STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A443	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Care Center	115 East 83rd Street Kansas City, MO 64114

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 21003 Based on interview and record review, the facility failed to follow facility policies and procedures for checking the Nurse Aide Registry for federal indicators of abuse as part of the Criminal Background Check (CBC) and in accordance with state requirements for two of four employees sampled for the criminal background screening. The facility census was 13 residents. Review of the facility's revised Abuse and Neglect policy and procedure dated 1/1/2024, showed: -All potential employees will be screened and trained to ensure that individuals with a documented history of abuse or other inappropriate conduct are not hired, and that all employees are properly trained regarding abuse of residents. -All employees will be screened prior to contact with facility residents, and quarterly, as follows: Federal Indicator List. 1. Review of two employee records showed: -Licensed Practical Nurse (LPN) B was hired on 2/5/24, and there was no Nurse Aide Registry Check completed. -Cook A was hired on 4/8/24, and there was no Nurse Aide Registry Check completed. During an interview on 6/12/24 at 12:16 P.M., the Human Resource Manager said: -He/She was not aware that the nurse aide registry was supposed to be completed on all employees. -He/She was going to complete an audit on all employee records to ensure the nurse aide registry is completed and in all employee files. -He/she was responsible for completing background checks.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on interview and record review, the facility failed to ensure the annual comprehensive Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) were completed timely for four sampled residents (Residents #59, #57, #1, #4) out of 8 sampled residents and one supplemental resident (Resident #160). The facility census was 13 residents. 1. Review of Resident #59's Face Sheet showed the resident was admitted on [DATE], with diagnoses including Post Traumatic Stress Disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), malnutrition, depression, high blood pressure, diabetes, low back pain and neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). Review of the resident's MDS assessments showed: -The resident's last annual assessment was dated 5/3/23. -The resident's annual assessment was due on 5/3/24. The electronic medical record showed this assessment was 26 days overdue. -There was a quarterly assessment dated [DATE] that showed in progress but was not completed (this assessment should have been the annual assessment). 2. Review of Resident #57's Face Sheet showed the resident was admitted with diagnoses including stroke, high blood pressure, glaucoma (a disease that damages your eye's optic nerve that can cause blindness), and history of transient ischemic attack (TIA- stroke-like attack that, despite resolving within minutes to hours, still requires immediate medical attention to distinguish from an actual stroke). Review of the resident's MDS assessments showed: -The resident's last annual assessment was completed 5/3/24. -The resident's annual assessment was due on 5/3/24 and was shown in the electronic medical record as being 26 days overdue. -There was a quarterly assessment started on 6/21/24 and was shown in the electronic record as in progress but was not completed (this assessment should have been the Annual assessment). 50579 3. Review of Resident #160's Face Sheet showed the resident admitted [DATE] with diagnoses including (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinary retention, anxiety, hemiplegia (paralysis of one side of the body following a stroke) of the right side, chronic pain, unspecified mood disorder, and a stage two pressure ulcer. Review of the resident's MDS assessments on 6/13/24 showed: -The resident's last annual assessment was completed 11/20/22 and was shown in the medical record as being 196 days overdue. -An annual assessment dated [DATE] was noted with a status of In Progress, but was incomplete and not submitted. 4. Review of Resident #4's Face Sheet showed the resident admitted [DATE] with diagnoses including cancer, depression, PTSD, and a personal history of other unspecified behavioral disorders. Review of the resident's MDS assessments on 6/13/24 showed: -The resident's last comprehensive assessment was the admission assessment, completed 4/13/23. -A comprehensive assessment was due 4/13/24, had not been completed, and was 46 days overdue. 5. Review of Resident #1's Face Sheet showed the resident admitted [DATE] with diagnoses including anxiety and depression. Review of the resident's MDS assessments on 6/13/24 showed: -The resident's last comprehensive assessment was a significant change assessment, completed 3/15/23. -A comprehensive assessment was due 3/15/24, had not been completed, and was 75 days overdue. 6. During an interview on 6/13/24 at 10:54 A.M., Licensed Practical Nurse (LPN) A said he/she does not complete the MDSs normally but as residents' care needs change, the nurse will let the MDS Coordinator know and the MDS Coordinator will update the residents' MDS assessments and care plans. During an interview on 6/13/24 at 11:12 A.M., the Director of Nursing (DON) said: -He/She expects for MDS to be completed and submitted timely. -Annual assessments should be completed according to the resident's MDS schedule yearly. -He/She was aware there were problems with the MDS submissions. -The former MDS Coordinator was not full time and the timeframe between when he/she left the position and when they found a new MDS Coordinator was when the submissions fell behind. -The current MDS Coordinator is in training and has not been able to get everything caught up yet but they are in the process of doing so.