residents. During an interview on 11/20/24 at 6:13 A.M., Licensed Practical Nurse (LPN) C said: -The resident required feeding assistance. -The CNA's do the feeding assistance. -They have their CNA classes and the CNA who they shadowed showed them the feeding assistance. -CNA D had not been monitored while feeding the resident. -CNA's should be sitting with the resident while feeding them. During an interview on 11/20/24 at 11:42 A.M., LPN B said: -He/She observed CNA's feeding the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had not noticed any issues. -CNA's were trained by the CNA they do orientation with. -There was no other training that he/she was aware of. During an interview on 11/21/24 at 12:44 P.M., CNA A said: -He/She had not received training on how to feed a resident. -He/She just treated them with patience and kindness. During an interview on 11/22/24 at 11:21 A.M., the Director of Nursing (DON) said: -In-services should be held monthly. -There were only about eight or nine so far this year. -Dignity and respect was talked but not always documented. -He/She did individual education when he/she saw a need, but it was not documented. -He/She did not provide individual education to CNA D regarding feeding assistance or dignity. -Staff competencies were monitored by the DON. -He/She averaged weekly monitoring due to being on the floor a lot. -Feeding residents was part of the CNA manual and would have received it during their classes. -The facility did not provide feeding assistance training. -There was no set process for feeding residents. -CNA's were expected to follow the training they received in their classes. -He/She expected CNA's to be sitting next to the resident they were feeding. -He/She would not expect them to be standing up next the resident.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 19916 Based on interview and record review, the facility failed to ensure the required bond amount was sufficient for the amount of the average monthly balance for the 12-month period from 11/23 through 10/24. This practice potentially affected 56 residents who allowed the facility to manage their resident trust accounts. The facility census was 89 residents. 1. Review of the Resident Funds Bond Worksheet showed: -The average monthly balance for 12 months of reconciled bank statements was $123,720.44. -The directions on the Resident Fund Bond Worksheet stated that amount should be rounded to the nearest thousand up or down. When rounded up, that amount was $124,000.00 -The directions on the Resident Funds Bond Works sheet then stated to multiply that amount by 1.5, after multiplied, that amount was $186,000.00. Review of the approved bond (an insurance agreement pledging that one entity will become legally liable for financial loss caused to another by the act or default of a third person), showed the bond amount was only $150,000.00 which was less than the required amount of $186,000.00. During an interview on 11/20/24 at 2:20 P.M., the Bookkeeper A said: -They will need to increase the bond amount. -The bond amount they have is the most recent one. -He/She did not have a process to check on the average monthly balance, but he/she can start a process.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation and interview, the facility failed to maintain the handrails in the dining room free from a buildup of food crumbs; failed to maintain the restroom ceiling vents free of a dust buildup in the following resident rooms: 202, 203, 204, 205, 206, 209, 211, 223, 104, 103, 107, 108, 109, 111, and 112; failed to maintain the large orange fan at the north end of the first floor free from a buildup of dust; failed to maintain resident use fan in the following rooms free from a buildup of dust: resident rooms 201, 209, 104, and 111. This practice potentially affected at least 55 residents who resided in those rooms or used those areas. The facility census was 89 residents. 1. Observation on 11/17/24 at 9:24 A.M., showed: -A buildup of food crumbs in the handrails which were on the north wall of the dining room. -Roaches crawled next to where the end of the handrail joined the wall in the dining room. During an interview on 11/1/7/24 at 9:24 A.M., the Dietary Manager (DM) said he/she was responsible for cleaning the food crumbs on the handrail and he/she noticed the roaches at the end of the handrail. During an interview on 11/17/24 at 12:22 P.M., Dietary Aide (DA) B said he/she would start cleaning the handrails once per week after seeing the buildup of crumbs inside the handrail. 2. Observation and interview on 11/18/24 with the Maintenance Director showed: -At 9:48 A.M., the personal fan in resident room [ROOM NUMBER] had a buildup of dust on the fan blades and a buildup of dust inside the restroom ceiling vent. -At 9:49 A.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 9:51 A.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 9:52 A.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 9:54 A.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 9:56 A.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 10:08 A.M., there was a buildup of dust on the fan and a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 10:12 A.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 11:27 A.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 12:55 P.M., there was a buildup of dust on the blades of the large orange fan at the north end of the first floor. -The Maintenance Director said he/she had not noticed the dust on the fan blades before. -At 12:59 P.M., the fan in resident room [ROOM NUMBER] had a large buildup of dust on the blades. -The Maintenance Director said he/she cleaned that fan on the previous day, 11/17/24. -At 1:02 P.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 1:08 P.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -The Maintenance Director said he/she had not gotten around to taking the ceiling vents down and cleaning them. - At 1:10 P.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. - At 1:12 P.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. - At 1:17 P.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER] and there was a personal fan that was dusty in that room. - At 1:18 P.M., there was a buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER].

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #69) was free from physical abuse, when on 1/10/25 at approximately 10:00 P.M., Resident #76 willfully hit Resident #69 on his/her face, resulting in swelling and pain. Resident #72 stated Resident #76 had threatened to beat up people and was violent. The facility census was 86 residents. An Abuse/Neglect policy was requested from the facility, but was not provided. Review of the facility's Abuse and Neglect Educational Material; Policy Regarding Abuse and Neglect of Facility Residents, undated showed: -Resident rights protected them from physical and mental abuse. -Abuse was defined as a willful infliction of injury. -Physical force that may result in physical pain or impairment included: --Pushing, slapping, hitting, shoving, striking with or without an object, pinching kicking or burning. 1. Review of Resident #76's Face Sheet, undated, showed: -The resident admitted to the facility on [DATE]. -His/Her diagnoses included: --Major Depressive Disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), single episode. --Other psychoactive substance abuse (a strong desire or sense of compulsion to take the substance) --Generalized anxiety disorder (a constant about everyday issues and situations). Review of the resident's care plan dated 1/13/25 showed: -The resident had potential for sad mood related to depression. -The resident was at risk for increased behaviors. --Monitor behavior episodes and attempt to determine underlying cause. Review of the resident's Physician Orders, dated January 2025, showed: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Buspirone (medication used to treat anxiety disorders); 5 mg twice a day. -Quetiapine (medication used to treat hallucinations) 25 mg twice a day. -Hydroxyzine (medication used to treat agitation) 50 mg three times a day. During an interview on 1/13/25 at 3:19 P.M., Resident #76 said: -He/She thought Resident #69 was going through his/her belongings. -He/She hit Resident #69 in the face. -He/She was unsure if anyone else was around when it happened. -The police came and arrested him/her and took him/her to the hospital. 2. Review of Resident #69's Face Sheet, undated, showed: -The resident admitted on [DATE]. -The resident's diagnoses included: --Schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and actions). --Major Depressive Disorder --Persistent Mood Disorder (a continuous, long-term form of depression). Review of the resident's Care Plan, dated 11/21/24, showed: -The resident was resistant to cares. -The resident received antidepressant medication. -The resident had chronic pain in the lower back. During an interview on 1/13/25 at 8:45 A.M., the resident said: -Resident #76 said he/she kidnapped his/her children. -He/She was sleeping when Resident #76 came in his/her room and hit him/her in the face. -He/She had swelling and pain on the left side of his/her face. -He/She asked for pain medication and an ice pack and received it. -He/She did not want to go to the hospital. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Resident #76 harassed him/her every day about going into Resident #76's room and taking his/her belongings, which never happened. -He/She talked to staff about Resident #76's behavior and they told him/her to stay away from Resident #76. -Resident #76 also bothered other resident's, saying they went into his/her room and took belongings. -He/She felt safe now that Resident #76 was gone. Observation on 1/13/25 at 8:45 A.M. showed: -A small amount of swelling in Resident #69's left cheek. 3. During an interview on 1/13/25 at 9:00 A.M., Resident #59 (roommate of Resident #69) said: -Resident #76 was in their room. -He/She saw Resident #76 go over to the other side of the room, but the curtain was drawn and did not see what happened. During an interview on 1/13/25 at 9:15 A.M., Resident #72 said: -Resident #76 yelled a lot at the residents and had paranoid episodes, saying people were in his/her room taking his/her items. -Resident #76 threatened to beat up people. -Resident #76 was violent. Staff told Resident #76 to stay in his/her room. -He/She heard Resident#69 and #76 argue on Friday night (1/10/25), but did not see anything. -He/she felt safe without Resident #76 around. During an interview on 1/13/25 at 9:25 A.M., Resident #37 said: -Resident #76 was unruly in the evenings. -Staff told Resident #76 to return to his/her room when he/she was acting up. -On Friday he/she saw Resident #76 go into Resident #69's room. -He/She could not see the head of the bed behind the curtain, but he/she saw the motion of Resident #76 swing his/her arms as if he/she had hit Resident #69. -He/She felt safe now that Resident #76 was gone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Staff tried to stop Resident #76 from hitting Resident #69. -He/She thought Resident #76 was going to hit the staff. -The staff ended up calling the police. During an interview on 1/13/25 at 9:35 A.M., Resident #11 (Resident #76's roommate) said: -Resident #76 was paranoid a lot. -He/She never saw anyone in their room. -He/She did not see what happened on Friday. During an interview on 1/14/25 at 9:41 A.M., CNA A said: -Resident #76 went out of the building and returned and he/she was angry, mad and paranoid. -Other resident's expressed being afraid of Resident #76. -He/She reported Resident #76's behaviors to the nurse. -On Friday Resident #76 was pacing and sweating a lot towards the end of his/her shift, around 7:00 P.M. -He/She talked to Resident #76 to try to calm him/her down and he/she told the nurse about the resident's behaviors. -Resident #76 said Resident #69 kidnapped his/her kids. -He/She tried to talk to Resident #76 and he/she calmed down a little. During an interview on 1/14/25 at 9:54 A.M., CNA B said: -Resident #76 and #69 used to be friendly with each other. -Recently they had arguments and disagreements, but nothing that went beyond that. During an interview on 1/14/25 at 10:02 A.M., Resident #69 said: -He/She was having pain in his/her back. -He/She still had pain in his/her face and jaw. -He/She had not reported it to the nurse, but was going to contact his/her doctor himself/herself. During an interview on 1/14/25 at 10:24 A.M., LPN B said: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She was working Friday night. -Residents #76 and #69 exhibited several hours of verbal altercations, including cussing at each other. -Resident #76 said he/she was going to kill Resident #69 while pacing in the hall. -He/She separated the resident's, directed them to remain on separate sides of the hall. -The other staff on shift were helping with other residents. -Resident #76 was sweating and acted paranoid. -Resident #76 believed people tapped into his/her phone. -Resident #76 believed Resident #69 was in his/her room going through his/her things. -He/She assured Resident #76 that Resident #69 was not in the room and explained how the setting on his/her phone worked to show that no one was tapping into their phone. -The resident returned to his/her room and LPN B returned to his/her duties. -Resident #69 came off the elevator saying he/she had gone down to smoke when Resident #76 hit him/her in the face. -Nursing staff came off the elevator with Resident #76 and instructed them both to remain on separate ends of the hall. -He/She went to Resident #69's room and assessed his/her injury. -He/She saw light redness and swelling, and the resident refused care, and asked for just an ice pack. -Twice Resident #76 tried to enter Resident #69's room, accusing Resident #69 of taking things from his/her room. -Resident #76 threatened LPN B at which time LPN B called the police. -When police arrived Resident #76 physically assaulted them as well as paramedics. -Paramedics administered a sedative and the resident was removed in handcuffs. During an interview on 1/14/25 at 10:59 A.M., Certified Medication Technician (CMT) A said: -He/She was working Friday night during the incident. -The charge nurse told him/her that Resident #76 was being volatile. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She did not see anything that happened until the police arrived. -Resident #76 had to be put in restraints. During an interview on 1/14/25 at 1:20 P.M., the Director of Nursing (DON) said: -Staff received quarterly training on abuse and neglect. -The DON and administrator were responsible for providing and documenting training which was offered monthly. -No residents or staff reported anything to him/her about Resident #76's past behaviors that would have indicated a problem. -Resident #76 went to the hospital last month but that was the first time he/she ever exhibited behaviors, that he/she was aware of. During an interview on 1/14/25 at 1:20 P.M. the Administrator said: -He/She was not made aware of issues between Resident #69 and Resident #76. -He/She expected the staff to separate the residents and when the issues continued to put Resident #76 on a one-on-one monitoring. -Someone should have been watching the resident. -Resident #76 was sent out to the hospital last month for behaviors, but to his/her knowledge that was the only previous issue with his/her behaviors. MO00247856

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26A293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 19916 Based on interview and record review, the facility failed to conduct a Criminal Background Check (CBC) and Employee Disqualification List (EDL) check for three sampled employees (Employees D, J and K) and to maintain records of the Social Security number, date of birth, date of employment, experience and education, references and the result of background checks required by section 660.317 of Revised MO Statutes for two employees (Employees J and K) out of 10 employee files requested. The facility census was 89 residents. Review of the Facility's Policy entitled Nursing Home Employee/Personal Records Policy dated 2022 showed: -Policy Statement: The facility is committed to maintaining accurate and confidential employee records, ensuring compliance with all applicable laws and regulations while providing employees with appropriate access to their personal employment information. -Scope: This policy applies to all current, former, and prospective employees of the Facility Record Types: Employment Application: Including contact information, employment history, education, references, and signed authorization forms. Hiring Documents: I-9 forms, signed employment agreements, job descriptions, and onboarding paperwork. Performance Management: Performance reviews, coaching notes, disciplinary actions, and improvement plans. Attendance Records: Timecards, absences, tardiness, and leave requests. Compensation Records: Salary information, pay adjustments, benefits enrollment, and payroll deductions. Training Records: Course completion certificates, training dates, and related evaluations. Medical Records: (maintained separately in accordance with HIPAA guidelines) Review of the facility's policy on Employee Disqualifcation Lists (EDL) and Criminal Background Check (CBC) for employees dated 2019, showed: -All prospective employees must have the employee disqualification list (EDL) and Criminal Background Check (CBC) prior actual employment that require resident . -All individuals with history of abuse or are on the MO EDL shall not be hired -All CBC and EDL shall be completed no longer than 5 days prior the first employment day -EDL check; criminal background check, license or certification verification for any hired staff on any restrictions for practice must be completed before hiring. -ALL registry information shall be mailed to the FCSR (Family Care Safety Registry) within 15 days of hire. Keep track of the mailing record by the log. 1. Review of Employee D's file showed: -Employee D was hired by the facility on 7/1/24. -CBC and EDL checks were conducted by a different facility on 9/2/21. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 11:27 A.M., the Administrator said: -Employee D also worked for another facility within the corporate network. -Employee D was hired by the other facility on 9/2/21. -His/her facility used a CBC and EDL that was provided to it by the corporation and did not conduct a more recent CBC and EDL check on Employee D when he/she was hired by the facility. 2. On 11/21/24, a request was made for Employees J's and K's files -The files were not available. -There was no evidence that a CBC and EDL check had been completed for Employees J and K. -The files were not received at the time of exit. During an interview on 11/21/24 at 10:53 A.M. the Administrator said he/she could not find the files for Employees J and K.

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F 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42955

Based on interview and record review, the facility failed to plan, coordinate, and provide a safe and appropriate discharge when the facility initiated an immediate discharge for one sampled resident (Resident #76) out of 36 sampled residents. The resident's discharge notice stated the transfer location was Facility B, however, the resident was transported to the hospital via Emergency Medical Services. Facility B was unaware the resident was to be discharged to them. The facility census was 86 residents.

Review of the facility's Discharge and Transfer Resident policy, dated 12/21/24, showed:

-The purpose of the policy was to ensure the appropriate procedure for transferring and discharging a resident.

-All residents who were discharged out of the facility under any circumstance was given an order from the attending physician.

-Provide written instruction with verbal explanation regarding care, treatment, use of medications or devices to the resident upon discharge.

-Order to discharge included the date and time of physician notification.

-Involuntary discharges must:

--Be reviewed by the Safety Committee.

--The physician shall be consulted.

--Can be immediate in the case of emergency due to:

---The safety of individuals at the facility was endangered due to clinical or behavioral status of the resident.

--Issue a discharge notice letter to the resident, including the reason for the discharge, that included a 30-day notice or immediate discharge.

--The Administrator would send the notice to the resident/Durable Power of Attorney (DPOA) and the local Ombudsman (an advocate for residents of nursing homes), which included the following:

---Reason for discharge.

---Effective date of discharge.

---Location to which the resident was discharged .

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	---A statement that the resident had the right to appeal. ---The name, mailing address, and telephone number of the Ombudsman. 1. Review of Resident #76's Face Sheet, undated, showed the resident admitted to the facility on [DATE] with the following diagnoses: -Major Depressive Disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), single episode. -Other psychoactive substance abuse (a strong desire or sense of compulsion to take the substance). -Generalized anxiety disorder (a constant about everyday issues and situations). Review of the resident's Notice of Discharge (Immediate notice), dated 1/11/25, showed: -The resident was immediately discharged for : --The safety of individuals in the facility was endangered due to clinical or behavioral status of the resident. --The health of individuals in the facility was otherwise endangered. --The discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility. -In The reason for your discharge section of the form Licensed Practical Nurse (LPN) B wrote: --discharged due to extreme violent behavior, drug use, causing a safety issue and being a danger to self or other residents, physically and verbally. -Police and fire department onsite. -The notice indicated the discharge was discussed with the resident and would be going to a different facility (Facility B). -The effective date was 1/11/25 at 12:14 A.M. Review of the resident's Physician Order Sheet dated January 2025 showed: -No order for discharge. During an interview on 1/14/25 at 10:24 P.M., LPN B said: -The resident had several hours of verbal altercations with other residents. -The resident was being paranoid and yelled at other residents and staff. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was physically aggressive toward police officers and paramedics. -The resident was handcuffed by the police, sedated by the paramedics, and taken to local hospital. -The resident hit another resident and started to come after staff. -He/She contacted the police and the Administrator and was instructed to provide the resident with an immediate discharge. During an interview on 1/14/25 at 10:24 A.M., LPN A said: -The Administrator and the Director of Nursing (DON) were responsible for preparing and sending out discharges and notices. During an interview on 1/14/25 at 1:20 P.M., the Administrator said: -He/She was responsible for initiating the discharge for the resident. -He/She spoke to LPN B on the phone and had him/her provide the paperwork to the resident. -LPN B gave it to the resident in person. -He/She made arrangements for the resident to go to Facility B once released from the hospital. -He/She contacted the Administrator at Facility B on the phone and made the arrangements. -The Ombudsman received a report at the end of the month with all the discharges. -The resident was in handcuffs and sedated at the time of discharge and was unable to sign the form. During an interview on 1/14/25 at 12:24 P.M., Social Services Director (SSD) B (from Facility B), said: -He/she had not received a referral from Facility A for any resident, including Resident #76. -He/She checked his/her fax, email and phone records and was unable to find a referral. During an interview on 1/14/25 at 2:15 P.M., Administrator B (from Facility B) said: -He/She had not heard from Administrator A in the last few days. -He/She was unaware of any referral from Facility A. During a phone interview on 1/17/25 at 3:00 P.M. the Ombudsman said: -The ombudsman office had filed an appeal. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she had contacted the facility Administrator, notified of the intent to appeal the discharge. -The facility discharge letter was incorrect. --The letter had no discharge location. --The Ombudsman information was 4 years old and was incorrect. --The contact information for the appeals unit was from two years ago and invalid. -The Administrator said he/she did not plan to let the resident return. MO00247856