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 50579 Based on interview and record review, the facility failed to ensure the completion of a necessary significant change Minimum Data Set (MDS, a federally mandated comprehensive assessment) for one resident with a hospice admission (Resident #161) out of 8 sampled residents. The facility census was 13. Review of a facility policy titled Minimum Data Set Assessments, dated 6/13/24, lacked information regarding triggering an MDS assessment and timing of assessments. Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual (a federally published guide for facility staff to complete and submit MDS assessments accurately and timely) instructed facilities to set a Significant Change Assessment Reference Date (ARD, the date of assessment initiation) no later than 14 days following the determination that a significant change had occurred. The RAI includes a hospice admission as a significant change and guides facilities to complete a Significant Change MDS assessment. 1. Review of Resident #161's Progress Note dated 4/10/24 at 1:13 P.M., showed the resident was admitted to Hospice A on 4/10/24. Review of the resident's Physician Order Sheet (POS) on 6/13/24 showed an order for admission to hospice placed on 5/1/24 to begin on 4/22/24. Note: the physician's orders did not get entered timely into the resident's medical record. Review of the resident's MDS assessments showed: -His/Her last assessment to be completed was a Quarterly Assessment, dated 12/11/23. -A Significant Change Assessment with the status of In Progress and an ARD of 5/24/24, 44 days from the hospice admission. During an interview on 6/12/24 at 11:48 A.M., Licensed Practical Nurse (LPN) A said: -He/she was recently hired by the facility in April and was responsible for completing MDS assessments. -He/she opened the Significant Change Assessment, but it was too late. -The Significant Change MDS Assessment should have been completed by now, but it has not. During an interview on 6/12/24 at 12:34 P.M., the Director of Nursing (DON) said: -LPN A was responsible for completing MDS assessments. -The Significant Change Assessment was the responsibility of the previous Assistant Director of Nursing (ADON), but he/she no longer worked at the facility. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff thought it was too late to complete the Significant Change Assessment, so it was not done. -MDS has been an ongoing problem for the facility. -The past ADON did not complete MDS assessments timely. -He/She expected MDS assessments to be completed within an acceptable timeframe per the RAI Manual.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on record review and interview, the facility failed to ensure Minimum Data Sets (MDS, a federally mandated assessment tool to be completed by facility staff for care planning) were completed quarterly for 8 residents (Residents #3, #5, #59, #57, #4, #1, #2, and #161) out of 8 sampled residents. The facility census was 13 residents. 1. Review of Resident #3's Face Sheet showed the resident was admitted on [DATE], with diagnoses including urinary tract infection, diabetes, vitamin deficiency, glaucoma (a disease that damages your eye's optic nerve that can cause blindness), high blood pressure, heart disease, paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), pain and edema (fluid in the tissues). Review of the resident's MDS assessments showed: -The resident's last Annual assessment was completed on 6/25/2023. -The resident's Quarterly assessment was due on 3/27/24. It was not completed and showed in the electronic medical record as being 63 days overdue. 2. Review of Resident #5's Face Sheet showed the resident was admitted on [DATE], with diagnoses including a below the knee amputation. Review of the resident's MDS assessments showed: -The resident's Admission assessment was completed on 11/29/23. -The resident's Quarterly assessment was due on 5/31/24. It was not completed and showed in the electronic medical record as being 2 days overdue. The electronic record showed the assessment was in process on 5/29/24. 3. Review of Resident #59's Face Sheet showed the resident was admitted on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), malnutrition, depression, high blood pressure, diabetes, low back pain and neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). Review of the resident's MDS assessments showed: -The resident's last annual assessment was dated 5/3/23. -The resident's quarterly assessment was due on 2/3/24. It was not completed and showed in the electronic medical record as being in process. This assessment was also shown as being 116 days overdue. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #57's Face Sheet showed the resident was admitted with diagnoses including stroke, high blood pressure, glaucoma, and history of transient ischemic attack (TIA-stroke-like attack that, despite resolving within minutes to hours, still requires immediate medical attention to distinguish from an actual stroke). Review of the resident's MDS assessments showed: -The resident's last Annual assessment was completed 5/3/24. -The resident's Quarterly assessment was due on 2/3/24. It was not completed and showed in the electronic medical record as being 116 days overdue. 50579 5. Review of Resident #4's Face Sheet showed the resident admitted [DATE] with diagnoses including cancer, depression, PTSD, and a personal history of other unspecified behavioral disorders. Review of the resident's MDS assessments on 6/13/24 showed: -The resident's last quarterly assessment was completed 1/14/24. -A quarterly assessment was due 4/15/24, had not been completed, and was 44 days overdue. 6. Review of Resident #1's Face Sheet showed the resident admitted [DATE] with diagnoses including anxiety and depression. Review of the resident's MDS assessments on 6/13/24 showed: -The resident's last quarterly assessment was completed 12/16/23. -A quarterly assessment was due 3/17/24, had not been completed, and was 73 days overdue. 7. Review of Resident #2's Face Sheet showed the resident admitted [DATE] with diagnoses including high blood pressure and hemiplegia (partial or complete paralysis on one side of the body) on the right side. Review of the resident's MDS assessments on 6/13/24 showed: -The resident's last quarterly assessment was completed 12/19/23. -A quarterly assessment was due 3/20/24, had not been completed, and was 70 days overdue. 8. Review of Resident #161's Face Sheet showed the resident admitted [DATE] with diagnoses including seizures, dementia, hemiplegia, and insomnia. Review of the resident's MDS assessments on 6/13/24 showed: -The resident's last quarterly assessment was completed 12/11/23. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A quarterly assessment was due 3/12/24, had not been completed, and was 78 days overdue. 9. During an interview on 6/13/24 at 10:54 A.M., Licensed Practical Nurse (LPN) A said: -He/She said she does not complete the MDS but normally as residents' care needs change, the nurse will let the MDS Coordinator know and the MDS Coordinator will update the resident's MDS and care plan. During an interview on 6/13/24 at 11:12 A.M., the Director of Nursing (DON) said: -He/She expects for MDS to be completed and submitted timely. -Quarterly MDS should be completed every three months as scheduled. -He/She was aware there were problems with the MDS submissions. -The former MDS Coordinator was not full time and the timeframe between when he/she left the position and when they found a new MDS Coordinator was when the submissions fell behind. -The current MDS Coordinator is in training and has not been able to get everything caught up yet but they are in process of doing so.

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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** 21003 Based on observation, interview and record review, the facility failed to ensure the care plans were updated as residents' care and needs changed for two sampled residents (Residents #59 and #161) out of 8 sampled residents. The facility census was 13 residents. 1. Review of Resident #59's Face Sheet showed the resident was admitted on [DATE], with diagnoses including Post Traumatic Stress Disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), malnutrition, depression, high blood pressure, diabetes, low back pain and neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool to be completed by facility staff for care planning, dated 11/3/23, showed the resident: -Was alert and oriented with no confusion or behaviors. -Had no upper or lower extremity impairments and ambulated independently. -The resident had no significant weight loss or weight gain and did not have any chewing or swallowing problems. -The resident did not have another MDS completed or submitted since 11/3/23. Review of the resident's Nutrition Notes, dated 2/8/24, showed: -The resident's weight on 2/3/24 showed 160.5 pounds (Lbs.) down 8.7 percent in one month, down 16.3 percent in three months, and down 17.5 percent in six months. -The resident received a regular diet with chopped meat. -The resident's meal intake is usually between 75-100 percent. -The staff reports the resident eats well, was trying to lose weight, and eats less between meals. -The resident's skin was intact. -Notes showed the resident was happy with weight loss. His/Her intake met his/her nutritional needs. Continue plan of care and monitoring. Review of the resident's Care Plan dated 2/29/24, showed the resident had poor oral health which led to oral/dental health problems. The resident was able to perform oral care independently. The resident received a regular diet and did receive dental services from the facility dentist and has upper and lower dentures. Interventions showed staff would: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Serve the resident's diet as ordered and chop meats upon request. -Consult with the facility dentist as needed for oral management. -Consult with the Dietician if chewing and swallowing problems change. -Monitor the resident, report and document any signs/symptoms of oral/dental problems that need attention. -Assist the resident as needed with nutritional choices to achieve his/her weight loss goal. -Educate the resident regarding nutritional needs and requirements. -Encourage the resident to consume adequate protein to maintain stable blood sugars. -Encourage the resident to consume nutritious foods. Review of the resident's Weight Record showed the resident was on weekly weights for monitoring. The resident's monthly weights showed: -1/27/2024 =162.4 pounds (Lbs.) -2/24/2024 =164.8 Lbs -3/30/2024 =156.6 Lbs -4/27/2024 =151.8 Lbs -5/25/2024 =150.8 Lbs -6/8/2024 =145.8 Lbs -The documentation showed the resident's weight loss of 10.49 percent in 6 months, 6.45 percent in 3 months, and 2.68 percent in one month was not significant weight loss but his/her weight loss was gradual. Review of the resident's Physician's Order Sheet (POS), dated 6/2024, showed physician's orders for: -Regular modified diabetic diet with chopped meats (8/22/23). -Weekly weights on Saturday, notify the physician for weight gain or loss of more than 5 pounds (1/6/24). -Cholecalciferol Tablet 1000 UNIT Give 2 tablet by mouth one time a day related to protein calorie malnutrition (3/21/24). -Glucerna shake at breakfast (4/16/24). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Trulicity pen injection 0.75 milligrams (mg) inject 1.5 mg subcutaneously (beneath the skin) once daily for diabetes (5/30/24). Review of the resident's electronic record showed no additional notes showing the resident had any problems with weight loss or justification for weight loss interventions after 2/29/24. Documentation showed there was no problems with the resident's gums, however the documentation showed that the facility dentist made adjustments to the resident's dentures. There was no documentation showing this affected the resident's intake. Review of the resident's Care Plan dated 6/12/23, showed there was no update to the resident's nutritional status to show the resident had weight loss that was being monitored, had a weight loss goal, was placed on a health shake, was taking medication that directly affected his/her weight loss or if the resident had reached weight loss goals or what the current status nutritional status of the resident was. Observation and interview on 6/12/24 at 9:19 A.M., showed the resident was in his/her bed resting but was awake. The resident was not wearing dentures. The resident was alert and oriented and said: -The facility dentist came and got his/her dentures to readjust them because they didn't fit anymore due to him/her losing weight. -He/She currently had his/her dentures, but it has taken him/her time to get used to wearing them. -It really had not affected him/her being able to eat. -He/She was trying to lose weight, but he/she was also on Trulicity, which induced weight loss. -During the time he/she was without his/her dentures he/she wasn't eating as much, but he/she did not mind the weight loss. Once he/she got the new dentures, he/she continued to lose weight, but he/she thought his/her continued weight loss was due to the Trulicity. Observation on 6/12/24 at 12:01 P.M., showed the resident sitting in the dining room eating a regular diet of pork loin, sweet potato, cabbage with choice of beverage. He/She was not wearing his/her dentures and was eating independently without an assistive device or staff assistance. The resident was eating without choking, coughing or swallowing difficulty. He/She ate 75 percent of his/her meal and once he/she was done, he/she got up and ambulated out of the dining room. During an interview on 6/12/24 at 2:50 P.M., Licensed Practical Nurse (LPN) A said: -The resident had weight loss that was self-initiated by the resident. -The resident wanted to lose some weight and stopped eating as much. -The resident was also started on Trulicity for diabetes, which also has a side effect of weight loss and so some of her weight loss also came from the medication. -The resident had not had any issues eating and ate independently. (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 usually ate without his/her dentures but does have and wear dentures. -He/She was not sure if the resident's continued weight loss was self induced. -She said the information regarding the resident's weight loss and interventions should be in the resident's care plan. 50579 2. Review of Resident #161's hospice facility admission orders, dated 4/10/24 and signed by a hospice Registered Nurse (RN), showed: -The resident was admitted to hospice services on 4/10/24. -An order for oxygen at 2 liters per minute as needed (PRN). -An order for Morphine (a narcotic pain medication) 5 milligrams (mg) every one hour as needed for pain or dyspnea (difficulty breathing). -An order for Lorazepam (a controlled medication used for anxiety) 0.5 mg every four hours as needed for anxiety. Review of the resident's POS on 6/13/24, showed orders for admission to hospice services and PRN oxygen. Review of the resident's undated Care Plan on 6/13/24 showed: -No information or direction for staff on the PRN oxygen order. -No information regarding indication, side effect monitoring or direction for staff on the Morphine or Lorazepam orders. -No indication the resident was admitted to hospice services, the date of service initiation, medication information, or what services the hospice agency would provide to the resident. 3. During an interview on 6/13/24 at 10:54 A.M., LPN C said: -The nurse usually will let the MDS Coordinator know when residents' care needs have changed, and the MDS Coordinator will update the resident's care plan. -The nurses will implement what the change in care is and write and implement new physician's orders (if there is a change in orders), but the nurses do not document any updates to the care plans. During an interview on 6/13/24 at 11:12 A.M., the Director of Nursing (DON) said: -Regarding the resident care plans, both the former and current MDS Coordinator did not keep up with updating care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The care plans were already past due because the MDS's were past due. -The MDS Coordinator is not the only person who can update the care plan, but this is how it was done before now. -He/She has been assisting with updating the care plans as residents' care changes. -The nurses can update the care plans as the residents' care changes. -The quarterly updates to the care plans will be done with the MDS.