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative(s) of a transfer to a hospital, including the reason for the transfer in writing and failed to provide the Ombudsman (a resident advocate who provides support and assistance with problems and/or complaints regarding the facility) a copy of the notification for two sampled residents (Residents #14 and #30) when sent to the hospital out of 18 sampled residents. The facility census was 89 residents. Review of the facility's Bed-Hold Policy and Readmitted d 2021 showed: -At the time of transfer of a resident for hospitalization the facility will provide to the resident and a family member or legal representative written notice. -Notify the family or legal representative and physician about the discharge and reason. -Logging on the discharge log (hospital transfer) by the Social Services Designee (SSD) or charge nurse to fax monthly to the Ombudsman office. -NOTE: There was not a separate policy for discharge notices. Review of a notification from the State Long Term Care Ombudsman office to state Long Term Care facilities dated November 13, 2017, showed: -On May 12, 2017, the Centers for Medicare & Medicaid Services (CMS) provided additional clarification in advance of formal interpretive guidance of 42 CFR 483.15(c)(3)(i), the reference is S&C:17-27-NH: --At the time of initial emergency transfer, sending a copy of the transfer notice to the Ombudsman only needed to occur as soon as practicable. --Copies of notices for emergency transfers must be sent to the Ombudsman, such as in a list of residents on a monthly basis. 1. Review of Resident #14's discharge Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility staff for care planning) dated 2/21/24 showed he/she discharged to an acute hospital with his/her return anticipated. Review of the resident's Nurse Note dated 2/21/24 at 4:30 P.M., showed: -He/She was sent to the hospital with complaints of chest and generalized pain. -No documentation of notification to the resident, family or legal representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed no discharge notice dated 2/21/24 of his/her transfer to the hospital sent to the Ombudsman. Review of the resident's MDS entry tracking showed the resident returned from the hospital on 2/27/24. Review of the resident's Nurse Note dated 2/27/24 at 8:40 P.M., showed: -He/She returned from the hospital. -His/Her family member (emergency contact) was notified of his/her return. Review of the resident's Nurse Note dated 3/1/24 at 5:55 A.M., showed: -He/She was sent to the hospital for evaluation by the Physician. -No documentation of notification to the resident, family or legal representative. Review of the resident's medical record showed no discharge notice dated 3/1/24 of his/her transfer to the hospital sent to the Ombudsman. Review of the resident's Nurse Note dated 3/2/24 at 9:10 P.M., showed: -He/She returned from the hospital. 2. Review of Resident #30's MDS discharge assessment dated [DATE] showed he/she discharged to an acute hospital with his/her return anticipated. Review of the resident's Nurse Note dated 7/11/24 at 8:15 P.M., showed: -He/She was sent to the hospital after being found sitting with head down and had to be shook to get a response. -No documentation of notification to the resident, family or legal representative. Review of the resident's medical record showed no discharge notice dated 7/11/24 of his/her transfer to the hospital sent to the Ombudsman. Review of the resident's Nurse Note dated 7/16/24 at 6:38 P.M. showed he/she returned from hospital. Review of the resident's Nurse Note dated 8/18/24 at 9:55 P.M., showed: -He/She was sent to the hospital for complaints of chest pain and not feeling well. -No documentation of notification to the resident, family or legal representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed no discharge notice dated 8/18/24 of his/her transfer to the hospital sent to the Ombudsman. Review of the resident's Nurse Note dated 8/19/24 no time noted showed he/she returned from hospital. 3. During an interview on 11/20/24 at 10:43 A.M., Licensed Practical Nurse (LPN) B said: -A resident's family or representative should be notified by the nurse when a resident was sent to the hospital. -The family or representative should be notified as soon as possible before or right after the resident left the facility. -Notification to the family or representative should be documented in the nurse's notes of who was notified, and the time notified. -A copy of the bed hold policy was sent with the resident or sent to the family or representative. -He/She did not know a discharge notice was sent to the resident or the resident's representative. -A list of all residents discharged to the hospital should be sent monthly to the Ombudsman's office. During an interview on 11/21/24 at 12:10 P.M., the SSD said: -The facility only sent a list of residents discharged from facility and not expected to return to the Ombudsman monthly. -The facility had not been sending a list of residents discharged to the hospital to the Ombudsman. During an interview on 11/22/24 at 11:20 A.M., the Director of Nursing (DON) said: -The facility only sent a list of residents discharged from facility and not expected to return to Ombudsman monthly. -The facility had not been sending a list of residents discharged to the hospital to the Ombudsman each month. -The facility should be sending a list of hospital discharges to the Ombudsman each month. -The facility had not been notifying the Ombudsman of resident's returning to the facility from the hospital. -The facility does keep a list of what is sent to the Ombudsman each month. -The facility did not send a written notice of discharge to the resident or the resident's representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She expected the charge nurse who sent the resident out to call and notify the resident's representative of the discharge and document in the resident's nurses notes.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on observation, interview and record review, the facility failed to accurately complete the Resident Assessment Instrument/Minimum Data Set (RAI/MDS-a document which helped nursing home staff gather information on a resident's strengths and needs), which was used to address a resident's individual care plan (a document created for a person that received healthcare, personal care, or other forms of support) when it failed to accurately assess and record the use of bed rails (a rail or board attached to the bed that can reduce the risk of residents rolling, sliding, slipping or falling out of bed and sustaining a serious injury), for one sampled resident (Resident #56) out of 18 sampled residents. The facility census was 89 residents. Review of the facility's RAI Process Protocol Policy, dated 2022, showed: -The purpose of the policy was to ensure accuracy and timeliness of all MDS assessments. -To develop a comprehensive care plan that reflected the resident's level of care and to meet their needs. -In the absence of an MDS Coordinator the Director of Nursing (DON) was responsible for training a new MDS Coordinator. -The MDS Coordinator reviewed the MDS with the Interdisciplinary Team (IDT- a team of nursing home department heads who worked together to help residents receive the care they need) to ensure the information was coded accurately and reflected the assessments, and medical records. -The MDS Coordinator or the DON was responsible for reviewing the completion of MDS items and information was documented in the care plan. 1. Review of Resident #56's face sheet, undated, showed: -The resident was admitted to the facility on [DATE]. -The resident was legally blind (severe vision loss). -The resident had dizziness. -The resident had glaucoma (an eye condition that damages the optic nerve). Review of the resident's annual MDS, dated [DATE], showed: -The resident was severely cognitively impaired. -Bed rails were not in use. Review of the resident's quarterly MDS dated [DATE], showed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was severely cognitively impaired. -Bed rails were not in use. Review of the resident's paper medical chart showed no assessment for bed rails was completed for the resident. Observation on 11/19/24 at 11:49 A.M. showed the resident sleeping in his/her bed. -The left side of the bed was against the wall. -The left side of the bed had a rail attached to head of the bed running length wise about one fourth of the length of the bed. -Both rails were upright and in position. -The right side of the bed had the same rail, same approximate size, running one fourth the length of bed. -Resident was sleeping with his/her head resting on the mattress and the bar. -Bed was in lowest position to the floor. During an interview on 11/19/24 at 2:23 P.M., Certified Nursing Assistant (CNA) A said: -He/She kept the resident's bed close to the floor. -The resident did not have bed rails. -The facility did not use them. -They cannot do restraints. During an interview on 11/19/24 at 2:41 P.M., CNA B said: -The resident had a positioning bar he/she used to move him/herself in bed. -The resident should have an assessment in the medical chart. -The DON did the MDS assessments. During an interview on 11/20/24 at 5:42 A.M., CNA F said: -The resident had side rails. -He/She was unsure why the resident had bed rails. -He/She believed they were for positioning. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was unaware if the resident was assessed, if he/she was assessed it would be in his/her chart. During an interview on 11/20/24 at 6:04 A.M., CNA G said: -The resident had bed rails on his/her bed. -He/She thought the resident was assessed for bed rails but was not sure. -He/She saw the resident using them to get in and out of bed. During an interview on 11/20/24 at 6:13 A.M., Licensed Practical Nurse (LPN) C said: -The resident had bed rails on the upper quarter of the bed. -He/She was unsure why the resident had them. -The DON did the assessments and would be in the resident's care plan. During an interview on 11/20/24 at 11:42 A.M., LPN B said: -The resident did not have bed rails. -The resident may have a positioning bar, he/she was unsure. During an interview on 11/22/24 at 11:21 A.M., the DON said: -The resident had a positioning bar. -The resident did not have bed rails. -Positioning bars were smaller and bed rails were longer. -A positioning bar was about this big (gesturing with his/her hands approximately 6-8 inches apart), fastened to the bed. -The resident held it when he/she was moving in and out of the bed. -There should be a physician order for a positioning bar. -The use of the positioning bar should be indicated in the MDS. -The facility did not have bed rails, just positioning bars. -He/She would not refer to positioning bars as bed rails. -There should be an initial bed rail assessment and repeated quarterly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Charge nurses were responsible for bed rail assessments. -Assessments should be documented on a summary form in the residents medical chart. -There may also be a progress note indicating the assessment was completed.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on interview and record review, the facility failed to review and revise a resident's person-centered care plan (a document created for a person that received healthcare, personal care, or other forms of support) when it failed to ensure resident safety by not addressing the use of bed rails (a rail or board attached to the bed that can reduce the risk of residents rolling, sliding, slipping or falling out of bed and sustaining a serious injury), for one sampled resident (Resident #56) and failed to ensure the resident's care plan was accurate by dating it eight days after the resident discharged from the facility for one sampled resident (Resident #90) out of 18 sampled residents. The facility census was 89 residents. Review of the facility's Policy for Care Plan, dated 2022, showed: -The purpose of the policy was to: --To effectively communicate a resident's comprehensive plan of care to all staff. --To develop a new care plan and revise an existing care plan that needed to accommodate resident's needs and instruct staff for implementation. --To identify care problems/services according to the Resident Assessment Instrument (RAI) schedule of review and evaluation. -The car plan team included: the Director of Nursing (DON), Minimum Data Set (MDS- MDS- a federally mandated assessment instrument completed by facility staff for care planning)/CP coordinator, Social Service Director, Dietary Manager, Activity Director, and other staff as indicated. -Develop new care plans for new conditions, changes. -Use the MDS information to develop the plans. -The care plan should be reviewed at least quarterly. -The charge nurses and the DON communicated the care delivery and progress to each other, and other providers of care. -The MDS Coordinator communicated with care staff and reviewed the medical records to obtain the information to develop the care plan. -The care plan addressed all Care Area Assessments (CAA). 1. Review of Resident #56's face sheet, undated, showed: -The resident was legally blind (severe vision loss). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had dizziness. -The resident had glaucoma (an eye condition that damaged the optic nerve). Review of the resident's care plan dated 9/12/24, showed no care areas were indicated for the resident to have bed rails on his/her bed. Review of the resident's quarterly MDS dated [DATE], showed: -The resident was severely cognitively impaired. -Bed rails were indicated to not be in use. Observation on 11/19/24 at 11:49 A.M. showed: -The resident sleeping in bed. -The left side of the bed was against the wall. -The left side of the bed had a rail attached to head of the bed running length wise about one fourth of the length of the bed. -The right side of the bed had the same rail, same approximate size, running one fourth the length of bed. -Both side rails were upright and in position. -Resident was sleeping with his/her head resting on the mattress and the bar. During an interview on 11/19/24 at 2:23 P.M., Certified Nursing Assistant (CNA) A said: -The resident did not have bed rails. -It would be in the care plan if he/she used bed rails or a positioning bar. During an interview on 11/19/24 at 2:41 P.M., CNA B said: -The resident's bed is lower to the floor. -He/She gets out of bed by rolling and crawling. -He/She has a positioning bar he/she used to move him/herself in bed. During an interview on 11/20/24 at 5:42 A.M., CNA F said: -The resident had bed rails. -He/She was unsure why the resident had bed rails. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It would be in the resident's care plan. During an interview on 11/20/24 at 6:04 A.M., CNA G said: -The resident had bed rails on his/her bed. -He/She thought the resident was assessed for bed rails but was not sure. -He/She saw the resident using them to get in and out of bed. -He/She thought it was in the care plan but could not be sure without looking. During an interview on 11/20/24 at 6:13 A.M., Licensed Practical Nurse (LPN) C said: -The resident had bed rails on the upper quarter of the bed. -He/She was unsure why the resident had them. -He/She was unsure if it was care planned. During an interview on 11/20/24 at 11:42 A.M., LPN B said: -The resident did not have bed rails. -The resident may have a positioning bar, he/she was unsure. -Either one should be care planned. During an interview on 11/22/24 at 11:21 A.M., the DON said: -The resident had a positioning bar, not bed rails. -A positioning bar was about this big (gesturing with his/her hands approximately 6-8 inches apart), fastened to one side of the bed. -The resident held it when he/she was moving in and out of the bed. -There should be a physician order for a positioning bar. -The use of the positioning bar should be indicated in the care plan and the MDS. During a follow up interview on 11/27/24 at 9:11 A.M. the resident's guardian said: -He/She was not aware if the resident had bed rails/position device. -He/She attended previous care plan meetings, and no one had discussed bed rails/positioning device. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	22727 2. Review of Resident #90's entry tracking forms showed the resident was admitted to the facility on [DATE]. Review of the resident's nurse's note dated 11/12/24 showed the resident called the facility and stated a family member picked him/her up from the hospital and he/she was going to discharge from the facility and stay with the family member. Review of the resident's discharge assessment showed he/she was discharged with his/her return not anticipated on 11/12/24. Review of the resident's 36-page care plan initiated 11/20/24 (eight days after the resident's discharge with return not anticipated) showed all focus areas, all goals initiated and all interventions were dated 11/20/24 except for one care plan for a skin issue which was dated 10/14/24. No documentation was provided by the facility to show a care plan had been developed and utilized for the resident prior to the resident's discharge from the facility. During an interview on 11/22/24 at 11:21 A.M., the DON and the Administrator said:. -Care plans should be reviewed every three months. -The DON was currently responsible for care plans. -The resident's care plan should not have been done after he/she was discharged from the facility. -The DON was doing the care plans at this time.

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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** 39469 Based on observation, interview and record review, the facility failed to ensure medications were not left at bedside for two sampled residents (Residents #23 and #50) and one supplemental resident (Residents #27) out of 18 sampled residents. The facility census was 89 residents. The facility did not have a policy regarding leaving medications at bedside or self medicating. 1. Review of Resident #23's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Depression (a common mental health condition that involves a long-lasting low mood or loss of interest in activities). -Psychosis (a mental disorder characterized by a disconnection from reality). -Vascular Dementia (brain damage caused by multiple strokes (damage to the brain from an interruption of its blood supply). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 9/20/24 showed: -He/She was admitted for Non Traumatic Brain Disorder (brain dysfunction not caused by an accident). -He/She had Depression. -He/She was Psychotic. -He/She was taking the following medications: -Antipsychotic (a medication used to treat Psychosis). -Antidepressant (a medication used to treat Depression). -Antiplatlet (medication used to prevent blood clots). Review of the resident's care plan dated 10/8/24 showed: -He/She needed supervision to eat. -He/She had impaired cognitive function/dementia and or impaired thought processes due to Dementia. -Staff was to administer medications as ordered. -Cue, reorient and supervise as needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/17/24 at 9:08 A.M. showed: -There were six pills in a medication cup on the resident's bedside tray table. -The resident was asleep. Observation on 11/17/24 at 12:56 P.M. showed: -There were six pills in the resident's medication cup on his/her bedside tray table. -The resident declined to be interviewed. Review of the resident's Physician's Order Sheet (POS) dated November 2024 showed the resident did not have an order to self administer his/her medications. 2. Review of Resident #27's face sheet showed he/she had been admitted to the facility on [DATE] with the following diagnoses: -Depression. -Psoriasis (a condition in which skin cells build up and form scaled and itchy, dry patches). Review of the resident's significant change MDS dated [DATE] showed: -He/She was cognitively intact. -Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) was not checked. Review of the resident's care plan dated 11/15/24 showed: -He/She was at risk for skin breakdown. -He/She had impaired visual function. -Did not show he/she could administer his/her own medications. Review of the resident's POS dated November 2024 showed: -Nystop 100,000 units/gram (gm) apply topically to breast folds two times a day for rash, dated 7/31/24. -There was no physician's order to self administer medications. -The resident was to see Physical Therapy (a combination of exercises, stretches and movements to increase a patients strength and mobility) and Occupational Therapy (health care that helps people who have physical, sensory, and cognitive issues) due to a decline in Activities of Daily Living (ADL)s, dated 11/19/24. (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 to have a Neurology (treats disorders of the nervous system) appointment related to Parkinson's symptoms. Observation on 11/17/24 at 10:07 A.M. showed: -The resident had Nystatin (Nystop) powder at bedside. -The resident was out of the room. Observation on 11/21/24 at 12:05 P.M. showed the resident had Nystatin powder at bedside. During an interview on 11/21/24 at 12:05 P.M. the resident said the physician said he/she could keep the medication at the bedside so he/she could apply it when he/she wanted to to his/her rash. 3. Review of Resident 50's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Traumatic Brain Injury (an injury to the brain caused by an external force). -Psychoactive substance abuse (a strong desire or sense of compulsion to take the substance). -Alcohol abuse (a pattern of drinking that interferes with day-to-day activities). -Psychotic disorder with Hallucinations (a severe mental disorder that causes a person to lose touch with reality). Review of the resident's annual MDS dated [DATE] showed: -He/She was cognitively intact. -He/She had a Traumatic Brain Injury. -He/She had a Psychotic disorder. Review of the resident's care plan dated 11/5/24 showed: -The controlled substances including narcotics, alcohols and other addictive agents were not to have been used without a physician's order, dated 4/22/22. -He/She had the potential for harm to self related to substance abuse. -Staff was to administer medications as physician ordered. -Did not show he/she could administer his/her own medications. Review of the resident's POS dated November 2024 showed there was no order to self administer his/her own medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/17/24 at 12:54 P.M. showed: -There were two round white pills in a medication cup on his/her nightstand. -The resident was not in the facility. During an interview on 11/17/24 at 2:30 P.M. the resident said: -He/She had left the facility for a while today. -If he/she was not in his/her room when staff passed medications staff would leave the medication for him/her to take when he/she came back to the room. 4. During an interview on 11/20/24 at 7:00 A.M. Certified Medication Technician (CMT) D said: -You never leave the resident's medications at bedside. -You were to watch the resident take the medication. -If the resident was not in their room he/she would write the room number in the bottom of the cup put it in the medication cart and come back later to give the medication. -If the resident was not in their room or was not able to have been found he/she would then throw the medication away and write the resident refused the medication. -At least once a month when he/she came on shift he/she would have found a medication cup with medications in it from the previous shift. -He/She had told the charge nurse about the previous staff leaving the medications at bedside but it had not done any good, it still happened. -None of the residents on the first floor had a physician's order to self administer their own medications. -You could not leave the medication in the rooms as someone else might take them. During an interview on 11/20/24 at 9:30 A.M. Licensed Practical Nurse (LPN) B said: -Staff should never leave medications at the bedside. -Staff were to watch the resident take the medication. -A physician would have to write an order in order to allow the resident to self administer medications, to his/her knowledge none of the residents had an order to self administer medications so nothing should be left at their bedside. -Anyone could come into the resident's room and take the medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff has had education provided by the Administrator concerning leaving medications at bedside. -The Director of Nursing (DON) was ultimately responsible for ensuring staff did not leave medications at bedside. -He/She had seen medications left at the resident's bedside at least once a month and he/she would throw the medication away. -He/She had told the Administrator and DON when he/she had seen medications left at a resident's bedside and they had provided education but it still happened. During an interview on 11/21/24 at 9:44 A.M. Housekeeper B said: -Every day he/she saw medications left at the residents' bedside. -He/She found a lot of medications on the floor when he/she swept up the residents' rooms. -It was like a whole medication pass on the floor. During an interview on 11/22/24 at 11:18 A.M. the Administrator and DON said: -Their expectation from staff was to watch the resident take their medication. -Staff should not have left medications at the bedside. -A resident would have had to have been evaluated to self administer medications. -The physician would have written an order stating the resident could self administer medications. -They were not aware of any resident who had an order to self administer their own medications. -Staff had been educated on the correct way to pass medications. -They would expect staff to report to them if medication was left at a resident's bedside.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on interview and record review, the facility failed to have a process in place to ensure Cardiopulmonary Resuscitation (CPR-a lifesaving technique useful in many emergencies, in which someone's breathing or heartbeat has stopped) certifications were on file for all staff with current CPR certification and certified staff were available on all shifts. This had the potential to affect 80 residents who were a full code status (would require CPR). The facility census was 89 residents. Review of the facility policy titled Policy for Medical Emergency Response dated 2023 showed: -At least one staff member must obtain CPR certification each shift, which may be a non-nursing staff member. -The facility will maintain a record of any staff members who are trained and capable of providing CPR and will be able to demonstrate current competency. Review of the facility policy titled CPR policy dated 2023 showed: -The Administrator and DON will review staffing to ensure a CPR certified nurse is on duty for each shift. -Each licensed staff member will attend an in-service to complete CPR training or certification and will be retrained/recertified every year. -Each new licensed employee will be required to attend CPR certification. -Medical records will monitor licensed employee files yearly for compliance with CPR certification. -Medical records will notify the Administrator with a list of employees who do not meet CPR certification requirement. 1. Requested copies of CPR cards for all staff who are certified from the Administrator on: -[DATE] at approximately 11:45 A.M. -[DATE] at approximately 9:15 A.M. -[DATE] at approximately 9:00 A.M. -[DATE] at approximately 1:00 P.M., received copies of CPR cards for four staff. -[DATE] at approximately 12:00 P.M., received copies of CPR cards for two more staff. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the staffing schedules from [DATE] through [DATE] showed the facility does eight-hour shifts on weekdays and 12-hour shifts on weekends. Out of the sampled 41 shifts there were a total of 16 shifts without verified CPR staff. Review of discharged residents from [DATE] through [DATE] no resident's expired during this time frame. During an interview on [DATE] at 1:50 P.M., the Administrator said: -He/She does the staffing schedule. -Has at least one CPR certified staff on each shift. -When he/she hires a new employee, he/she asks if they are CPR certified and requests a copy of their card. -Not everyone gives him/her their CPR card to copy. -He/She has been trying to contact the staff who are certified to get copies of their cards since they were requested. -Should have someone monitoring and following up to get copies of CPR cards. -At this time the facility does not have a system to keep track of who has CPR cards. During an interview on [DATE] at 8:50 A.M., Certified Nursing Assistant (CNA) B said: -Had been working here for over [AGE] years. -Had CPR training in the past. -Not sure if his/her CPR card is current It has been a while since last did training. -The Administrator should have a copy of his/her card. During an interview on [DATE] at 8:59 A.M., CNA A said: -Had been working here about a year. -Is not CPR certified. -Doesn't remember if the facility offered CPR training or not. During an interview on [DATE] at 9:07 A.M., Licensed Practical Nurse (LPN) B said: -Had been worked here almost eight years. -Did not think his/her CPR card is current at this time. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Believes the facility had offered CPR training not sure when the last time it was offered. During an interview on [DATE] at 11:20 A.M., the Director of Nursing (DON) and the Administrator said: -There should be CPR certified staff in the facility for each shift. -The Administrator keeps track of which staff are CPR certified. -The Administrator keeps a file of CPR certified staff. -Administrator said he/she does not have copies of all the CPR cards for certified staff. -Administrator said he/she does not have a system at this time to keep track of staff CPR cards or when they are due to be renewed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to ensure staff were smoking in designated smoking areas; and failed to ensure two sampled residents (Resident #50 and #55) were smoking in designated smoking area and not smoking in resident rooms, out of 18 sampled residents. The facility census was 89 residents. Review of the facility's policy, Resident Smoking Policy, dated 5/03/12 showed: -Each resident who smoked would have been reassessed quarterly for the safe smoking capacity. -If a resident began to exhibit unsafe smoking practices, that resident would have been immediately reassessed. -Residents were allowed to smoke at designated times (which were posted and announced). -They were allowed to smoke in designated smoking areas. -The smoking areas were the Day Room on each Resident Care floor and outside of the facility. -Resident smoking material would have been locked up and would have been passed out by the staff member who was assigned to supervise the resident during smoking time. -If a resident was found to have been smoking in undesignated areas, he/she would have been placed on a 15-minute check, which would have been completed by the Certified Medication Technician (CMT) on that resident care floor. -The Director of Nursing (DON) and Administrator would have determined the length of monitoring (minimum of 48 hours on 15-minute monitoring). -There would have been a log of such activity. -Once the resident had successfully completed one hour of his/her monitoring period without smoking in the undesignated area the 15-minute check may have been stopped and returned to hourly checks. -The CMT would have been responsible for reporting the information to the Charge Nurse. -Any resident allowed to go outside would do so without supervision would have been assessed as a resident who was capable of safe practices. -Any resident who was in non-compliance with this policy would have an updated Plan of Care as well as documentation of such behavior. Review of the facility's policy, Substance Abuse - Resident, dated 2020 showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility prohibits the use of substance abuse including, trading, exchanging, selling, buying, and storing. -The controlled substances included narcotics, alcohols and other addictive agents were not to have ben used for the residents without a physician's order. -The following activities were strictly prohibited and may have lead to discipline, up to and including immediate discharge: --The sale, manufacture, distribution, purchase, use, or possession of alcohol, alcoholic beverages, illegal substances, non-prescribed controlled substances, or drug paraphernalia by an employee or residents on facility premises at any time. --Resident would have been subject to counsel, including possible discharge, if he/she violated this policy in any way. -This policy would have been reviewed annually by the facility (with the residents). Review of the facility's policy, Smoking Policy and Procedure - Resident Version, dated 2023 showed: -All residents and employees were to follow this policy and procedure or smoking privileges would be revoked. -Residents were to only smoke in posted designated areas during designated times posted located on the Front Porch, Car Port, and Second Floor Smoking Room. -A smoking assessment would have been completed upon admission, annually, and PRN. -Non-smoking areas would have had posted signs to ensure no smoking activity. -Staff would have made rounds every hour to monitor residents who were identified with risk behavior from history of smoking in non-designated areas. -If a resident was identified by the Administrator, DON, or Charge Nurse as having risk behavior for smoking in the room, a 15-minute to an hourly monitoring process would have begun for 14 days. -If a resident was found to have been non-compliant with the smoking policy, the staff would have implemented a Smoke Watch Log. -The resident area of non-compliance would have been monitored every 15 minutes until total compliance was confirmed. -The Administrator and staff would have monitored during daily rounds. -If a resident continues to have been non-compliant after having the smoking privileges revoked, a 30-day notice for non-compliance with the facility policy would have been issued by the Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26A293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The notice would have been given to the resident and family, guardian, and/or Designated Power of Attorney. -Prohibited smoking areas were: --Resident rooms, restrooms, shower rooms. --Staff and community bathrooms. Review of the facility's policy, Smoking Policy and Procedure - Employee Version, dated 2023 showed: -Employees were allowed to smoke in designated smoking areas only. -Ensure the combustible material were not nearby smoking areas during smoking activities. -Prohibited smoking areas were resident rooms, restrooms,staff and community bathrooms. -Designated smoking areas were the front porch, car port, and Second Floor Smoking Room. 1. Observation on 11/17/24 at 8:30 A.M. showed: -A kitchen staff member (he/she was wearing an apron and hair covering) was sitting on milk crates outside the kitchen door smoking. -There was a No Smoking sign directly on the outside of the building, behind the area the staff member was smoking. -There were 50 plus dried leaves on the ground where the staff member was smoking and flicked the cigarette ashes. Observation on 11/17/24 at 8:41 A.M. showed: -A second kitchen worker went outside of the back of the building by the kitchen door and was smoking. -There was a No Smoking sign directly on the outside of the building, behind the area the staff member was smoking. -There were 50 plus dried leaves on the ground where the staff member was smoking and flicked the cigarette ashes. Observation on 11/17/24 at 8:51 A.M. showed: -There was a half smoked cigarette in the toilet in the women's restroom. -The restroom smelled of cigarette smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was a sign on the wall by the paper towel dispenser in the restroom which said NO SMOKING. -There were no visitors in the facility at that time. Observation on 11/19/24 at 11:15 A.M. showed: -A third kitchen worker was smoking a cigarette outside of the kitchen door. -There was a NO SMOKING sign behind where the staff member stood. -He/She then walked around the side of the building to go into the side entrance, smoking the cigarette and flicking ashes on the ground. -There were leaves on the driveway. -He/She threw the cigarette on the driveway when he/she was done smoking it and returned to the building. -There was an ashtray by the door to the side entrance. 2. Review of Resident #50's face sheet showed he/she had been admitted to the facility on [DATE] with the following diagnoses: -Traumatic Brain injury with loss of consciousness of greater than one hour (brain dysfunction caused by an outside force,usually a violent blow to the head). -Psychoactive substance abuse (dependence on a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). -Alcohol abuse (dependence on alcohol). -Psychotic disorder with hallucinations due to known physiological condition (a severe mental illness that cause abnormal thinking and perceptions, including seeing things that were not real). Review of the resident's medical record showed no documentation a safe smoking assessment had been completed by the facility staff. Review of the resident's Care Plan dated 7/26/24 showed: -He/She had the potential for Harm to Self related to Substance abuse, dated 4/22/22. -It was the responsibility of each resident in the facility to adhere to the substance abuse policy. -Notify the facility staff of any suspicions of drug use in/on the facility premises. -Cooperate fully with any investigation related to alleged violations of this policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Accept and understand the facility reserves the right to check and deny Controlled Substances from unauthorized access. -The resident would have been subject to counsel, including possible discharge, if he/she violated this policy in any way. -The facility prohibited the use of substance abuse including, trading exchanging, selling, buying, and storing, dated 4/22/22. -The following activities were strictly prohibited and may have lead up to discipline, up to and including immediate discharge: --The sale, manufacture, distribution, purchase, use, or possession of alcohol, illegal substances, or drug paraphernalia by an employee or residents on facility premises at any time, dated 4/22/22. -The resident was a smoker. -Instruct the resident about the facility policy on smoking locations, times, and safety concerns. -Notify the Charge Nurse immediately if it was suspected the resident had violated the facility smoking policy. -The resident could smoke unsupervised, dated 8/21/23. -The resident could light his/her own cigarette and was able to keep a lighter at bedside, dated 8/21/23. Review of the resident's Annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 10/18/24 showed: -He/She was cognitively intact. -He/She had Traumatic Brain Injury. -He/She had a Psychiatric disorder. Observation on 11/17/24 at 12:54 P.M. showed the resident had a lighter and a package of cigarettes on his/her nightstand. During an interview on 11/17/24 at 12:54 P.M. the resident said he/she kept his/her own cigarettes and lighter in his/her room. Observation and interview on 11/17/24 at 1:20 P.M. showed: -The resident was sitting in his/her room and smelled strongly of marijuana. -He/She said that he/she was a smoker but not of marijuana. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/18/24 at 10:40 A.M. showed: -The resident was in his/her room. -He/She smelled strongly of marijuana. Observation on 11/19/24 at 4:30 P.M. showed: -There was a strong smell of marijuana coming from the resident's room. -There was a strong smell of marijuana 30 feet down the hallway. -There were cigarette ashtrays outside of the front doors (Front Porch). -There were three cigarette butts on the ground by the front door 10 feet from the ashtray. During an interview on 11/19/24 at 4:30 P.M. the resident said: -He/She threw his/her cigarette butts on the ground when done smoking on the front porch. -He/She had been smoking marijuana but had smoked it off of the property. During an interview on 11/19/24 at 4:35 P.M.: -The Administrator was notified that the resident's room smelled like marijuana. -The Administrator and Maintenance Director went into the resident's room to counsel him/her about smoking marijuana in his/her room. During an interview on 11/19/24 at 4:45 P.M. the Administrator said: -15 minute checks were initiated by staff. -The staff member was educated what to do, he/she was to check every 15 minutes, initial the form, and document what the resident was doing. -The Social Service Designee (SSD) was in charge of ensuring staff was providing the 15 minute smoke checks. Review of the Social Service Notes dated 11/20/24 showed: -It was brought to the SSD's attention that the resident's room smelled like marijuana. -The resident was placed on smoke checks after the incident occurred. -He/She had spoke with the resident over the smoking policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had the resident sign a new policy stating that he/she would be placed on hourly checks for the next 14 days. Review of the resident's Smoking assessment dated [DATE] showed: -He/She had been assessed earlier and was safe to smoke. -He/She did not consistently use an ashtray to manage ashes and self-extinguish cigarettes. -He/She had received education and understood the policy, and had signed verifying he/she understood the smoking policy. Review of the resident's 15 minute check log on showed: -On 11/19/24 at 5:30 P.M. the staff started to do 15 minute smoking checks on the resident -On 11/19/24 from 7:15 P.M. until 11/20/24 at 7:15 A.M. there were no smoking checks documented for the resident. During an interview on 11/20/24 at 11:30 A.M. the Administrator said: -They have counseled the resident about smoking in his/her room. -He/She was to have been checked on every 15 minutes all night to ensure he/she was not smoking in his/her room but it was not done. -The night CMT should have been responsible for checking on the resident to ensure he/she was not smoking, it had not been done. Observation and interview on 11/20/24 at 12:10 P.M. with Housekeeper B showed: -Staff was doing a deep clean of the resident's room. -There was a glass jar with 50+ bags of a green grassy residual that appeared to have been marijuana in them. -There were three aluminum foil packs with black tarry substances in them. -There were three pens that had the ink cartridge removed with a black tarry residue that appeared to be drugs. -He/She said the resident uses the bottom part of the ink pen to smoke weed and maybe other substances. -He/She thought the green substance in the bags was weed (marijuana). -He/She thought the black tar like substance was another drug. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 2:00 P.M. the Maintenance Director said: -Housekeeping has been doing a deep clean in the resident's room twice a week for about a year. -They always find small plastic bags with what looks like marijuana residue in them. -This was the second time in the last couple of months they had found bags with what appeared to have marijuana in them. -Last time found a little roach cigarette (marijuana) rolled up in weed paper. -They take the weed to SD and he/she put him/her on 15 minute smoke checks. -He/She did not think the black tar substance was heroin (an illegal narcotic) maybe it was Hash (Hashish -a compressed form of marijuana). -The resident had refused a few times to allow staff to deep clean his/her room and it was documented. Continuous observation on 11/21/24 from 9:00 A.M. to 10:30 A.M. did not show any smoking checks completed for the resident. During an interview on 11/21/24 at 9:37 A.M. Housekeeper B said: -They have done a deep cleaning in that resident's room at least every other week. -They have found bags with weed residue a couple times a month. -He/She had told the Administrator or Maintenance Director. -He/She had seen aluminum packets before. -People will put the drug, maybe heroin, in an aluminum packet light it up and smoke it through the bottom of an ink pen. -When he/she had showed the Maintenance Director he/she just threw it away. During an interview on 11/21/24 at 2:00 P.M. with the Administrator said: -When they found out the resident was smoking weed in his/her room he/she had counseled him/her. -Staff was to have done 15 minute checks for an unspecified time then hourly for three days. -They did 15 minute checks until about 7:00 P.M -Night shift was educated on what was expected of them and they had not done the checks. Observation on 11/21/24 at 3:10 P.M. showed: (continued on next page)

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	26A293	A. Building B. Wing	11/22/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was a marijuana smell coming from the resident's room. -The resident was in his/her room. -There was a three inch long silver pipe with dark colored substance in it. During an interview on 11/21/24 at 3:10 P.M. the resident said he/she was not smoking in his/her room, while he/she grabbed the silver pipe and put it in his/her coat and hurriedly left the room. Observation on 11/22/24 at 9:25 A.M. showed: -There was a strong smell of marijuana coming from the resident's room. -The smell of marijuana could be smelled from 20 feet down the hallway. -The resident was not in his/her room. -There was a lighter and empty bag with marijuana debris on his/her nightstand. During an interview on 11/22/24 at 9:30 A.M. the resident's roommate said: -His/Her roommate did smoke in the room, almost weekly. -He/She was afraid to say if the resident smoked cigarettes or marijuana. -He/She did not say anything to the staff as he/she was afraid of retribution. -He/She did not say if they were afraid of retribution from the resident or staff. 3. Review of Resident #55's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: did you interview any staff about this resident's smoking? NO -Amnesia (a temporary or long term memory loss). -Polyneuropathy (a disorder that affects multiple nerves simultaneously, causing them to malfunction). -He/She was their own responsible party. Review of the resident's quarterly MDS dated [DATE] showed: -The resident was moderately cognitively impaired. -Had decreased range of motion on one side. -Used a walker or wheel chair. -Had a stroke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan dated 9/5/24 showed: -He/She was a smoker. -He/She could smoke unsupervised. -Notify the nurse immediately if it was suspected the resident had violated the facility smoking policy. -Observe clothing and skin for signs of cigarette burns. -He/She had a stroke. Observation on 11/17/24 at 10:08 A.M. showed the resident had a lighter and a package of cigarettes in his/her pocket. During an interview on 11/17/24 at 10:08 A.M. the resident said: -Last year the staff had caught him/her smoking in his/her room. -The staff told him/her not to smoke in his/her room. -He/She still smoked in his/her room. -He/She smoked in his/her room just the other day. During an interview on 11/21/24 at 10:14 A.M. the resident said: -He/She still smoked in the bathroom. -He/She would put the cigarette in the toilet when he/she was done smoking. Review of the resident's chart showed: -He/She had been assessed for smoking. -He/She was able to smoke without supervision. 4. During an interview on 11/20/24 at 6:00 A.M. Certified Medication Technician (CMT) D said: -The residents should smoke in designated areas with an ash tray or in the smoking room on the second floor. -As you came into the building by the elevator there was a sign which said This is a no smoking building. -If he/she found someone smoking in their rooms, he/she would have asked them to give up their smoking materials. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The residents keep their smoking materials with them. -The residents can go out to smoke whenever they want to. -Some residents have been caught smoking cigarettes or marijuana in their rooms. -He/She did not want to name the residents who had been smoking in their rooms. -If he/she found someone smoking in the facility, he/she would tell the Social Worker and the Charge Nurse. -If staff was to do 15-minute checks it would have been written on the 24 hour sheet. -There was nothing documented on the 24 hour sheet that showed he/she was to do 15-minute checks on any of the residents. -He/She did not know he/she was supposed to do the smoke checks last night. -Staff should not have been smoking outside the kitchen door. -No one should have been smoking in the restrooms. During an interview on 11/20/24 at 9:00 A.M. the SSD said: -The facility had a smoking policy. -If a resident was found smoking they would have been put on a smoke watch every hour for 14 days. -If a resident was found smoking in their room they would have been put on an every 15 minute smoke watch but he/she did not know how long the 15 minutes checks continued before staff did the hourly checks. -If found smoking the facility would hold the resident's cigarettes and lighter for them. -The next time the resident was found smoking he/she would have been issued a 30-day discharge. -The residents had signed a smoking contract with the facility agreeing to the terms of smoking. During an interview on 11/20/24 at 9:20 A.M. Licensed Practical Nurse (LPN) B said: -The residents were to smoke in the designated areas not in their rooms. -If a resident was caught smoking in their room their lighter and cigarettes would have been kept by the CMT. -A resident on the first floor was recently caught smoking in his/her bathroom, he/she did not want to say which resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident would have been put on a 15 minute smoke watch. -He/She had been notified that Resident #50 had been found smoking marijuana in his/her room the other day. -Resident #55 had an issue in the last year for smoking in his/her room. -Smoke checks should have been done by staff. -The Director of Nursing (DON) was responsible for ensuring staff was completing the smoke watch. -Staff were to smoke in the designated areas which would have had a sign that designated the area as a smoking area and had an ashtray. -Staff should not have been smoking outside the kitchen if there was a no smoking sign there. During an interview on 11/22/24 at 11:18 A.M. the DON and Administrator said: -If a resident was found to have been doing drugs or smoking in the facility he/she would have been put on 15 minute checks. -They were not sure how long the 15 minute checks were done before starting the hourly checks. -SSD oversaw the smoke checks. -The DON was ultimately responsible for ensuring staff had completed the smoke checks. -Staff were expected to search the resident's room for smoking equipment/drugs. -If staff found smoking equipment/drugs they were expected to confiscate them. -A smoking assessment was done on each resident that smoked at least annually. -If a resident was found smoking they would have been counseled. -The residents who wished to smoke had signed a smoking contract. -Both Resident #50 and Resident #55 had signed smoking contracts. -Staff and residents should have only smoked in designated areas. -A designated area would have had a sign designating it as a smoking area and had an ashtray. -There should not have been a cigarette in the toilet. Complaint # MO00244880

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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 42955

Based on observation, interview and record review, the facility failed to maintain acceptable nutritional status by not following physician instructions for weighing residents resulting in an unplanned weight loss for one sampled resident (Resident #56) out of 18 sampled residents. The facility census was 89 residents.