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	26A443	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Care Center	115 East 83rd Street Kansas City, MO 64114

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50579 Based on interview and record review, the facility failed to transcribe medication orders accurately and periodically reconcile physician orders when an antipsychotic medication was added to a resident's medical record without an order for one resident (Resident #161) of 5 residents sampled for unnecessary medications. The facility census was 13. A policy for order transcription and medication reconciliation was requested on 6/13/24 but was not received prior to exit. 1. Review of #161's face sheet showed diagnoses including seizures, dementia without behavioral disturbances, adjustment disorder (excessive reactions to stress that involve negative thoughts, strong emotions, and changes in behavior), stroke, and insomnia (difficulty sleeping). Review of the resident's hospice facility admission orders, dated 4/10/24 and signed by a hospice Registered Nurse (RN), showed: -The resident was admitted to hospice services on 4/10/24. -A section of the orders titled Comfort Kit orders had standing orders and instructions to circle NO for all declined orders and draw a line through the order. -An order circled NO for Haloperidol (an antipsychotic drug used to treat certain types of severe mental disorders that can cause major, lasting side effects) 2 milligrams per milliliter (mg/ml), 1mg by mouth or sublingually (under the tongue) every four hours as needed for delirium, agitation, nausea and/or vomiting. -The order for Haldol had a line through the text and an X to the left of the order. Review of the residents Physician Order Sheet (POS) on 6/13/24, showed an order for Haloperidol 1mg sublingually, every four hours as needed for delirium, agitation, nausea and/or vomiting beginning on 4/10/24 with no end date. Review of the residents Medication Administration Record (MAR) since 4/10/24 showed the resident had not received any Haloperidol. During an interview on 6/12/24 at 12:05 P.M., Licensed Practical Nurse (LPN) A said he/she had not input any hospice admission orders yet but would think that a medication that was circled no with a line through the text would be a non-valid order and should not have been input into the resident's record. During an interview on 6/12/24 at 12:34 P.M., the Director of Nursing (DON) said: -The nurse would be responsible for transcribing hospice orders from the sheet and inputting them into the resident record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse on duty on 4/10/24 put the hospice orders in the computer and the DON verified the orders. -Medication orders should be reconciled once per month to ensure accuracy. -He/she had not reconciled medications in the previous two months. -The Haloperidol order should not have been input into the resident's medical record and should have at least been discontinued after 14 days per standard of practice for antipsychotic drugs.

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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** 21003 Based on observation, interview and record review the facility failed to ensure initial and quarterly smoking assessments were completed to establish a resident's capacity for smoking and establish a baseline for the resident's ability to smoke, determine assistance as necessary, and ensure safe smoking habits were in place and continuing for two sampled residents (Residents #3 and #59) out of 9 residents who smoked in the facility. The resident sample was 8 residents. The facility census was 13 residents. Review of the facility Smoking policy and procedure, dated 9/25/23, showed the purpose was to establish a healthy environment for residents, visitors and employees. Additionally, the facility must comply with federal, state and local regulations regarding smoking in healthcare facilities. The policy showed: -Residents may smoke outside of the building in designated areas and away from the facility's exterior doors. -Employees are responsible for reminding residents, visitors and other employees of the smoking policy if they see someone violating the smoking policy. -Residents, family members and visitors will be notified -Smoking assessments will be completed upon admission, quarterly and with significant change of condition in conjunction with the Minimum Data Set (MDS), a federally mandated assessment tool to be completed by facility staff for care planning. -Generally, all residents will be supervised smoking upon admission and up to 72 hours after admission. -Residents who have been assessed as having the cognitive and functional ability to smoke independently may smoke in the designated areas independently as desired. These residents may keep their cigarettes and smoking materials. 1. Review of Resident #3's Face Sheet showed the resident was admitted on [DATE], with diagnoses including glaucoma (a disease that damages your eye's optic nerve that can cause blindness), high blood pressure, heart disease, paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), pain and edema (fluid in the tissues). 1. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool to be completed by facility staff for care planning, dated 1/26/23, showed the resident: -Was alert and oriented without confusion or behaviors. -Had bilateral lower extremity impairment and mobilized in a wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Needed moderate to total assistance with transfers, bathing, dressing (lower body), and toileting. -The MDS did not show the resident used tobacco products. Review of the resident's Care Plan dated 5/2/24, showed: -The resident smoked cigarettes. -Interventions instructed staff to: --Instruct the resident about smoking risks and hazards and smoking cessation aids available. --Instruct the resident on the facility smoking policy. --Notify the charge nurse immediately if the resident violates the facility smoking policy. --Observe the resident for signs of cigarette burns on his/her skin and body. -Resident was educated on not throwing cigarette butts into the grass and not to smoke under the awning. --The resident was able to light his/her own cigarette and keep his/her own lighter. --The resident was able to smoke unsupervised. Review of the resident's electronic medical record showed there was no documentation showing the facility staff completed an initial smoking assessment, annual smoking assessment or any quarterly assessments thereafter on the resident. There was no documentation showing the resident's continued ability to safely smoke and abide by the facility smoking policy. Observation on 6/12/24 at 9:28 A.M., showed the resident was sitting in his/her wheelchair outside smoking. He/She was positioned upright without any noticed contracture or loss of upper body control. The resident was in the designated smoking area with other peers smoking safely. There was staff outside with the residents. 2. Review of Resident #59's Face Sheet showed the resident was admitted on [DATE], with diagnoses including high blood pressure, diabetes, low back pain and neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). Review of the resident's most recent quarterly MDS dated [DATE], showed the resident: -Was alert and oriented with no confusion or behaviors. -Had no upper or lower extremity impairments and ambulated independently. -Was independent with bathing, dressing, toileting, transferring and eating. -The MDS did not show the resident used tobacco products. (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 3/2/23 showed: -The resident smoked cigarettes. -Interventions instructed staff to: --Instruct the resident about smoking risks and hazards and smoking cessation aids available. --Instruct the resident on the facility smoking policy. --Notify the charge nurse immediately if the resident violates the facility smoking policy. --Observe the resident for signs of cigarette burns on his/her skin and body. -The resident was educated on not throwing cigarette butts into the grass and not to smoke under the awning. --The resident was able to light his/her own cigarette and keep his/her own lighter. --The resident was able to smoke unsupervised. Review of the resident's electronic medical record showed there was no documentation showing the facility staff had completed an initial smoking assessment, annual smoking assessment or quarterly smoking assessments on the resident. There was no documentation showing the resident's continued ability to safely smoke and abide by the facility smoking policy. Observation on 6/11/24 at 2:00 P.M., showed the resident was sitting outside dressed for the weather smoking in the designated smoking area. He/She was smoking safely without assistance. When he/she was finished, he/she disposed of the smoking materials in the self-enclosed receptacle. 3. During an interview on 6/13/24 at 10:54 A.M., Licensed Practical Nurse (LPN) C said: -The nurses complete the initial smoking assessments, and they are in the resident's electronic medical record. -She said all smoking assessments are done in the facility electronic record system, not on paper. -The nurses should be completing quarterly smoking assessments, but he/she really had not seen any smoking assessments on residents that smoke. During an interview on 6/12/24 at 11:42 A.M., the Director of Nursing (DON) said: -He/She was not able to find the smoking assessments for the residents requested. -He/She did not realize that the smoking assessments had not been populating in the facility's electronic record system. -He/She was unable to find the handwritten smoking assessments except for one. (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 completed the requested smoking assessments today and was auditing all of the files for the residents who smoke to ensure there are smoking assessments in their records. During an interview on 6/13/24 at 11:12 A.M., the DON said: -There were 9 residents who smoked in the facility and he/she was able to find smoking assessments on 5 residents. -He/She completed smoking assessments, in the electronic medical record, on everyone who smoked. -The residents should have an initial/annual smoking assessment and staff are supposed to complete quarterly assessments thereafter. -He/She did not find any quarterly assessments in the electronic records for the residents that smoked. -He/She discussed this in their team meeting and realized that the assessments were not being done appropriately and they are now going to ensure the assessments are going to be done with the quarterly MDS.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50579 Based on observation, interview and record review, the facility failed to ensure staff administered medications with a rate less than 5%. Facility staff made eight medication errors out of 29 attempts, resulting in a medication error rate of 27.59%. This affected three of seven sampled residents (Residents #2, #4, and #160) for medication pass. The facility census was 13. A facility policy titled Medication Administration-General Guidelines, dated 9/1/2006, showed: -Medications were to be administered per physician orders. -Medications were to be administered within 60 minutes of the ordered time. -The individual who administered the medication was to document the administration directly after the medication was given. 1. Resident #160's Physician Order Sheet (POS), obtained 6/13/24, showed: -An order for Carbidopa-Levodopa (a medication given for tremors) 25 milligrams (mg) Carbidopa/100 mg Levodopa, four times daily (9:00 A.M., 12:00 P.M., 5:00 P.M., and 9:00 P.M.) -An order for Lorazepam (a controlled medication given for anxiety) 0.5 mg, three times daily (between 7:00 A.M.-10:00 A.M., between 11:00 A.M.-1:00 P.M., and between 7:00 P.M.-9:00 P.M.) During an interview on 6/13/24 at 7:20 A.M., Certified Medication Technician (CMT) A said: -The night nurse would often pass some day shift medications but would not document the medications as given. -He/She would have to look through the medication cart to see who had received medications and who had not. -The only way to tell if the medications had been given was to look at the timed/dated pill packs that some of the medications came from the pharmacy in to see if they were missing. -If the medication pack was missing, he/she would assume all the resident's morning medications had been given, even if they were not documented as given by the night shift nurse. During an observation of the medication pass on 6/13/24 at 7:30 A.M.: -CMT A reviewed Resident #160's Medication Administration Record (MAR). -The MAR indicated the only medication due for the resident was Carbidopa-Levodopa. -CMT A said the night nurse gave many of the morning meds, and he/she was unsure which had been given. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-After review of the resident MAR, CMT A removed a Lorazepam 0.5 mg tablet from the locked narcotic box and signed the tablet out of the narcotic book. -CMT A administered the 0.5 mg Lorazepam tablet to the resident. -CMT A documented in the MAR that he/she gave Carbidopa-Levodopa, but did not document that he/she gave Lorazepam. Surveyor reconciliation of the medication administration on 6/13/24 at 8:14 A.M., showed Carbidopa-Levodopa had been signed out at 7:00 A.M. by Licensed Practical Nurse (LPN) B and again at 7:30 A.M. by CMT A. Further reconciliation revealed LPN B had documented the Lorazepam being given at 6:14 A.M. During an interview on 6/13/24 at 8:24 A.M., CMT A said he/she had given the resident only Lorazepam at the 7:30 A.M. administration. During review of the MAR and an interview on 6/13/24 at 8:28 A.M., CMT A then said he/she administered both Lorazepam and Carbidopa-Levodopa to the resident and he/she did not know why the MAR documentation did not show he/she gave the Lorazepam. CMT A verified the MAR showed Lorazepam was administered at 6:14 A.M., but that he/she gave the resident a second dose at 7:30 A.M. Review of the resident's medication administration record (MAR) on 6/13/24, showed: -One documented administration of Lorazepam at 6:14 A.M. by LPN B. -A documented administration of Carbidopa-Levodopa at 7:32 A.M. by CMT A. -The CMT documented in error that he/she gave the Carbidopa-Levodopa, when he/she gave the resident a second dose of Lorazepam instead. During an interview on 6/13/24 at 8:30 A.M., the Director of nursing (DON) said: -He/she would not expect the Carbidopa-Levodopa to be documented if not given. -The Lorazepam appeared to be given to the resident twice within a one-hour timeframe. 2. Review of Resident #4's POS on 6/13/24 showed physician orders for: -Metoprolol (a drug given for high blood pressure and an elevated heart rate) 50mg tab to be given at 9:00 A. M. -Gabapentin (a drug given for nerve pain) 100 mg to be given at 9:00 A.M. -Cyclobenzaprine (a drug given for muscle spasms) 10mg to be given at 9:00 A.M. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/24 7:34 A.M., CMT A said Resident #4 had already had his/her medications administered because some had been documented on by night shift and the pill pack containing all of the medications was missing, so he/she would not be giving the resident any medications that morning. Review of the resident's MAR on 6/13/24 at 7:35 A.M., at that time, indicated Gabapentin, Metoprolol and Cyclobenzaprine had not been administered and were due at 9:00 A.M. During an interview on 6/13/24 at 7:36 A.M., CMT A stated again he/she would not be administering those medications, as they had already been given by the night shift and were not in the medication cart. Review of the MAR provided by the facility on 6/13/24 at 11:00 A.M., showed the doses of Gabapentin, Metoprolol, and Cyclobenzaprine had not been administered. 