Review of the facility's policy titled, Weight Management - Unplanned Weight Change dated 2023 showed:

-The Director of Nursing (DON)/Assistant DON (ADON) would be responsible for establishing monthly/weekly weight schedule.

-The appointed nursing staff were responsible for obtaining weight for each resident according to the schedule.

-The staff who were responsible for weighing the residents would compare the current weight and the previous weight and re-weigh the resident if there was a five or more pound change.

-Residents who exhibit weight gain or loss more than 5% in 30-day period; 7.5% in 90-day period or 10% in 180-day period shall be:

--Assessed by a licensed nurse for causative factors, contributing factors, and risks.

--Referred to the registered dietician for further evaluation.

--Notified to the physician for medical interventions.

--Referred to the weight committee for reviewing and revising the care plan.

-Charge nurses were responsible for documentation, progress, and implementation of treatment.

-The care plan shall reflect the interventions recommended by the dietician.

-The dietitian should be consulted.

-Implement dietitian recommendations and physician orders.

-Interventions should be developed:

--Monitor weekly weight to determine the improvement progress to change treatments or interventions.

--Feeding assistance with restorative feeding.

--Dietary approaches such as food preferences.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Implementation of plan and monitor for outcomes as instructed by the weight committee. -Weight loss interventions should be evaluated: --Trending the weight values (monthly for weekly weight; quarterly for monthly weight). --Review the goals and outcomes and repeat the above steps if needed. 1. Review of Resident #56's quarterly Minimum Data Set (MDS-a standardized assessment tool that measured health status in nursing home residents), dated 6/13/24, showed: -The resident was severely cognitively impaired. -The resident required substantial/maximal eating assistance (helper did more than half of the effort). -The resident weighed 157 pounds. Review of the resident's Care Plan (a document created for a person that received healthcare, personal care, or other forms of support), dated 9/12/24, showed: -The resident had impaired vision related to blindness. -Set up meals as needed and assist with opening cartons, cutting up food, and tray orientation. -The resident was at risk for nutrition deficit. -The resident will maintain adequate nutritional status as evidenced by maintaining weight. --Initiated on 3/21/24. -The resident was at risk for nutritional deficit due to a Low Concentrated Sweets (LSC- a diet designed to control blood sugar) diet. -Provide dietary services as instructed or recommended by the attending physician or the registered dietician. -The resident required extensive assistance while eating. -The resident had Diabetes Mellitus (a disease in which the body was unable to control the amount of sugar in the blood). -Monitor/document/report weight loss. Review of the resident's quarterly MDS, dated [DATE], showed: -The resident weighed 148 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident required substantial/maximal eating assistance. Review of the resident's 2024 weight record showed: -In June the resident weighed 156 pounds -In July the resident weighed 147 pounds. --The resident had a significant weight loss of 5.77% in 30 days. -No documentation the physician or RD was notified of the weight loss. -No weight was recorded for August. -No weight was recorded for September. -In October the resident weighed 145 pounds. -There was no weight recorded for November at the time of the survey. -From June to October 2024 the resident lost 11 pounds which was a 7.05% weight loss. Review of the October 2024 Medication Administration Record (MAR)/Treatment Administration Record (TAR), located in the resident's paper chart, showed: -Weekly weights ordered by the physician for Mondays on the 7:00 A.M. to 3:00 P.M. shift. --No weights were documented on the MAR/TAR. -The health shakes were not documented on MAR/TAR. Review of the resident's October 2024 Physician Order Summary (POS), showed: -The physician ordered weekly weights on 5/20/24. -The physician ordered health shakes with meals (no start date indicated). Review of the Vital Signs and Weights chart for October 2024, located in the resident's paper chart, showed: -No weight was recorded for 10/7/24. -Resident was weighed on 10/14/24 (146 pounds). -No weight was recorded for 10/21/24. -No weight was recorded for 10/28/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No weights were documented for November 2024. Review of the Nurse Progress Notes, dated 10/8/24, showed: -Health shakes were ordered by the RD, three times a day with meals to address weight loss. -No weights were documented on the Nurse Progress Notes. Review of the November 2024 MAR/TAR, located in the resident's paper chart, showed: -Weekly weights ordered by the physician for Mondays on the 7:00 A.M. to 3:00 P.M. shift. --No weights were documented on the MAR/TAR. -Health shakes three times a day was documented on the MAR/TAR. -Health shakes were given each day, three times a day, documented with initials and 100% consumed of every health shake. Review of the Nurse Progress Notes for November 2024, showed: -11/4/24 the resident weighted 147 pounds. -11/11/24 no weights documented. -11/18/24 no weights documented. During an interview on 11/19/24 at 2:23 P.M., Certified Nursing Assistant (CNA) A said: -The resident ate in the dining area where he/she helped the resident eat. -The resident had a health shake three times a day at each meal. -CNA's do the weights for each resident on the first of each month. -CNA's gave the weights to the nurses to document in the resident's chart. -He/She was unaware of the resident's current weight but was ordered a health shake. During an interview on 11/19/24 at 2:41 P.M., CNA B said: -CNA's weighed the residents on the first of each month. -CNA's gave the weights to the nurses to document. -The resident had a health shake and liked to drink them with every meal. -He/She weighed the resident on 11/1/24 and believed it was 149. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She wrote the weights down and gave them to the DON. -The DON put the weights in the resident's chart. Observation on 11/19/24 at 5:38 P.M. showed there was no health shake on the resident's tray. The resident ate the dinner meal and was wheeled out of the dining room. During an interview on 11/20/24 at 6:13 A.M., Licensed Practical Nurse (LPN) C said: -He/She was unaware of weight loss for the resident. -CNA's weighed the residents and gave them to the DON to document in the resident's chart. -If the resident was ordered a health shake the kitchen sent them up with the meals. -CNA's made sure the resident received their health shakes. Observation on 11/20/24 at 8:15 A.M. showed: -The resident was in the dining room with his/her breakfast tray and CNA A sitting with him/her. -There was no health shake on his/her tray. -Health shakes were on ice on the meal tray cart. During an interview on 11/20/24 at 11:42 A.M., LPN B said: -The resident was weighed weekly. -CNA's weighed the resident. -He/She had a nurse's book where he/she wrote the weights down. -When asked where the nurse's book was he/she presented it with blank areas for weight documentation. -He/She said he/she must have wrote it somewhere else. -He/She also put it on the TAR. -The resident was usually compliant with getting weighed. -If the resident was not compliant, they would try three more times and he/she was usually compliant. -If the resident refused it would be documented on the TAR and the nurse's book. -The resident had orders for health shakes for weight loss, three times a day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The health shakes came up from the kitchen with the meal trays. -The CNA's were responsible for making sure the resident had his/her health shake. During a follow up interview on 11/21/24 at 12:44 P.M., CNA A said: -The resident usually ate more than 50% of his/her meals. -It was documented in chart. -The kitchen sent up the health shakes with the meals. -They were kept on ice on the tray carrier until the resident was done with his/her meal. -He/She made sure the resident had one. -NOTE: At this time CNA A got up and retrieved a health shake from the meal tray cart and gave it to the resident. During an interview on 11/22/24 at 11:21 A.M., the DON said: -Resident's were weighed monthly. -If the resident had an order for weekly weights, then they were weighed weekly. -The CNA's weighed the residents and reported to the charge nurse who documented the weights on MAR/TAR. -The DON tracked resident weights and the dietician was made aware of any changes. -There was a RD and he/she was unsure if he/she was able to review the resident's chart. -If the resident was ordered a health shake, they should receive it as ordered. -The health shakes were sent up by the kitchen staff on the trays with the milk. -CNA's were aware of who was ordered shakes and were responsible to ensure the resident received them. -He/She expected CNA's to offer the resident the health shake. -CNA's were responsible for reporting to the charge nurse who documented it in the TAR. During an interview on 12/2/24 at 9:05 A.M., the RD said: -He/She had only been working at the facility for one month. -He/She had to have the resident's medical paper chart to know what his/her orders were. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had not charted on the resident and had no notes available to indicate if the resident triggered for weight loss. -He/She had not been there long enough to evaluate weight loss. -He/She had not seen weights prior to him/her being hired by the facility. -The DON gave him/her a list of the annual assessments and he/she looked at those for weight loss. -He/She did not have access to the resident's diet or previous RD notes. -He/She expected the facility to follow any orders regarding health shakes or weight measurements.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to ensure respiratory equipment such as oxygen tubing, Continuous Positive Airway Pressure (CPAP - a method of noninvasive ventilation assisted by a flow of air delivered at a constant pressure throughout the respiratory cycle), and a nebulizer (a device that was used to administer medication in the form of a mist inhaled into the lungs) were cleaned and stored in a sanitary condition for three sampled residents, (Resident #22, #34, and #62) out of 18 sampled residents. The facility census was 89 residents. Review of the facility's policy, Respiratory Therapy Policy, dated 2022 showed: -The equipment should have the individual's name and have been cleaned by the staff (the policy did not stated how often) and as needed. -Tubing, cannula, and bottle should have been stored properly in an infection controlled manner. Review of the facility's policy, Policy for Respiratory Care Equipment, dated 2022 showed: -To maintain the proper infection control technique when providing respiratory care for the residents. -To ensure the medical devices were maintained in good condition, clean and free of contamination. -All respiratory equipment should have been checked and cleaned daily/weekly and as needed. -Nebulizers: --Wipe the outside of the machine as necessary with a damp cloth. --Wash all parts in warm soapy water. --Rinse well in running tap water. --Soak overnight in a solution of white vinegar and water in a one to three ratio. --Rinse well in running tap water. --Allow to air dry. If not used that day place in a plastic bag or store in a dust free area. -Oxygen concentrator (machine that delivers oxygen): --Wipe off as necessary with a damp cloth. --The cannula (nose tubing) replace every 30 days or as needed. --The cannula could have been cleaned with a damp cloth. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CPAP machine: --Should have been cleaned once per week and as needed. --Wash parts in a mild dish washing detergent and warm water. --Rinse in clear water. --Let air dry. --Alternate two nebulizers. 1. Review of Resident #22's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnosis: -Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and makes it hard to breathe). Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated 9/17/24 showed: -He/She was cognitively intact. -He/She had COPD. -Did not show oxygen therapy. Review of the resident's care plan, dated 9/17/24 showed: -He/She had COPD related to smoking. -Staff was to administer aerosol (liquid particles suspended in the air) as ordered, dated 7/7/23. -He/She was at risk for difficulty breathing related to COPD. -Staff were to monitor for Shortness of Air (SOA) and administer oxygen as needed, dated 10/26/19. Review of the resident's Physician's Order Sheet (POS) dated November 2024 showed the following order: -Ipratropium bromide/albuterol (combination of medications used to treat COPD) 0.5 -3 (2.5) milligrams (mg) inhale one vial via nebulizer every six hours as needed for SOA or cough, dated 1/3/24. -There was no order for oxygen. Observation on 11/17/24 at 12:56 P.M. showed: -The nebulizer pipe was not in a bag or dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It was hanging off of his/her nightstand touching the floor. Observation on 11/21/24 at 10:02 A.M. showed: -The nebulizer pipe was hanging off of the nightstand lodged between the stand and the resident's bed. During an interview on 11/21/24 at 10:02 A.M. the resident said: -Staff did not change the pipe or tubing more than once a month. -Staff did not clean the pipe or put it in a bag. -He/She rinsed the pipe sometimes, but did not have any dish soap to clean it. -He/She did not know how often the pipe should have been cleaned. Observation on 11/23/24 at 11:28 A.M. showed: -The resident was asleep. -The nebulizer pipe was sitting on top of his/her nightstand. -The area he/she put his/her mouth to use it was yellowed. -The nebulizer pipe was not in a bag, it did not have a date on it. 2. Review of Resident #34's POS dated November 2024 showed the following order: -CPAP on at bedtime with a setting of 7 and off in the morning. -CPAP machine, cleanse mask and tubing daily with soap and water, dated 9/10/19. Review of the resident's quarterly MDS dated [DATE] showed: -He/She was cognitively intact. -Pulmonary (lung or breathing) issues was not checked. -CPAP was not checked. Review of the resident's care plan dated 11/12/24 showed: -He/She had altered respiratory status, difficulty breathing related to Sleep Apnea (a serious sleep disorder in which breathing repeatedly stops and starts), dated 11/12/24. -CPAP setting was at 7. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NOTE: There was no mention of cleaning or storage of the CPAP mask / tubing. Observation on 11/17/24 at 9:41 A.M. showed: -He/She had a CPAP machine sitting on the nightstand. -The CPAP mask was not in a bag. -There was no bag available in the room. Observation on 11/21/24 at 11:31 A.M. showed: -The CPAP machine was sitting on the top of the resident's nightstand. -The CPAP mask was sitting inside a drawer of the resident's nightstand mixed in with his/her belongings. -The CPAP mask was not in a bag. -Thee was no bag available in the room. During an interview on 11/21/24 at 11:31 A.M. the resident said: -Staff took care of the CPAP machine and mask. -He/She was not sure how long it had been since the staff cleaned the CPAP mask or the machine, maybe a month or so. -He/She did not think staff ever put the CPAP mask in a bag. Observation on 11/22/24 at 10:09 A.M. showed: -The CPAP machine and mask were sitting on the top of his/her nightstand. -The CPAP mask was not in a bag. -The CPAP mask was slightly yellow tinged. -There was no bag available in the room. 3. Review of Resident #62's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -COPD. -Chronic Respiratory Failure (a long term condition that prevents the body from exchanging oxygen and carbon dioxide properly). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS dated [DATE] showed: -He/She was cognitively intact. -He/She had COPD. -He/She had Respiratory Failure. -He/She was on oxygen therapy. Review of the resident's care plan dated 9/13/24 showed: -Staff were to change the nasal cannula tubing and humidifier bottle weekly on Fridays. -Store oxygen tubing and cannula in a closable bag with date. -Do not place on floor, dated 1/4/24. -Change nebulizer with tubing weekly on Friday. -Store the nebulizer in a closable bag with date. -Do not place on floor dated 1/4/24. -Oxygen therapy as ordered, dated 1/4/24. -Change tubing weekly on Wednesdays, dated 6/11/24. -Oxygen tubing was to have been in a bag when not in use, dated 6/11/24. Review of the resident's POS dated November 2024 showed the following orders: -Ipratropium bromide/albuterol 0.5 -3 (2.5) mg inhale one vial via nebulizer into the lungs twice daily for COPD, dated 6/27/23. -Change oxygen tubing one weekly on Wednesdays, dated 6/27/24. Observation on 11/17/24 at 9:01 A.M. showed: -He/She was on oxygen. -The oxygen nasal cannula (tube that delivers oxygen into a person's nose) was laying on the floor not in a bag. During an interview on 11/17/24 at 9:01 A.M. the resident said: -He/She used oxygen at night. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/17/24 at 12:00 P.M. showed: -Oxygen tubing was wound around the oxygen concentrator not in bag. -Nebulizer mask was laying on the floor not in a bag. -There was no bag available in the room. During an interview on 11/21/24 at 9:55 A.M. the resident said: -Staff changed out the tubing every couple of weeks. -He/She put the oxygen tubing in an old bag he/she had for the last month. -Staff ran water over the nebulizer mask maybe monthly, but did not use any kind of detergent to clean it. -He/She did not have any detergent in his/her room to clean the nebulizer mask. 4. During an interview on 11/20/24 at 7:00 A.M. Certified Medication Technician (CMT) D said: -The CMT or the nurse on night shift was responsible for changing out the oxygen tubing, ensuring it was in a bag with the date it had been changed out written on it. -He/She changed out the tubing if he/she had time, it had not always been done. -The nebulizer pipes/masks should have been run under the faucet to clean them, it was not usually done. -The staff had received education on ensuring the oxygen equipment was kept clean, stored in a bag, and not on the floor by the Administrator. During an interview on 11/20/24 at 9:30 A.M. Licensed Practical Nurse (LPN) B said: -Oxygen tubing should have been changed every week on the night shift by the CMT or nurse. -Oxygen tubing should have been stored in a clean/new bag with the date written on the bag that it had been change. -Oxygen tubing should never have been on the floor. -Nebulizer pipe/masks and CPAP masks should have been in a bag with the date written on it. -He/She did not know anything about what nebulizer masks/pipes or CPAP masks should have been cleaned with, maybe rinse them out after each use. -The Director of Nursing (DON) or Administrator were responsible for providing education to ensure oxygen equipment was kept clean and in a sanitary bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The DON and Administrator has done spot checks but changing the tubing out has not been done as it should have. During an interview on 11/22/24 at 11:18 A.M. the DON and Administrator said: -Oxygen tubing should have been changed out on Wednesday nights by the nurse. -The tubing should have been stored in a bag with the date it was changed out written on it along with the initials of the person who changed it out. -Oxygen equipment should have never been on the floor or in a drawer, or hanging down alongside of the bed. -The night nurse was responsible for ensuring the masks/pipes had been cleaned. -They have provided education to the staff many times regarding the oxygen equipment.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to provide ongoing communication and collaboration with the dialysis (the process of removing blood from an artery (as of a kidney patient), purifying it by dialysis, adding vital substances, and returning it to a vein) facility regarding dialysis care and services for one sampled resident (Resident #7) out of 18 sampled residents. The facility identified two residents as receiving dialysis. The facility census was 89 residents. Review of the facility's policy titled Policy on Dialysis and Care for the Shunt (a surgically created connection between an artery and a vein that provides access to the bloodstream for dialysis) dated 2023 showed instructions to: -Send a communication record for dialysis treatment each day the resident attended dialysis and complete the section of form titled Completed by [NAME] Manor Nursing Home. -Provide information and training on what information is obtained from the dialysis center, how the information is communicated between the facility and the dialysis center, how often the communication takes place, and where communication is recorded. 1. Review of Resident #7's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 9/26/24 showed the resident received dialysis. Review of the resident's care plan dated 10/8/24 showed the resident required dialysis due to renal failure. Review of the resident's communication record for dialysis treatment forms for October 2024 and November 2024 (through 11/17/24) showed: -There were six forms present when there should have been 20 for October 2024 through 11/17/24. -Three of the six forms were not dated. Review of the resident's nurses' notes showed: -On 11/1/24, it was documented the dialysis form was sent with the resident. -On 11/18/24, it was documented that the dialysis form was sent with the resident, but it did not return with the resident. Observation and interview on 11/18/24 at 10:32 A.M. showed the resident had a shunt in his/her left arm and the resident said the nurses have a dialysis book where his/her communication forms are located and he/she went to dialysis on Mondays, Wednesdays, and Fridays. During an interview on 11/21/24 at 12:00 P.M., Licensed Practical Nurse (LPN) A said: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurses were supposed to send the dialysis forms with the resident to dialysis. -If the form was not sent back with the resident after dialysis, the nurse should have called the dialysis center to get the information required on the form. During an interview on 11/22/24 at 11:20 A.M., the Director of Nursing (DON) said: -There's a form that the nursing staff should fill out the top portion of and send it to dialysis with the resident. -The dialysis center was supposed to weigh the resident before and after dialysis and document it on the form along with other information. -The nursing staff should call the dialysis center and request the form if it was not returned with the resident. -When they didn't receive the dialysis form back after dialysis, they didn't know the resident's weight before and after dialysis.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42955 Based on observation, interview, and record review, the facility failed to ensure resident safety by not following their Restraint Policy and providing bed rails (a rail or board attached to the bed that can reduce the risk of residents rolling, sliding, slipping, or falling out of bed) to one resident (Resident #56) out of 18 sampled residents. The facility census was 89 residents. Review of the facility's Side (Bed) Rail Policy, dated 2024, showed: -Residents with compromised mobility were reassessed upon admission for the use of bed rails. -Residents who used bed rails were screened or assessed monthly according to the monthly assessment schedule. -The care plan reflected the use of bed rails. -The care plan team discussed the use of bed rails during care plan meetings. -The physician was notified of the assessment and recommendations. -Residents who used bed rails were alerted to all nursing staff or frequent checks and observations. -The risks involved with the use of bed rails was discussed with the resident/resident representative and family. -Risk assessments and evaluations were completed and documented quarterly or when indicated with changes to condition, mobility levels and falls risks. 1. Review of Resident #56's face sheet, undated, showed: -The resident was legally blind (severe vision loss). -The resident had dizziness. -The resident had glaucoma (an eye condition that damages the optic nerve). -The resident was admitted on [DATE]. Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated 3/13/24 showed: -The resident was severely cognitively impaired. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clara Manor Nursing Home	3621 Warwick Boulevard Kansas City, MO 64111

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident used a wheelchair for mobility. -Bed rails were not used for this resident. Review of the resident's care plan dated 9/12/24, showed no care areas were indicated for the resident to have bed rails on his/her bed. Review of the resident's quarterly MDS dated [DATE], showed: -The resident was severely cognitively impaired. -Bed rails were indicated to not be in use. Review of the resident's physician order summary (POS), for October 2024 showed no order for bed rails or positioning bar. Review of the resident's POS, for November 2024 showed no order for bed rails or positioning bar. Review of the resident's paper medical chart showed no assessment for bed rails was completed for the resident. Observation on 11/19/24 at 11:49 A.M. showed the resident in his/her bed. -The left side of the bed was against the wall. -The left side of the bed had a rail attached to head of the bed running length wise about one fourth of the length of the bed. -The right side of the bed had the same rail, same approximate size, running one fourth the length of bed. -Resident was sleeping with his/her head resting on the mattress and the bar. -Bed was in lowest position to the floor. During an interview on 11/19/24 at 2:23 P.M., Certified Nursing Assistant (CNA) A said: -He/She kept the resident's bed close to the floor. -The resident did not have bed rails. -The facility did not use them. -They cannot do restraints. -It would be in the care plan if he/she used bed rails or a positioning bar. During an interview on 11/19/24 at 2:41 P.M., CNA B said: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's bed is lower to the floor. -He/She gets out of bed by rolling and crawling. -He/She had a positioning bar he/she used to move him/herself while in bed. During an interview on 11/20/24 at 5:42 A.M., CNA F said: -The resident had bed rails. -He/She was unsure why the resident had bed rails. -It would be in the resident's care plan. -He/She believed they were for positioning. During an interview on 11/20/24 at 6:04 A.M., CNA G said: -The resident had falls so he/she checked on the resident very frequently. -The resident was able to get out of bed without assistance. -The resident had bed rails on his/her bed. -He/She thought the resident was assessed for bed rails but was not sure. -If the resident had an assessment it would he in his/her chart. -He/She saw the resident using the bed rails to get in and out of bed. During an interview on 11/20/24 at 6:13 A.M., Licensed Practical Nurse (LPN) C said: -The resident climbed out of bed. -The resident had bed rails on the upper quarter of the bed. -He/She was unsure why the resident had them. -He/She was unsure if it was care planned. -The assessment would be in the resident's chart. During an interview on 11/20/24 at 11:42 A.M., LPN B said: -The resident did not have bed rails. -The resident may have a positioning bar, he/she was unsure. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 11:21 A.M., the DON said: -The resident had a positioning bar, not bed rails. -A positioning bar was about this big (gesturing with his/her hands approximately 6-8 inches apart), fastened to one bed of the bed. -The resident held it when he/she was moving in and out of the bed. -There should be a physician order for a positioning bar. -The use of the positioning bar should be indicated in the care plan and the MDS. --NOTE: The side rails on the residents bed were longer than 6-8 inches. During a follow up interview on 11/27/24 at 9:11 A.M. the resident's guardian said: -He/She was not aware if the resident had bed rails/positioning bar. -He/She attended previous care plan meetings, and no one had discussed it. -He/She did not recall approving the use of bed rails/positioning bar. -He/She expected the facility to communicate those kinds of issues with him/her.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 37576 Based on observation, interview, and record review, the facility failed to ensure staffing was posted correctly at the beginning of each shift including the total number and actual hours of nursing staff worked per shift which could have the potential to affect all visitors and residents in the facility. The facility census was 89 residents. A policy regarding posting staffing was requested but not received at the time of exit. Observation on 11/17/24 at 8:30 A.M., showed: -No posted staffing noted at the front entrance reception or the first-floor nurse's station. During an interview on 11/17/24 at 9:40 A.M., Certified Medication Technician (CMT) C said: -He/She was not sure where the staffing sheets were located, he/she said probably at the nurse's station. -The first floor had one Registered Nurse (RN), one CMT, and one Certified Nursing Assistant (CNA) for this shift. -The residents on the first floor were mostly self-care residents. -The second floor had one nurse, one CMT, and two CNAs. Observation on 11/17/24 at 12:38 P.M., of the second-floor staffing sheet showed: -The staffing sheet attached to a clipboard lying on top of the nurse's station counter not readily accessible to any resident in a wheelchair. -The staffing sheet listed the number of staff per floor and shift but did not list the total hours worked per nursing discipline. Observation on 11/18/24 at 10:10 A.M., showed: -The first-floor staffing sheet was posted at the front nurse's station on a clipboard hanging on the wall above the counter. -The staffing sheet was not readily accessible to visitors who came into the front entrance and went up to the second floor. -The second floor the staffing sheet was on a clipboard on top of the nurse's station counter not readily accessible to any resident in a wheelchair. -The staffing sheets on both floors listed the number of staff per floor and shift but did not list the total hours worked per nursing discipline. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/19/24 at 1:43 P.M., showed: -The first floor the staffing sheet was posted at the front nurse's station on a clipboard hanging on the wall above the counter. -The staffing sheet was not readily accessible to visitors who came into the front entrance and went up to the second floor. -The second floor the staffing sheet was on a clipboard laying under the desk phone behind the counter not readily accessible to any residents or visitors. -The staffing sheets on both floors listed the number of staff per floor and shift but did not list the total hours worked per nursing discipline. Observation on 11/20/24 at 5:48 A.M., showed: -The first floor the staffing sheet was posted at the front nurse's station on a clipboard hanging on the wall above the counter. -The staffing sheet was not readily accessible to visitors who came into the front entrance and went up to the second floor. -The second floor the staffing sheet was on a clipboard on top of the nurse's station counter not readily accessible to any resident in a wheelchair. -The staffing sheets on both floors listed the number of staff per floor and shift but did not list the total hours worked per nursing discipline. Observation on 11/21/24 at 9:50 A.M., showed: -The first floor the staffing sheet was posted at the front nurse's station on a clipboard hanging on the wall above the counter. -The staffing sheet was not readily accessible to visitors who came into the front entrance and went up to the second floor. -The second floor the staffing sheet was on a clipboard on top of the nurse's station counter not readily accessible to any resident in a wheelchair. -The staffing sheets on both floors listed the number of staff per floor and shift but did not list the total hours worked per nursing discipline. During an interview on 11/22/24 at 8:50 A.M., CNA B said: -The same staff usually work the same floor each shift they work -The residents know who the staff are that work their floor. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Most of the residents have been in the facility a long time and if they had visitors come the visitors usually know the staff working the floor the resident is on. During an interview on 11/22/24 at 11:20 A.M., the DON said: -The staffing sheets are posted daily at each nurse's station on both floors where residents and visitors are able to see it. -The staffing sheets show the date, day, facility census, name of the RN on duty, the name of each staff discipline working each floor and shift. -The staffing sheets do not show the total hours work for each nursing discipline.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on observation, interview and record review, the facility failed to effectively manage behaviors by not providing appropriate behavior interventions for one sampled resident (Resident #76) when the resident physically assaulted and injured Resident #69 by hitting him/her in the face causing pain, swelling, and redness. The facility census was 86 residents. Review of the facility's Behavior Management Program, undated, showed: -A behavior symptom was defined as an indication or characteristic of a negative physical or psychosocial outcome which may have resulted in disturbing of others. -A behavior could also inhibit the resident in attaining or maintaining his/her highest practical well-being. -The purpose of the policy was to promote a healthy environment that provided comfort to all residents. -The staff may detect early changes in mental or psychosocial status for appropriate interventions, which included: medication regimen, activities, counseling, visits (not specified) or social therapy. -Residents who exhibit behavior symptom concerns were monitored and/or treated to prevent incident. -Monitoring included checking for patterns and occurrence. -Residents who exhibited behavior concerns that fluctuated should be observed or monitored for increased/decreased and factors that contribute to elevate behavior symptoms. -Residents who often exhibited outburst behaviors, aggression, verbal and/or physical abusive behavior were monitored for safety, based on each individual and decided by the safety committee or Quality Assurance (QA) team. -Residents who exhibit fluctuated behavior or new behavior symptoms or indicators: --Monitor for underlying medical conditions and notify the Director of Nursing (DON) to revise the care plan. --Daily observation and documentation on each resident's behavior flow sheet determined by the charge nurse. --All staff were responsible to communicate and recommend what behavior needs to be monitored. 1. Review of Resident #76's Face Sheet, undated, showed: (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-The resident was admitted to the facility on [DATE]. -His/Her diagnoses included: --Major Depressive Disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), single episode. --Other psychoactive substance abuse (a strong desire or sense of compulsion to take the substance). --Generalized anxiety disorder (a constant about everyday issues and situations). Review of the resident's initial care plan dated 1/10/24 showed the resident: -Had a history of drug use/abuse. --The goal was the resident would understand the expectations of the facility, no drug use, and sign a contract. --The only intervention was the resident would understand that breaking the contract would result in discharge. ---NOTE: This care plan was not updated or revised. Review of the resident's Pre-Admission Screening/Resident Review (PASRR- a federally mandated screening process for individuals with serious mental illness, intellectual disability/developmental disability, and/or related condition who reside in a Medicaid Certified nursing facility), dated 6/13/24, showed: -The resident qualified for care. -The resident had a serious mental illness. -The resident had a history of Schizophrenia (a serious mental illness that affected how a person thought, felt and behaved). -The resident needed continued support and services. --Monitoring of behavioral symptoms. --Tools of choice or other positive behavioral support services. --Mental status to be monitored for signs/symptoms of depression, changes in mood, agitation and aggression. --Anger management may be helpful by teaching coping skills to deal with his/her emotions appropriately. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	--Staff to provide support and redirection as needed. -Resident would like to see a psychologist. Review of the resident's care plan showed: -There were no updates to the initial care plan of any new focus areas or interventions that addressed the resident's mood, mental status, and anger management. -There were no interventions that showed how to provide support and redirection to the resident. Review of the resident's Psychiatric Periodic Evaluation dated 10/3/24 showed: -The form was completed by an outside Psychiatric provider. -Was a psychiatry evaluation and medication management at the facility. -The resident denied feeling depressed or anxious. -The resident said the recent medication changes had helped his/her anxiety. -Staff noted no concerns, no new psychiatric issues or complaints. -Labs and medications list were reviewed, continue to monitor for changes and medication adjustment as needed. -Monitor for depression symptoms and document. -Psychological service to improve coping skills. -Safety concerns were addressed, staff were instructed regarding communication and redirection needed in caring for psychiatric and mental health residents. -Continue to monitor closely, redirect to promote safety, and utilize nursing intervention and behavioral modification. -Continue to offer activities, social events, group initiating, and resident one-on-one when needed. -Encourage sleep-wake cycle. -Monitor for changes in mood or behaviors and notify psychiatry if agitation or resident symptoms worsen. Review of the resident's care plan showed: -There were no updates, new focus areas, or new interventions that addressed safety concerns, communication, redirection, behavior modification, or placing the resident on 1:1 monitoring. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress notes dated 10/24/24 showed: -The resident was agitated, kicking and screaming. -The resident was taken to the hospital for evaluation and treatment of increased agitation and aggressiveness. -The social worker notified the Administrator and Director of Nursing (DON) of the resident's behaviors and being admitted to the hospital. Review of the resident's care plan showed: -There were no updates or new focus areas initiated following the resident's hospitalization for behaviors. -There were no updates or new focus areas that addressed the resident's behaviors and interventions including 1:1 monitoring. Review of the resident's Psychiatric Periodic Evaluation dated 10/31/24 showed: -Psychiatric medication regimen was reviewed. -Continue current psychiatric medications. -Continue to monitor response and make adjustments as needed. -Resident could benefit from psychological services to enhance coping skills. -Monitor for changes in mood or behaviors. -No new psychiatric concerns/complaints noted. Review of the resident's Psychotherapy Progress Note dated 10/31/24 showed: -Was completed by an outside psychological provider. -Staff reported resident behaviors of fighting with others, emotionally labile, fighting with staff. -Therapist focused on the resident's current mental health status and progress towards management of mood and anxiety symptoms. -Therapist encouraged the resident to set short-term goals that involved only him/her and did not depend on anyone else's involvement in his/her life. -Therapist encouraged the resident to focus on attainable and short-term goals to manage mood and anxiety. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-Therapist encouraged the resident to let staff know of needs as needed. -Therapist will follow up in one to three weeks. Review of the resident's progress notes dated 11/6/24 showed: -The resident was aggressively knocking on other resident's doors, yelling and screaming at them saying they owed him/her money. -The facility social worker notified the DON. -The facility social worker and DON talked with the resident. -The resident was placed on the list to be seen by psychology. Review of the resident's care plan showed: -There were no updates or new focus areas that addressed the safety of the resident or others. -There were no updates or new focus areas that addressed the resident's aggression, -There were no updates or new focus areas that addressed the resident's behaviors. -There were no updates or new focus areas that addressed the resident's behaviors and interventions including 1:1 monitoring. -There were no new interventions that addressed behavior modification when the resident became aggressive. Review of the resident's progress notes showed: -There was no documentation that mentioned changes in care needed following episodes of increased aggression and increased behaviors. -There was no documentation that mentioned psychology or psychiatry were notified of the resident's increased behaviors and aggression. Review of the resident's Psychotherapy Progress Note dated 11/7/24 showed: -The resident refused psychotherapy services. -The therapist will follow up in one to three weeks. Review of the resident's progress notes dated 11/7/24 showed: -The social worker and the DON talked with the resident. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-The DON notified the psychiatrist of the resident's increased behaviors and asked for medication management and adjustment as needed. Review of the resident's Psychotherapy Progress Note dated 11/21/24 showed: -The resident refused psychotherapy services and said his/her mind was all crazy and he/she couldn't think. -The therapist will follow up in one to three weeks. Review of the resident's Psychotherapy Progress Note dated 11/27/24 showed: -The resident was extremely agitated and unreasonable. -The resident expressed distrust with residents and staff. -The resident expressed significant agitation and frustration. -The resident expressed thoughts of suicide, but did not report a plan. -Therapist attempted to reduce the resident's emotional distress and to problem solve around the crisis. -The resident reported disinterest in hospitalization . -The resident's distress and agitation were lessened with the opportunity to express difficult emotion with the therapist. -At the end of the session, the resident denied thoughts of suicide. -The therapist reported to the resident that his/her original expression of suicide would be shared with the staff. -The therapist discussed the resident's presentation and safety planning with the Administrator, DON, charge nurse, and floor nurses. --Issues of safety were discussed with all. Review of the resident's care plan showed: -There were no updates or new focus areas that addressed the safety of the resident or others. -There were no updates or new focus areas that addressed the resident's aggression, -There were no updates or new focus areas that addressed the resident's behaviors. -There were no new interventions that addressed behavior modification when the resident became aggressive. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-There were no updates or new focus areas that addressed the resident's behaviors and interventions including 1:1 monitoring. Review of the resident's progress notes showed there was no documentation that mentioned changes in care needed following episodes of increased aggression and increased behaviors. Review of the resident's Psychiatric Periodic Evaluation, dated 11/28/24, showed: -Psychiatric medication regimen was reviewed. -Staff noted increased behavioral concerns as others were afraid of the resident because of his/her aggressive posture on the unit. -No new psychiatric issues or complaints were observed during the visit. -Mental status examination included: --Perseveration, pressured speech, coherent with loud tone and value speech. --Mood was noted to be irritable. --Affect was suspicious and irritable. --No response to hallucinations. --Poor concentration, insight, and judgement. -Start Seroquel (an antipsychotic used to treat hallucinations) 25 milligrams (mg) twice a day. Review of the resident's Psychiatric Periodic Evaluation, dated 12/19/24, showed: -Psychiatric medication regimen was reviewed. -The resident reported auditory hallucinations. -Staff noted increased behavioral concerns with anxiety and agitation. -No new psychiatric issues or complaints were observed during the visit. -Mental status examination included: --Perseveration, pressured speech, coherent with loud tone and value speech. --Mood was noted to be irritable. --Affect was suspicious and irritable. -Start Hydroxyzine (an antihistamine used to treat anxiety and agitation) 50 mg three times a day. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's care plan showed: -There were no updates or new focus areas that addressed the safety of the resident or others. -There were no updates or new focus areas that addressed the resident's hallucinations. -There were no new interventions that addressed behavior modification when the resident became aggressive. Review of the resident's progress notes showed there was no documentation that mentioned changes in care needed with episodes of hallucinations and increased aggression. Review of the resident's Physician Orders, dated January 2025, showed the resident was ordered: -Sertraline (medication used to treat depression); 150 mg daily (order updated on 11/7/24). -Buspirone (medication used to treat anxiety disorders); 5 mg twice a day (order updated on 11/7/24). -Quetiapine (medication used to treat hallucinations) 25 mg twice a day (order started on 11/29/24). -Hydroxyzine (medication used to treat agitation) 50 mg three times a day (order started on 12/19/24). Review of the resident's Psychotherapy Progress Note dated 1/3/25 showed: -The resident reported significant distress over current level of functioning. -The resident expressed his/her mind was racing. -The resident reported auditory hallucinations and explained them as hearing voices of people he/she knew just talking, both day and night all the time. -The resident reported poor sleep with difficulty falling and staying asleep. -The therapist encouraged the resident to let staff know of needs as needed and appropriate. -The resident would benefit from continued psychotherapeutic support maintain current level of progress and stability. -The therapist discussed the resident's presentation and plan of care with the unit nurse, nurse manager, and the social worker. Review of the resident's care plan showed: -There were no new focus areas or interventions that addressed the resident's increased behaviors. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-There were no new focus areas or interventions that addressed the resident's increased aggression towards other resident's and staff. Review of the resident's progress notes showed: -There was no documentation that addressed if changes in care were needed following episodes of increased aggression, hallucinations, and increased behaviors. -There was no documentation that addressed psychology or psychiatry was notified of the resident's increased behaviors, hallucinations, and increased aggression. Review of the resident's Psychotherapy Progress Note dated 1/9/25 showed: -The resident initially presented with agitation and anxiety. -The resident described his/her disappointment with his/her current family situation. -The resident had feelings of isolation and resentment. -The therapist helped the resident problem solve around preparing broken relationships. -The therapist determined the resident had periodic intermittent drops in mood and increased anxiety due to various personal issues, acute and chronic health conditions, strained family relationship dynamics, and ongoing situational stressors and challenges. -The therapist discussed the resident's recent presentation and plan of care with unit nurse, nurse manager, and the facility social worker. Review of the resident's care plan dated 1/13/25, showed: -The resident had a history of drug use/abuse. -The resident had potential for sad mood related to depression. --Administer medications as ordered. --Allow the resident to express feelings. --Behavioral health consults as needed. --Encourage the resident to attend activities of his/her choice. --Psychiatry consultation as needed. -The resident was at risk for increased behaviors related to a history of auditory hallucinations. --Administer medications as ordered. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	--Assist the resident to develop more appropriate methods of coping and interacting. --Encourage the resident to express feelings appropriately. --Caregivers were to provide opportunity for positive interactions, attention. --Stop and talk with him/her as passing by. --Monitor behavior episodes and attempt to determine underlying cause. --Consider location, time of day, persons involved, and situations. --Document behavior and potential causes. --Monitor behavior episodes and attempt to determine underlying cause. -The interventions / recommendations from the psychologist and psychiatrist were not added to the care plan. During an interview on 1/13/25 at 3:19 P.M., Resident #76 said: -He/She thought Resident #69 was going through his/her belongings. -He/She hit Resident #69 in the face. During an interview on 1/13/25 at 8:45 A.M., Resident #69 said: -Resident #76 said he/she kidnapped his/her children. -He/She was sleeping when Resident #76 came in his/her room and hit him/her in the face. -Resident #76 harassed him/her every day about going into Resident #76's room and taking his/her belongings, which never happened. -He/She talked to staff about Resident #76's behavior and they told him/her to stay away from Resident #76. -Resident #76 also bothered other residents, saying they went into his/her room and took belongings. -He/She felt safe now that Resident #76 was gone. During an interview on 1/13/25 at 9:15 A.M., Resident #72 said: -Resident #76 yelled a lot at the residents and had paranoid episodes, saying people were in his/her room taking his/her items. -Resident #76 was crazy, he/she threatened to beat up people. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-Resident #76 was violent. Staff told him to stay in his/her room. -He/She heard Residents #69 and Resident #76 argue on Friday night (1/10/25), but did not see anything. -He/she felt safe without Resident #76 around. During an interview on 1/13/25 at 9:25 A.M., Resident #37 said: -Resident #76 was unruly in the evenings. -Staff told Resident #76 to return to his/her room when he/she acted up. -On Friday he/she saw Resident #76 go into Resident #69's room. -He/She could not see the head of the bed behind the curtain, but he/she saw the motion of Resident #76 swing his/her arms as if he/she had hit Resident #69. -He/She felt safe now that Resident #76 was gone. -Staff tried to stop Resident #76 from hitting Resident #69. -He/She thought Resident #76 was going to hit the staff. -The staff ended up calling the police. During an interview on 1/13/25 at 9:35 A.M., Resident #11 (Resident #76's roommate) said: -Resident #76 was paranoid a lot. -He/She never saw anyone in their room. -He/She did not see what happened on Friday. During an interview on 1/14/25 at 11:16 A.M., Resident #29 said: -He/She had seen Resident #76's explosive behaviors before Friday. -He/She was afraid of the resident and felt safer now that Resident #76 was gone. -He/She noticed that staff stayed with Resident #76 during his/her explosive behaviors and tried to keep him/her busy. During an interview on 1/13/25 at 9:43 A.M., Certified Nursing Assistant (CNA) B said: -He/She was not working Friday night. -Resident #76 had some paranoia, anger issues which increased over the last few months. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-He/She reported behaviors to the nurse, he/she was unsure if anything was done. During an interview on 1/13/25 at 9:59 a.m., CNA A said: -Resident #76 had behaviors like pacing, sweating, and cussing at other residents. -He/She reported behaviors to the nurse. -Resident #76 was usually fine on the day shift, but was informed by staff and residents of his/her behaviors on the evening and night shifts. During an interview on 1/14/25 at 9:41 A.M., CNA A said: -When Resident #76 first arrived at the facility there were no behaviors. The last few months his/her behaviors increased. -Resident #76 went out of the building and returned angry, mad and paranoid. -Other resident's expressed being afraid of Resident #76. -He/She reported Resident #76's behaviors to the nurse. -He/She talked to Resident #76 to try to calm him/her down and he/she told the nurse about the resident's behaviors. During an interview on 1/14/25 at 9:54 A.M., CNA B said: -When Resident #76 first got to the facility there were no issues. -The last few months Resident #76 started showing more behaviors like cussing at other residents, accusing other residents of being in his/her room, yelling at staff and residents and pacing, generally paranoid. -He/She told the nurse about the behaviors. During an interview on 1/14/25 at 10:08 A.M., License Practical Nurse (LPN) A said: -When Resident #76 would start showing paranoia he/she would tell Resident #76 to go back to his/her room and calm down. -Resident #76 acted up on the night shift, because they didn't know how to handle the resident. -He/She separated the resident from other residents when he/she started to act up. -He/She did not report the behaviors because he/she was able to handle them. During an interview on 1/14/25 at 10:24 A.M., LPN B said: (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-Residents #76 and Resident #69 exhibited several hours of verbal altercations, including cussing at each other. -Resident #76 said he/she was going to kill Resident #69 while pacing in the hall. -He/She separated the residents, directing them to remain on separate sides of the hall. -Resident #76 was sweating and acting paranoid. -Resident #76 believed people were tapping into his/her phone. -Resident #76 believed Resident #69 was in his/her room. -Twice Resident #76 tried to enter Resident #69's room, accusing Resident #69 of taking things from his/her room. -Resident #76 threatened LPN B at which time LPN B called the police. -When police arrived Resident #76 physically assaulted the police as well as the paramedics. -Paramedics administered a sedative and the resident was removed in handcuffs. During an interview on 1/14/25 at 10:59 A.M., Certified Medication Technician (CMT) A said: -He/She was working Friday night during the incident. -The charge nurse told him/her that Resident #76 was being volatile. -He/She did not see anything that happened until the police arrived. -There were 11 officers and paramedics who responded to the 911 call. -Resident #76 had to be put in restraints. -Several residents told him/her they were afraid of Resident #76. -Resident #76 was usually easily redirected. -Resident #76 tended to be more aggressive toward people he/she believed to be more vulnerable. During an interview on 1/14/25 at 1:20 P.M., the DON said: -No residents or staff reported anything to him/her about Resident #76's behaviors. -Resident #76 went to the hospital last month, but that was the first time Resident #76 ever exhibited behaviors, that he/she was aware of. During an interview on 1/14/25 at 1:20 P.M. the Administrator said: (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-He/She was not made aware of any previous behaviors by Resident #76. -Resident #76 was sent out to the hospital last month for behaviors, but to his/her knowledge that was the only previous issue with his/her behaviors. -He/She would expect staff to separate the resident from other residents, place on one on one observation, someone should have been watching the resident, and call the police as the resident was very intimidating. MO00247856

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 39469 Based on observation, interview, and record review, the facility failed to ensure the only sink in the Medication Room on the first floor was clean, failed to ensure staff was checking the refrigerator temperature which held the residents prescribed medications, failed to ensure there were no expired medications in the medication refrigerator, and failed to ensure resident's prescribed medications were stored in a dry environment. The facility census was 89 residents. Review of the facility's policy,Storing Medications/Medication Carts, dated 2019 showed: -Drugs were to have been stored at proper temperatures. -Drugs requiring storage at room temperatures were to have been stored at a temperature of not less than 36 degree Fahrenheit (F) or more than 46 degrees F. -A thermometer was to have been kept in the refrigerator containing medications to help assure proper temperatures. -Drugs were not to have been kept on hand after the expiration date which appeared on the label. -Outdated, contaminated, or deteriorated drug, and those in containers which were cracked, soiled or without secure closures were to have been immediately withdrawn from stock, re-ordered from the pharmacy and disposed of in accordance with the procedures for drug destruction. -Maintain infection control at all time. 1. Observation on 11/20/24 at 5:39 A.M. of the first floor medication room with Certified Medication Technician (CMT) D showed: -There was no temperature log for the resident's medication refrigerator. -The temperature on the thermometer inside the refrigerator showed 46 degrees F. -Underneath the freezer compartment the boxes of insulin (medication used to control high blood sugars) were wet. -Two boxes of Admelog Solostar Insulin (a fast acting medication used to control high blood sugars) pens. -Two boxes of Lispro Insulin (a short acting medication used to treat high blood sugars) pens. --One of the boxes tore apart when it was moved. -One box of Lantus Insulin (a long acting medication used to treat high blood sugars) pens. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Water ran off of the box when it was moved. -Each box contained eight Insulin pens. -One opened vial of Tuberculosis skin test (TB - a test administered by injecting a small amount of TB under the skin to determine if a person had been exposed to TB) had expired on 5/24/24. -The only sink in the medication room for staff to wash their hands was dirty and rusty. During an interview on 11/20/24 at 5:45 A.M. CMT D said: -The temperature in the medication refrigerator should have been checked every shift and charted on a log. -There was no temperature log in the medication room or at the nurses' desk. -He/She did not know who was responsible for checking the temperature of the refrigerator. -He/She did not check the temperature of the medication refrigerator. -There may have been something wrong with the refrigerator to have water run on the boxes of Insulin. -The Charge Nurse or Maintenance Director should have been notified. -He/She did not know if anyone had been notified about the wet boxes of Insulin. -He/She did not notify anyone. -Whoever was in charge of checking the medication refrigerator's temperature should have also checked to ensure there were no expired medications in the refrigerator or medication room. -The sink in the medication room should have been cleaned daily, maybe by housekeeping. 2. Observation on 11/20/24 at 8:15 A.M. of the second floor medication room with Licensed Practical Nurse (LPN) B showed: -There was no temperature log for the resident's medication refrigerator. -The temperature on the thermometer inside the refrigerator showed 38 degrees F. -There was no temperature log for the medication refrigerator in the medication room or at the Nurses' station. -One vial of TB had expired on 5/24/24. During an interview on 11/20/24 at 8:20 A.M. LPN B said: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was not able to find a temperature log for the medication refrigerator. -The medication refrigerator's temperature should have been checked nightly by the night nurse and documented on the Medication Refrigerator Log which used to be attached to the refrigerator. -There should not have been any expired medications in the medication room. -The night nurse should have also checked for expired medications and removed them. -There should not have been wet Insulin boxes in the first floor medication refrigerator, they should have been removed and the temperature of the medication refrigerator should have been checked to ensure it was correct, or maintenance should have been contacted to ensure the refrigerator was ok to use. -Housekeeping should have been cleaning the medication room daily including the sink. -The Director of Nursing (DON) was ultimately responsible for ensuring staff were doing their jobs. -He/She did not contact maintenance about the refrigerator. During an interview on 11/22/24 at 11/18 A.M. the DON and Administrator said: -The night nurse was responsible for ensuring the temperature of the medication refrigerators were checked and within range. -The temperature should have been checked nightly and documented on a temperature log which should have been attached to the refrigerator. -They had not been told there were boxes of Insulin that were wet. -They would have to consult with Pharmacy to see what to do about the Insulin. -The nurse that checked the refrigerator temperature also should have ensured there were no expired medications. -Housekeeping should have been cleaning the floors and the sink in the medication rooms daily.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 19916 Based on interview and record review, the facility failed to ensure the Dietary Manager (DM) met one of the qualifications for a Certified Dietary Manager (CDM) by having a national certification for food service management and safety, from a national certifying body, or at least an associate's degree in food service management or in hospitality, or had 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management. This practice potentially affected all residents. The facility census was 89 residents. 1. Review of the new Employee hire list showed the DM was hired on 9/7/23. During an interview on 11/18/24 at 12:49 P.M., the DM said he/she has worked as as DM since September 2023 and the facility has not assisted him/her in obtaining the requirements to be a CDM. During an interview on 11/20/24 at 3:49 P.M., the Administrator said: -He/She knew that the DM had worked more than a year. -He/She has spoken with the DM about obtaining the requirements to be a CDM, but the conversation about the DM being a CDM, was as far as it went.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 19916 Based on observation, record review and interview, the facility failed to follow the menu on the following three occasions: Lunch on 11/17/24, lunch on 11/19/24 and dinner on 11/19/24. This practice potentially affected all residents. The facility census was 89 residents. 1. Review of the Week at Glance menu dated 2024 showed the 11/17/24 lunch meal consisted of: -Fried chicken. -Mashed potatoes with gravy. -Mixed greens. -Homemade Peach Crisp. -Dinner roll. Observation during the lunch service 11/17/24 from 11:45 A.M. through 12:35 P.M., showed the Homemade Peach Crisp was not served. During an interview on 11/178/24 at 11:53 A.M., Dietary [NAME] (DC) A said he/she ran out of time to make the Homemade Peach Crisp. 2. Review of the Week at Glance menu dated 2024 showed the 11/19/24 lunch meal consisted of: -Sweet and Sour Chicken. -Steamed Rice. -Oriental Vegetables. -Mandarin Orange Gelatin. Observation during the lunch service on 11/19/24 from 11:45 through 12:20 P.M., showed the residents received a rye swirl bread sandwich with fries. The residents did not get sweet and sour chicken. 3. Review of the Week at Glance menu dated 2024 showed the 11/19/24 dinner meal consisted of the following: -Pasta Fagioli Soup. -Classic Patty Melt. -Crispy French Fries. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Whipped Gelatin. Observation during the dinner service on 11/19/24 from 5:00 P.M. through 5:40 P.M., showed: -The residents received the Pasta Fagioli Soup and a choice of a ham with cheese sandwich, a turkey with cheese sandwich, or a grilled cheese sandwich. No fries were served with the dinner meal. During an interview on 11/21/24 at 9:33 A.M., DC A said -On 11/17/24 the residents got orange ice cream instead of the peach crisp because the dietary staff ran out of time to make it. -There was not a cook to prepare certain ingredients in advance. -The residents did not get Oriental Vegetables with lunch on 11/19/24, -The residents got a rye swirl bread sandwich for lunch on 11/19/24. -He/She did not use the chicken for the Sweet and Sour Chicken because the chicken was used as a substitute for a meal on 11/14/24 because the pulled pork that should have been used was not pulled (removed from the freezer) in a timely manner for defrosting. -On 11/19/24 the dinner meal consisted of soup and ham and cheese sandwiches, turkey and cheeses sandwiches or grilled cheese sandwiches. -There were no fries for dinner meal because fries were used for lunch meal.

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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. 19916 Based on observation and interview, the facility failed to ensure that Dietary Aide (DA) A's hair completely within a hair restraint; failed to ensure a bottle of jelly was refrigerated according to the label; failed to remove the grime from under the dishwasher; failed to clean the fan vent covers in the walk-in refrigerator; failed to remove food buildup from the bread toaster knobs; and failed to ensure the fan closest to the steam table was free from dust on the blades of the fan. This practice potentially affected all residents who ate food from the kitchen. The facility census was 89 residents. 1. Observations on 11/17/24 from 8:50 A.M. through 12:50 P.M., showed: -DA A worked in the the kitchen with his/her hair not completely restrained from 8:50 A.M. through 10:58 A.M. -One bottle of jelly not in the refrigerator label which stated Refrigerate After Opening. -A buildup of grime on the pipes under the dishwasher. -A buildup of food grime and crumbs on the bread toaster knobs. -A buildup of dust on the fan vent covers of the walk-in refrigerator. During an interview on 11/17/24 at 10:01 P.M., Dietary [NAME] (DC) A said he/she expected dietary staff to place items in the refrigerator which need refrigeration and the night cook should walk the kitchen to ensure that items need to be refrigerated are refrigerated. During an interview on 11/17/24 at 10:09 A.M., the Dietary Manager (DM) said no one in the dietary department has touched the toaster. During an interview on 11/17/24 at 10:58 A.M., DA A said he/she did not obtain help to get all his/her hair within a hairnet. During an interview on 11/17/24 at 12:43 P.M., the DM said he/she cleaned the fan vent covers back in May 2024. During an interview on 11/17/24 at 12:50 P.M., the DM said the last time the area under the dishwasher was cleaned was in July 2024. Observation on 11/19/24 at 3:30 P.M., during the dinner meal preparation showed the fan closest to the steam table blowing with a heavy buildup of dust on the blades. During an interview on 11/19/24 at 3:33 P.M., DC A said the fan had not been cleaned in a while.

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NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview and record review, the facility failed to ensure that foods stored in the resident use refrigerator was labeled with a resident's name and the date the food was brought in to clearly identify it as a food brought in by visitors and guests. This practice potentially affected at least three residents whose food was stored in the refrigerator. The facility census was 89 residents. Review of the facility's policy entitled Regarding Use and Storage of Foods Brought to Residents by Family and Other Visitors dated 2109, showed: -The facility is responsible for storing food brought in by family or visitors in a way that is either separate or easily distinguishable from facility food. -Clear identify what food has been brought in by visitors for residents and guests when served. 1. Observation on [DATE] at 11:38 A.M. showed the refrigerator at the 2nd floor nurse's station had: -One package of ham that was expired on [DATE]. -One container of milk that was opened and expired on [DATE]. -Two packages of food without a name of a resident or labeled with the date the the food was brought in. During an interview on [DATE] at 11:41 A.M., Licensed Practical Nurse (LPN) B said he/she has not worked on his/her shift at the facility for the last several days and he/she was not sure of whose job it was to check on items that needed to be discarded from that refrigerator.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 19916 Based on observation and interview, the facility failed to maintain the outdoor dumpster with the lids closed. The facility census was 89 residents. 1. Observation on 11/17/24 at 9:08 A.M. 9:58 A.M. ,and 10:15 A.M., showed the lid of the outdoor dumpster, remained open. 2 Observations on 11/18/24 at 9:49 A.M., 1:27 P.M., 2:06 P.M., and 2:47 P.M., showed the lid of the outdoor dumpster, remained open. 3. Observations on 11/18/24 at 11:20 A.M., and 12:33 P.M., showed the lid of the outdoor dumpster, remained open. During an interview on 11/18/24 at 12:35 P.M., Dietary [NAME] (DC) A said he/she expected facility staff to close the lids after they dump trash. During an interview on 11/18/24 at 12:50 P.M., the Dietary Manager (DM) said he/she expected facility staff to close the lids of the outdoor dumpster.

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 22727

Based on interview and record review, the facility failed to ensure the resident's care plan was accurate by dating it eight days after the resident discharged from the facility for one sampled resident (Resident #90) out of 18 sampled residents. The facility census was 89 residents.

Review of the facility's policy titled Care Plan dated 2019 showed:

-The comprehensive care plan was required to be completed within 21 days of admission.

-The Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) coordinator follows the Resident Assessment Instrument (RAI - helps the facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan) manual to develop the care plan and coordinates the RAI process.

-The care plan schedule follows the RAI requirements and can be reviewed and revised anytime to ensure it reflected the resident's current conditions.

1. Review of Resident #90's entry tracking forms showed the resident was admitted to the facility on [DATE].

Review of the resident's discharge assessment showed he/she was discharged to the hospital with his/her return anticipated on 10/15/24.

Review of the resident's entry tracking forms showed the resident returned to the facility on [DATE].

Review of the resident's medical record showed no notes about the resident leaving the facility or being sent to the hospital 11/3/24 to 11/11/24.

Review of the resident's nurse's note dated 11/12/24 showed the resident called the facility and said a family member picked him/her up from the hospital and he/she was going to discharge from the facility and stay with the family member.

Review of the resident's discharge assessment showed he/she was discharged with his/her return not anticipated on 11/12/24.

Review of the resident's 36-page care plan initiated 11/20/24 (eight days after the resident's discharge with return not anticipated) showed all focus areas, all goals initiated, and all interventions were dated 11/20/24 except for one care plan for a skin issue which was dated 10/14/24.

During an interview on 11/22/24 at 11:20 A.M., the Director of Nursing (DON) and the Administrator said.

-Care plans should be reviewed every three months.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The DON was currently responsible for care plans. -The resident's care plan should not have been done after he/she was discharged from the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 22727

Based on observation, interview, and record review, the facility failed to follow their policy for tuberculosis (TB-a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) screening annually for five sampled residents (Residents #22, #23, #58, #79, and #56) out of five residents sampled for TB; failed to ensure proper infection control practices were followed in the monitoring of blood glucose levels for five sampled residents (Residents #36, #140, #142, #33, and #143), by not sanitizing a glucometer (machine that measures the amount of blood sugar in a resident's blood) between uses; failed to maintain records of complete screening of new employees for TB for 10 sampled employees (Employee A, B, C, D, E, F, G, H, J, and K) out of 92 new employees; failed to initiate Enhance Barrier Precautions (EBP) in the facility, including one sampled resident (Resident #7), failed to educate staff on EBP, and failed to sanitize the end of an insulin (regulates the amount of glucose [sugar] in the blood) pen for two supplemental residents (Resident #21 and #88) before placing the needle cap on the pen out of 18 sampled residents and 14 supplemental residents. The facility census was 89 residents.

Review of the facility's Insulin Administration policy dated 2018 showed:

-Remove the pen cap.

-Wipe the rubber stopper end of pen with an alcohol swab.

-Screw the needle cap onto the pen tightly.

Review of the facility's TB Screening for Long Term Care Residents flow chart, dated 2023, showed:

-Administer tuberculosis skin test (TST) within one month prior to or within one week after admission to the facility.

-Read results of first step TST two to three days after administration.

-If there were negative results administer second step of the TST within one to three weeks.

-Read results of second step TST two to three days after administration.

-Annual evaluation completed to rule out signs/symptoms of TB.

-No further skin testing required unless exposed to infection TB or develop signs/symptoms of TB.

Review of the Centers for Medicare and Medicaid Services (CMS a federal agency that provides health coverage) policy by Health Quality Innovators dated Fall 2024 showed:

-EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A resident would have been placed on EBP during high contact resident care activities; -Infection or colonization with a Centers for Disease Control and Prevention (CDC -a government agency that was the national public health agency) MDRO when contact precautions did not apply. -Wounds. -Indwelling medical devices. -Staff should have worn gowns and gloves with these high contact resident care activities. -Dressing. -Changing linens. -Bathing/Showering. -Changing briefs or assisting with toileting. -Transferring. -Device care or use; central line (a thin flexible tube that was inserted into a large vein in the neck, upper chest or groin) , urinary catheter (a flexible tube that collects urine from the bladder into a drainage bag), feeding tube (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth), tracheostomy (a surgical procedure that creates an opening in the neck and into the windpipe to assist a person when breathing). -Providing hygiene. -Wound care; any skin opening requiring a dressing. -Environmental considerations include: -Personal Protective Equipment (PPE - clothing, gear, or other equipment that protects the wearer from injury or infections) outside of the room and ABHR inside and outside of the room. -Signage on the door. -Trash can placement inside the room by the exit. -Staff education should have included EBP policy and procedure. The facility did not have a policy for EBP. Review of the facility policy titled, Policy for Tuberculosis - Resident Version dated 2020 showed: -The TB log record was kept by the Administrator and DON. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The TB test results would be documented in the medical record. -Re-evaluate the resident yearly to assure absence of signs and symptoms for TB disease and document the findings in the records. 1. Review of Resident #23's Tuberculosis Test and Assessment Record showed: -The resident received a two-step TB test in 2021. -The resident had an annual TB signs and symptoms screen completed in January 2022 and January 2023. -There were no TB tests or screens since January 2023. 2. Review of Resident #22's entry tracking form showed the resident admitted to the facility on [DATE]. Review of the resident's medical record showed no documentation regarding TB testing or screening. 3. Review of Resident #58's Tuberculosis Test and Assessment Record showed: -The resident had an annual TB signs and symptoms screen completed on 6/6/23. -There were no TB tests or screens since 6/6/23. 4. During an interview on 11/21/24 at 12:00 P.M., Licensed Practical Nurse (LPN) A said: -Any of the nurses could complete signs and symptoms assessment for TB. -The nurses were supposed to document the TB screen on a TB test and assessment form. -A TB screening should be done annually. During an interview on 11/22/24 at 11:20 A.M., the Director of Nursing (DON) was present, and the Administrator said: -Signs and symptoms review for TB should have been done annually on a form and the form should be kept on the chart. -Normally the DON was responsible for completing the signs and symptoms reviews for TB but he/she had not done them because he/she had been busy with other stuff. -If the TB screening was not in the chart, it was not done. 5. Review of Resident #7's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 9/26/24 showed the resident received dialysis (the process of removing blood from an artery (as of a kidney patient), purifying it by dialysis, adding vital substances, and returning it to a vein). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan dated 10/8/24 showed the resident needed dialysis due to renal (kidney) failure. Observation and interview on 11/18/24 at 10:32 A.M. showed: -The resident had a shunt (a surgically created connection between an artery and a vein that provides access to the bloodstream for dialysis) in his/her left arm. -There were no PPE supplies inside or outside of the resident's room. -The resident said he/she went to dialysis on Monday, Wednesday, and Friday. Observation on 11/20/24 at 6:20 A.M. showed there were no PPE supplies inside or outside of the resident's room. During an interview on 11/21/24 at 12:00 P.M., LPN A said he/she wore gloves only (not a mask) when checking the resident's dialysis shunt. Observation on 11/21/24 at 12:18 P.M. showed there were no PPE supplies inside or outside of the resident's room. During an interview on 11/22/24 at 11:20 A.M., the DON said he/she was not aware of the EBP requirements and what residents the EBP covered. 19916 6. Review of the Facility's Undated Finger Stick and Procedure Policy, showed: -Purpose: To ensure the proper technique for infection control and proper maintenance of glucometer. Glucometer Maintenance: -Glucometers should be assigned to individual residents. If a glucometer has been used for one resident must be reused for another resident, the device must be cleaned and disinfected. Review of the manufacturer's recommendations dated 9/24, showed Germicidal wipes, germicidal disposable wipes, and bleach wipes could be used to clean and disinfect the glucometer used at the facility. Review of Resident #36's Physician's Order Sheet (POS) dated November 2024 showed a physician's order dated 12/19/23, to obtain accuchecks four times daily with meals and at bed time. Observation on 11/19/24 at 4:48 P.M., showed: -CMT A checked the resident's blood glucose level in the dining room. -CMT A did not disinfect the glucometer after checking the resident's blood glucose level. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #140's POS dated November 2024 showed a physician's order dated 8/31/20, to obtain accuchecks four times daily with meals and at bed time. Observation on 11/19/24 at 4:55 P.M., showed: -CMT A checked the resident's the blood glucose level in the dining room. -CMT A did not disinfect the glucometer after checking the resident's blood glucose level. 8. Review of Resident #142's POS dated November 2024, showed a physician's order dated 6/27/24, to obtain accuchecks four times daily with meals and at bedtime. Observation on 11/19/24 at 5:04 P.M., showed: -CMT A checked the resident's blood glucose level in the dining room. -CMT A did not disinfect the glucometer after checking the resident's blood glucose level. 9. Review of Resident #33's POS dated November 2024, showed a physician's order dated 4/25/24, to obtain accuchecks four times daily with meals and at bedtime. Observation on 11/19/24 at 5:13 P.M., showed: -CMT A checked the resident's blood glucose level in the dining room. -CMT A did not disinfect the glucometer after checking the resident's blood glucose level. 10. Review of Resident #143's POS dated November 2024, showed a physician's order dated 11/24/23, to obtain accuchecks four times daily with meals and at bedtime. Observation on 11/19/24 at 5:28 P.M., showed: -CMT A checked the resident's blood glucose level in the dining room. -CMT A did not disinfect the glucometer after checking the resident's blood glucose level. 11. During an interview on 11/20/24 at 9:34 A.M., LPN B said staff who use glucometers, should use bleach wipes to wipe the glucometer. Observation on 11/20/24 at 9:36 A.M., showed LPN A and LPN B could not find a container of bleach wipes in the first floor medication room. During an interview on 11/20/24 at 10:59 A.M., the DON said: -He/she expected the CMT to wipe off the glucometer machine with bleach or disinfectant wipes. -There should be a paper towel between the glucometer and the table when they set it down. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she would expect the CMT to wipe off the area where the glucometer was set down. -He/she went over the process with CMT A on the night of 11/17/24 on how glucometer checks should be done, but he/she did not keep any documentation of that in-service. -It had been months since an in-service regarding the process of checking blood glucose levels had been done. 12. Review of the facility's policy titled Policy for Tuberculosis Employee Version dated 2023, showed: -All potential employees shall be asked to participate in TB test or chest X-ray for possible tuberculosis. -The TB test is performed by subcutaneous (under the skin) injection. Reading is from 48-72 hours upon the injection. -Chest X-ray if the potential employee reports of positive result from the previous test or if the employees in not-US born. -The previous record of Mantoux (a method to determine if someone has a latent tuberculosis (TB) infection) test is acceptable if it was performed no longer than 6 months from the hired date. -The previous chest X-ray record is acceptable if it was performed no longer than 3 months from the hired date. -The licensed nurses perform the test. -The log record to be kept by the administrator or Human Resource personnel (corporate) -Perform the first step of Mantoux test. Document the location of injection and the lot of the vial. -Arrange the reading schedule after 7-10 days. -Document the result of the skin reaction to the test. -Arrange chest X- ray if needed. -Keep the result in the employee file separately than the EDL and CBC file. Review of Employee A's employment file showed: -He/She was hired on 5/8/24. -No documentation of a TB skin test since hire. Review of Employee B's employment file showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was hired on 5/20/23. -No documentation of a TB skin test since hire. Review of Employee C's employment file showed: -He/She was hired on 7/19/23. -No documentation of a TB skin test since hire. Review of Employee D's employment file showed: -He/She was hired on 7/1/24. -No documentation of a TB skin test since hire. Review of Employee E's employment file showed: -He/She was hired on 8/14/24. -No documentation of a TB skin test since hire. Review of Employee F's employment file showed: -He/She was hired on 3/20/24. -No documentation of a TB skin test since hire. Review of Employee G's employment file showed: -He/She was hired on 4/13/24. -No documentation of a TB skin test since hire. Review of Employee H's employment file showed: -He/She was hired on 11/10/22. -No documentation of a TB skin test since hire. Review of Employee J's employment file showed: -He/She was hired on 1/27/24. -No documentation of a TB skin test since hire. Review of Employee K's employment file showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was hired on 9/27/23. -No documentation of a TB skin test since hire. During an interview on 11/21/24 at 10:55 A.M., the Administrator said: -Once they do the readings of the TB tests they should place the results in the files. -LPN B and the DON were responsible for doing the TB testing and placing the results in the employee files. 37576 13. Observation on 11/20/24 at 7:23 A.M., showed CMT E who was certified to administer insulin as of 7/11/2016 administer the following Insulin's to Resident #21: -Humalog (a fast-acting insulin starts within 15 minutes and lasts for about 4-6 hours) Insulin. --Did not clean the rubber end of the insulin pen with an alcohol pad. -Levemir (long-acting insulin, helps keep blood sugar levels steady) Insulin. -- Did not clean the rubber end of the insulin pen with an alcohol pad. Observation on 11/20/24 at 7:56 A.M., showed CMT E administer the following Insulin's to Resident #88: -Levemir Insulin. --Did not clean the rubber end of the insulin pen with an alcohol pad. -Novolog (a rapid-acting starts within 5-10 minutes and lasts 2-4 hours) Insulin. --Did not clean the rubber end of the insulin pen with an alcohol pad. 14. During an interview on 11/22/24 at 10:30 A.M., CMT E said: -He/she would wipe the top of an insulin vial with alcohol when administering insulin with a syringe because there was no cap on the vial. -He/she did not alcohol wipe the end of the insulin pen before placing the needle cap on the pen. -An insulin pen had a replaceable cap, and the end did not need to be alcohol wiped before placing the needle cap on. During an interview on 11/22/24 at 10:40 A.M., LPN B said Insulin pen ends should be alcohol wiped before placing the needle cap on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/22/24 11:20 A.M., the DON said the end of insulin pens should be alcohol wiped off before attaching the needle cap. 15. Review of Resident #79's Admission sheet showed he/she was admitted on [DATE] with the following diagnoses: -Chronic Obstructive Pulmonary Disease (COPD-condition involving constriction of the airways and difficulty or discomfort in breathing) 4/11/24. -Chronic Respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide [a gas waste product produced by the body and exhaled from the lungs]) with hypoxia (low oxygen levels in the body tissues) 4/11/24. -Dependence on supplemental oxygen 4/11/24. Review of the resident's medical record showed he/she was not offered or given: -The first step of the Mantoux skin test on admission. -Chest x-ray for possible tuberculosis on admission. -Signs or symptoms evaluation for tuberculosis on admission. 42955 16. Review of Resident #56's face sheet showed the resident was admitted with the following diagnoses: -Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). -Legal blindness. -Anxiety (feelings of tension, worried thoughts, and physical changes like increased blood pressure). Review of the resident's Tuberculosis test and assessment record, undated, showed: -The resident received the two-step TB test in 2022. -The resident had no review of TB signs or symptoms or TB test in 2023 or 2024. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 9/13/24, showed: -The resident was severely cognitively impaired. 17. During an interview on 11/22/24 at 11:21 A.M., the DON said: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There should be an annual signs/symptoms review check list in the resident's file. -One should be completed on each resident. During an interview on 11/22/24 at 11:21 A.M., the Administrator said: -Normally the DON did the TB tests and the annual reviews. -Annual screenings should be in the resident's chart. -If it was not in the chart then it was not done. 39469 18. During an interview on 11/20/24 at 5:39 A.M. CMT D said: -He/She did not know what EBP was. -He/She had no education provided by the facility about EBP. During an interview on 11/20/24 at 7:12 A.M. CMT B said: -He/She did not know what EBP was. -He/She had no education provided by the facility about EBP. -There were residents who had a Foley catheter. -There was one resident who had an open wound. During an interview on 11/20/24 at 8:15 A.M. LPN B said: -He/She did not know what EBP was. -He/She had no education provided by the facility about EBP. -There were residents who had a Foley catheter. -There was one resident who had an open wound. During an interview on 11/21/24 at 12:20 P.M. the Administrator said: -They do not currently have an Infection Preventionist (IP - a medical staff who had completed the course and was certified for Infection control), he/she had started the course. -The IP would have been in charge of the EBP and ensuring the staff had received education on what was expected of them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-They were not doing EBP at the facility. -Staff had not received education on EBP. -He/She received information from the Center for Medicare and Medicaid Services (CMS). -There were residents in the facility who had catheters, Dialysis shunts, and open wounds. -There should have been a physician's order for the resident's to have EBP. -EBP should have been included on the residents' care plans. -There should have been a sign on the resident's name plate signifying they should have had EBP. -There should have been an isolation cart with Personal Protective Equipment (PPE) outside the resident's door. -The Administrator and the DON were responsible for ensuring staff had received education. During an interview on 11/22/24 at 11:18 A.M. the DON said: -They had not been aware of EBP at the facility. -There were residents who should have been on EBP. -The Administrator received information from CMS. -He/She did not know anything about EBP. -They were not practicing EBP at this time. Observation from 11/17/24 to 11/22/24 showed: -There were no signs on residents' doors showing EBP should have been used while providing cares with the resident. -There were no isolation carts with PPE outside any of the residents' rooms.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 39469 Based on interview and record review, the facility failed to have an certified Infection Preventionist (IP) employed at the facility. The facility census was 89 residents. Review of the facility's undated policy, Required Primary Professional Training for Infection Preventionists, showed: -This policy was to define the primary professional training requirements for Infection Preventionists to ensure they possessed the knowledge and skills necessary to manage and prevent infections in healthcare environments. -The Infection Preventionist must complete training programs offered through CDC TRAIN (a comprehensive platform that provides access to online training materials and resources from the Centers for Disease Control and Prevention). -All completed training and certifications through CDC TRAIN must be documented and maintained in the employee's personnel record. 1. During an interview on 11/21/24 at 12:20 P.M. the Administrator said: -They have not had an IP employed at the facility since August this year. -He/She had started the course but had not finished it. During an interview on 11/22/24 at 9:30 A.M. Licensed Practical Nurse (LPN) B said he/she did not think the facility had an IP at this time. During an interview on 11/22/24 at 11:18 A.M. the Director of Nursing (DON) said the facility did not currently have an IP.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on interview and record review, the facility failed to ensure an influenza (flu) vaccine (an annual vaccine to protect against the influenza virus) was offered to three sampled residents (Residents #22, #23, and #79) and failed to ensure pneumococcal (pneumonia) vaccine (a vaccine to protect against pneumococcal disease caused by the bacteria Streptococcus pneumoniae) was offered, administered or documented five years after a previous pneumonia vaccine for two sampled resident (Resident #23, and #56) out of five residents sampled for immunizations. The facility census was 89 residents. Review of the facility's policy titled Influenza and Pneumococcal Immunizations dated 2023 showed: -All newly admitted residents will be offered to receive the immunizations of influenza and pneumococcal in the facility. -Education was provided at the admitted or agreement time. -Flu vaccines were offered yearly. -Residents would be offered flu immunizations from October through March 31 annually unless medically contraindicated or he/she has been immunized during this time period. -The Director of Nursing (DON) would provide the schedule. -The DON was responsible for keeping record for residents who received the pneumococcal immunization. -The second pneumonia vaccine would be offered five years from the first pneumonia vaccine after consulting the Physicians or the Nurse Practitioners. -Residents or their legal representatives have the right to refuse or accept the offer of immunization. -Obtain the consent for immunizations for accepting or declining the offer. -All immunizations must be documented using the facility form. -The Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) Coordinator ensured the documentation of the vaccine was recorded in the MDS. 1. Review of Resident # 23's entry tracking forms showed the resident was originally admitted to the facility on [DATE]. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Severely cognitively impaired. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Received the flu vaccine for the last flu season on 11/21/23. -His/Her pneumonia vaccine was not up to date and the resident declined the pneumonia vaccine. Review of the resident's immunization record showed: -The resident received a flu vaccine on 11/11/21. -No documentation of any additional flu vaccines being administered. -The resident was over [AGE] years old. -The resident's most recent pneumonia vaccine was received on 3/12/17. -There was no documentation regarding any additional pneumonia vaccines being offered or administered five years or more after 3/12/17. Review of the resident's medical record showed: -No documentation regarding flu vaccines for the flu season of 2023 or 2024. -No documentation that the resident declined a pneumonia or flu vaccine. After the surveyor requested copies of the immunization records on 11/20/24, the facility provided a form dated 11/20/24 that the resident signed indicating he/she declined the flu vaccination. 2. Review of Resident #22's admission MDS dated [DATE] showed the resident admitted to the facility on [DATE]. Record review of the resident's immunization record showed there was no documentation that the resident received the flu vaccine or declined the flu vaccine. After the surveyor requested copies of the immunization records on 11/22/24, the facility provided a form dated 11/22/24 that the resident signed indicating he/she declined the flu vaccination. 37576 3. Review of resident #79's MDS dated [DATE] showed he/she was admitted on [DATE] with the following diagnoses: --Cardiorespiratory condition (a range of conditions that affect the heart and lungs). --Diabetes Mellitus II [condition that affects the way the body processes blood sugar (glucose)]. --Respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation) -Cognition was intact. Review of the resident's undated Missouri Immunization Record -Official document showed: -Influenza vaccine was due 7/1/24. Review of the resident's medical record showed that the pneumonia and influenza vaccines were not offered, administered or declined when he/she was admitted . After the surveyor requested copies of immunization records on 11/20/24, the facility provided a form dated 11/21/24 that the resident signed indicating he/she declined the flu vaccination. 42955 4. Review of Resident #56's face sheet, undated, showed the resident was admitted to the facility on [DATE] with a diagnosis of COPD. Review of the resident's quarterly MDS dated [DATE], showed: -The resident was severely cognitively impaired. -The pneumococcal vaccine was not given to the resident. -The pneumococcal vaccine was not offered to the resident. Review of the medical record showed the pneumonia vaccine was not offered, administered or declined. 5. During an interview on 11/21/24 at 12:00 P.M., Licensed Practical Nurse (LPN) A said: -Usually, a nurse manager got vaccine consents in September. -Any nurse could give the vaccines once consents were obtained by the nurse manager. During an interview on 11/22/24 at 9:30 A.M., LPN B said: -Residents were offered vaccines. -The administrator offered the vaccines to the residents and tracked the vaccines and documented them. -A local pharmacy came out to the facility for a vaccine clinic a couple of times in the last month or so. -The administrator tracked the vaccines and documented them. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It should be documented in the residents chart. During an interview on 11/22/24 at 11:20 A.M., the DON was present, and the Administrator said: -The pneumonia vaccine should be offered during flu season starting October 1st, but it could also be offered throughout the year. -He/She usually talked to the residents about whether they wanted to get a vaccine, provided education on the risks/benefits of the vaccines, and had them fill out a form indicating whether they wanted the vaccine or not. -He/She didn't have time this year to get it done, so he/she's having other nursing staff members do it. -They had a pharmacy come to the facility to administer COVID-19, flu, and Respiratory Syncytial Virus (RSV) vaccines on 10/29/24 and 11/12/24. -He/She was the one who kept track of when the residents received a pneumonia vaccine so another one could be administered after five years. During an interview on 11/22/24 at 11:21 A.M., the DON said: -Residents were offered the pneumonia vaccine throughout the year. -A local pharmacy came to the facility for a vaccine clinic, including the pneumonia vaccine. -The clinic for the pneumonia vaccine was not scheduled yet. -There was no pneumonia vaccine clinic held this year. -The administrator offered vaccines to the residents. During an interview on 11/22/24 at 11:21 A.M., the Administrator said: -He/She provided risks and benefit education regarding all vaccines, including pneumonia to the residents and/or responsible party or family at the time of the vaccine clinic or when it was given. -Some residents declined the pneumonia vaccine and the signed in a declination form indicating the declined. -That form should be in the residents medical files, and their electronic health record (EHR). -He/She looked in resident #56's chart and did not see a form indicating the pneumonia vaccine was offered to the resident or the guardian.

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F 0887

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 22727

Based on interview and record review, the facility failed to ensure the 2024-2025 COVID-19 (a new disease caused by a novel (new) coronavirus) vaccine was offered, administered, or documented for two sampled residents (Resident #23 and #79) out of five residents sampled for immunizations. There were 18 residents in the survey sample. The facility census was 89 residents.

Review of the Centers for Disease Control and Prevention (CDC) website dated 10/3/24 showed everyone ages 6 months and older should get a 2024-2025 COVID-19 vaccine.

A COVID-19 vaccine policy was requested but not provided by the facility.

1. Review of Resident #23's entry tracking forms showed the resident was originally admitted to the facility on [DATE].

Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff) dated 9/20/24 showed the staff assessed the resident as severely cognitively impaired.

Review of the resident's immunization record showed:

-The resident received the two initial COVID-19 immunizations on 1/25/21 and 2/23/21.

-The resident received one COVID-19 booster on 11/3/21.

-There was no documentation regarding the 2024-2025 COVID-19 vaccine being administered or offered.

2. Review of resident #79's MDS dated [DATE] showed he/she was admitted on [DATE] with his/her cognition intact.

Review of the resident's undated Missouri Immunization Record -Official document showed COVID-19 vaccine was due 8/22/24.

Review of the resident's medical record showed that the COVID-19 vaccines were not offered, administered or declined when he/she was admitted .

After the surveyor requested copies of immunization records on 11/20/24, the facility provided a form dated 11/21/24 that the resident signed indicating he/she declined the COVID-19 vaccinations.

3. During an interview on 11/21/24 at 12:00 P.M., Licensed Practical Nurse (LPN) A said:

-Usually, a nurse manager got vaccine consents in September.

-Any nurse could give the vaccines once consents were obtained by the nurse manager.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/22/24 at 11:20 A.M., the Director of Nursing (DON) was present, and the Administrator said: -They should be offering the COVID-19 vaccines now. -He/She usually talked to the residents about whether they wanted to get a vaccine, provided education on the risks/benefits of the vaccines, and had them fill out a form indicating whether they wanted the vaccine or not. -He/She didn't have time this year to get it done, so he/she's having other nursing staff members do it. -They had a pharmacy come to the facility to administer COVID-19 vaccines on 10/29/24 and 11/12/24.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, and interview, the facility failed to ensure the facility's call system was audible at the attendant's area for the residents on the 2nd floor. This practice potentially affected 46 residents who resided on the 2nd floor. The facility census was 89 residents. 1. Observations on 11/18/24 showed: -At 10:04 A.M., there was no audibility (the quality or state of being able to be heard) at the nurse's station, when the call light in resident room [ROOM NUMBER] was activated. -At 10:11 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 10:15 A.M., there was no audibility at the nurse's station when the call light in the shower room was activated. -At 10:31 A.M., there was no audibility at the nurse's station when the call light in the whirlpool room was activated. -At 10:48 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 10:51 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:02 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:03 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:04 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:07 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:14 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:16 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:18 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:19 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:21 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. -At 11:27 A.M., there was no audibility at the nurse's station when the call light in resident room [ROOM NUMBER] was activated. During an interview on 11/18/24 at 10:23 A.M., Licensed Practical Nurse (LPN) A said , We keep up with the residents in response to a question regarding how do they monitor residents when they cannot hear the call lights if they are not in the hallways. During an interview on 11/18/24 at 10:54 A.M., Certified Nursing Assistant (CNA) B said the call lights only blink on the panel at the 2nd floor nurse's station, the staff just cannot hear the call lights. During an interview on 11/18/24 at 11:08 A.M., the Maintenance Director said the issue with the call lights not being audible has something to do with the panel. During an interview on 11/20/24 at 10:26 A.M., the Corporate Maintenance Person said: -The reason why the call lights on the 2nd floor were not audible was because the volume was turned down way too low because the North Stairwell door from the 2nd floor to the stairwell to the 1st floor was activated, so it overrides the volume of the call light panel. -The 2nd floor panel needed to be reset after a door to the stairwell was opened.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 19916 Based on observation and interview, the facility failed to ensure there was not a heavy buildup of dust under the vending machines in the second floor dining room and failed to ensure the threshold (a horizontal strip of material that covers the gap between the floor and a door frame) of the door between the carport and the basement entrance was securely affixed to the floor. This practice potentially affected at least 25 residents who used the carport as a smoking area and an unknown number of facility staff who entered the facility through that door. The facility census was 89 residents. 1. Observation on 11/18/24 at 10:39 A.M., showed a heavy buildup of dust under the vending machines in the 2nd floor dining room. During an interview on 11/18/24 at 10:40 A.M., the Maintenance Director said: -It was difficult for staff to get under the vending machines because the vending machines are heavy and difficult to move. -He/She would have to call the vending machine company to move the machines so his/her staff can clean under the machines. 2. Observations on 11/17/24 at 12:35 P.M., 11/19/24 at 12:25 P.M., and on 11/20/24 at 11:46 A.M., showed the threshold of the door between the carport and the entrance to the basement was loose and was a tripping hazard. During an interview on 11/21/24 at 12:15 P.M., the Maintenance Director said the threshold has been loose for a few weeks.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview and record review, the facility failed to carry out pest control measures to limit the presence of roaches in the kitchen, the dining room, and in resident rooms 214 and Resident #25's room. This practice affected all areas of the kitchen and the part of the dining room next to the kitchen. The facility census was 89 residents. 1. Observations on 11/17/24 from 8:58 A.M. through 12:47 P.M., showed: -Dead roaches in the drawer under the table with the microwave. -Roaches crawling on the wall behind reach-in refrigerator -Roaches inside of the electrical outlet behind ice machine. -Numerous roaches under the dishwasher, where there was a buildup of grime and food debris. During an interview on 11/17/24 at 9:24 A.M., the Dietary Manager (DM) said he/she was responsible for cleaning the food crumbs on the handrail and he/she noticed the roaches at the end of the hand rail. During an interview on 11/17/24 9:28 A.M., the DM said they could only scrub so much of the grime and food crumbs under the dishwasher because it was a tight spot. During an interview on 11/17/24 at 9:32 A.M., the Maintenance Director said they have the exterminator coming two times per month and the exterminators got under the dishwashers when they come to the facility. During an interview on 11/1724 at 9:46 A.M., the Maintenance Director said the pipes under the dishwasher with the grime under them can be lifted off the floor. 2. Observations on 11/17/24 at 9:22 A.M. showed: -Numerous roaches under the tea maker where the state surveyor was set up for observations. Roaches crawled on the table next to the surveyor's computer and on the wall behind the table. -Roaches crawled on the wall next to the North door from the kitchen to the hallway outside the kitchen. -Roaches crawled next to where the end of the handrail joined the wall in the dining room and a buildup of food crumbs in the handrails which were on the north wall of the dining room. During an interview on 11/17/24 at 9:24 A.M., the Dietary Manager (DM) said he/she was responsible for cleaning the food crumbs on the handrail and he/she noticed the roaches at the end of the hand rail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26A293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/17/24 at 9:32 A.M., the Maintenance Director said there have been periodic shortages of staff in the kitchen over the few months and housekeeping was supposed to help in the cleaning of the dining room. 3. Observations on 11/17/24 at 10:17 A.M. showed: -Roaches crawled on the wall behind the table where the seasonings and spices were stored. -Roaches crawled inside the box with high density plastic bag. -Roaches crawled on ceiling above the reach-in refrigerators. -At 10:20 A.M., the DM said I'm so tired of roaches as a roach crawled on the table where he/she placed two cans of canned greens on the table next to the 3-compartment sink. -At 10:34 A.M., there were roaches crawling in the tea bag box. -At 11:25 A.M., one roach was observed inside the delivery tray cart (before the cart was loaded with trays of food) for the second floor. During an interview on 11/17/24 at 11:27 A.M., the DM said the dietary staff checked the cart daily, it just so happens that one roach was seen by the state surveyor. 4. Observation on 11/17/24 at 12:03 P.M. showed Dietary [NAME] (DC) A used his/her feet to stomp a roach that crawled on the wall next to the steam table that she served food from. Observation on 11/17/24 at 12:47 P.M., showed the presence of roaches in two boxes on a shelf, across from the dishwasher. During an interview on 11/17/24 at 12:49 P.M., the DM said the roaches started coming out into the kitchen in September, 2024 from the wall behind the spice storage table. During an interview on 11/17/24 at 12:51 P.M., the DM said the last he/she cleaned under the dishwasher area was about four months ago. 5. Observation on 11/18/24 at 10:49 A.M., with the Maintenance Director, showed roaches crawled on the floor and the wall of resident room [ROOM NUMBER]. Observation on 11/18/24 at 12:58 P.M., roaches were seen crawling on the floor on Resident #25's room. During an interview on 11/18/24 at 12:59 P.M. Resident #25, a resident who was identified as cognitively intact by the Minimum Data Set (MDS- a federally mandated assessment tool required to be completed by facility staff for care planning), dated 8/16/24, said he/she has seen roaches in his/her room in the past. 7. During an interview on 11/17/24 at 9:48 A.M., the Maintenance Director said they have the exterminator coming two times per month. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Observation on 11/18/24 at 1:47 P.M., showed an unwrapped jelly sandwhich in resident room [ROOM NUMBER] in a drawer. The resident was not in the room at the time to interview. Review of the extermination service inspection reports showed that Pest Extermination Company A, had been to the facility on the following dates over the last 6 months to treat for roaches: 4/30/24, 5/24/24, 7/25/24, 8/28/24, 9/27/24, and 10/29/24. During an interview on 11/20/24 at 10:11 A.M., the Maintenance Director said they are going to request that the extermination company comes to the facility at least twice per month so they can get better control of the pest situation in the kitchen. During an interview on 11/20/24 at 1:07 P.M.I the Health Inspector from the municipal Health Department said: -He/She was previously at the facility on 11/14/24. -He/She inspected the kitchens of long-term care facilities four times per year. -He/She saw a lot of roaches on 11/14/24. -He/She saw many roaches under the dishwasher. -At that time, he/she saw a lot of grime and debris under the dishwasher. -They're everywhere down in the kitchen. During an interview on 11/20/24 at 3:50 P.M., the Administrator said he/she has never seen so many pests in the kitchen, before this year (2024). During an interview on 11/21/24 at 12:59 P.M., the Director of Operations said he/she became aware of the pest problem about two weeks prior to the survey and at that time he/she notified Pest Extermination Company A to start going to the facility twice per month instead of once per month. Complaint # MO00244880.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on interview and record review, the facility failed to provide the required annual 12 hours of in-service training for Certified Nursing Assistants (CNA), and maintain records which indicate the subject of, and attendance at, all in-service sessions. The facility census was 89 residents. Review of the facility's CNA Continuing Education policy dated 5/25/23 showed: -All CNA's must complete a minimum of 12 hours of continuing education annually, in accordance with state and federal regulations. -Education may be provided through: --On-site training sessions. --Online learning platforms approved by the facility. --Workshops and seminars. -Supervisors will track compliance and maintain records in personnel files. -Failure to meet continuing education requirements may result in: --Written warnings. --Suspension of shifts until compliance is achieved. --Termination for repeated non-compliance. -The Director of Nursing (DON) will create an annual training schedule and ensure relevant topics are covered. -CNA's will be informed of mandatory training sessions via email, bulletin board postings, or staff meetings. -Supervisors will review training records quarterly to ensure compliance. -The Human Resource (HR) department will provide reminders of upcoming deadlines for continuing education requirements. 1. During an interview on 11/19/24 at 12:30 P.M., the Administrator said: -He/She was unable to locate any copies of in-services/education for the last year. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Was unsure of how many in-services/educations were held during the last year or what the topics would have been. During an interview on 11/20/24 at 8:50 A.M., CNA B said: -He/She had been working at the facility for over [AGE] years. -It had been a while since the facility had any in-services/education. -He/She had not had resident behavioral education for quite a while. -The facility does not offer any type of online computer education. During an interview on 11/20/24 at 8:59 A.M., CNA A said: -He/She had been here about a year. -It had been a while since he/she had any type of in-service or education here. -He/She had not had any education here on handling behavioral issues with residents. -He/She had resident behavioral education at another facility. -The facility does not offer any type of online computer education. During an interview on 11/20/24 at 9:07 A.M., Licensed Practical Nurse (LPN) B said: -He/She had been working here almost eight years. -He/She believes there was an in-service last month about abuse/behaviors on what to do if residents are acting up. -He/She was not working on that in-service day. -The facility had not had any in-services or education classes for staff in a very long time. During an interview on 11/21/24 at 1:59 P.M., the DON said: -He/She monitors staff competencies by randomly observing how staff perform resident cares and how staff interact with residents. -If there are concerns with a staff on any cares or interactions with residents then he/she re-educates that staff at that time. -He/She does not have a set schedule as to when he/she observes staff for competencies. -He/She observes staff when he/she is out on the floor or if he/she is made aware of a staff needing re-education. (continued on next page)

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

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She usually does eight to nine in-services a year. -He/She does not always document the in-services done. -The facility does not do any online computer education. During an interview on 11/22/24 at 11:20 A.M., the DON said: -In-services should be held monthly for all nursing staff. -CNAs should receive at least 12-hours of in-services a year. -He/She does do individual education when he/she sees there is a need but he/she does not document the education for that staff. -He/She does not always do a scheduled in-service, does talk to the CNA's often on how things should be done. -He/She did eight or nine in-services throughout the last year, but these were not documented.