3. Review of Resident #2's POS showed physician orders for: -Acetaminophen (an over-the-counter pain medication) 500 mg, two tablets, at 8:00 A.M. -Metoprolol 50mg to be given at 9:00 A.M. -Tramadol (a narcotic pain medication) to be given at 9:00 A.M. -Linzess (a drug for maintaining healthy bowel movements) to be given at 9:00 A.M. During an observation on 6/13/24 at 8:01 A.M.: -CMT A took two Acetaminophen 500 mg tablets from the medication cart and attempted to administer them to the resident. -The resident declined and said he/she had already received all their medications that morning, including the Acetaminophen. -No medications were administered. -CMT A returned to the medication cart and documented Acetaminophen, Metoprolol, Tramadol and Linzess as administered at 8:08 A.M. Review of the resident's MAR provided by the facility on 6/13/24, showed the medications had been documented as administered at 8:08 A.M. 4. During an interview on 6/13/24 at 8:30 A.M., the Director of nursing (DON) said: -Night shift may pick and choose some medications to administer for the day shift. -He/She expected medications to be given no earlier than one hour before or no later than one hour after the time on the MAR. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She expected any medications given by the night shift to be documented by the staff administering the medication. -He/She would not expect the day shift to have to guess who had received medications. -He/she expected staff to only document administration of medications they had administered themselves. -He/she expected the medications to be documented as they were given, not hours later.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50579 Based on observation, interview and record review, the facility failed to ensure medications were administered without significant errors when staff administered Lorazepam (a controlled medication given for anxiety) two times within one and one-half hours. This affected one resident (Resident #160) out of seven sampled residents for medication pass. The facility census was 13. A facility policy titled Medication Administration-General Guidelines, dated 9/1/2006, showed: -Medications were to be administered per physician orders. -Medications were to be administered within 60 minutes of the ordered time. -The individual who administered the medication was to document the administration directly after the medication was given. 1. Review of Resident #160's Physician Order Sheet (POS), obtained 6/13/24, showed: -An order for Carbidopa-Levodopa (a medication given for tremors) 25 milligrams (mg) Carbidopa/100 mg Levodopa, four times daily (9:00 A.M., 12:00 P.M., 5:00 P.M., and 9:00 P.M.) -An order for Lorazepam (a controlled medication given for anxiety) 0.5 mg, three times daily (between 7:00 A.M.-10:00 A.M., between 11:00 A.M.-1:00 P.M., and between 7:00 P.M.-9:00 P.M.) During an interview on 6/13/24 at 7:20 A.M., Certified Medication Technician (CMT) A said: -The night nurse would often pass some day shift medications but would not document the medications as given. -He/She would have to look through the medication cart to see who had received medications and who had not. -The only way to tell if the medications had been given was to look at the timed/dated pill packs that some of the medications came from the pharmacy in to see if they were missing. -If the medication pack was missing, he/she would assume all the resident's morning medications had been given, even if they were not documented as given by the night shift nurse. During an observation of the medication pass on 6/13/24 at 7:30 A.M.: - Certified Medication Technician (CMT) A reviewed Resident #160's Medication Administration Record (MAR). -The MAR indicated the only medication due for the resident was Carbidopa-Levodopa. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CMT A said the night nurse gave many of the morning meds, and he/she was unsure which had been given. -After review of the resident's MAR, CMT A removed a Lorazepam 0.5 mg tablet from the locked narcotic box and signed the tablet out of the narcotic book. -CMT A administered the 0.5 mg Lorazepam tablet to the resident. -CMT A documented that Carbidopa-Levodopa was given in the MAR, but did not document Lorazepam in the MAR. Surveyor reconciliation of the medication administration on 6/13/24 at 8:14 A.M., showed Carbidopa-Levodopa had been signed out at 7:00 A.M. by Licensed Practical Nurse (LPN) B and again at 7:30 A.M. by CMT A. Further reconciliation revealed LPN B had documented the Lorazepam being given at 6:14 A.M. During an interview on 6/13/24 at 8:24 A.M., CMT A said he/she had given the resident only Lorazepam at the 7:30 A.M. administration. During an interview on 6/13/24 at 8:28 A.M., during review of the MAR, CMT A said he/she administered both Lorazepam and Carbidopa-Levodopa to the resident and he/she did not know why the MAR documentation had not shown the Lorazepam. CMT A verified the MAR showed Lorazepam was administered at 6:14 A.M., but that he/she gave it at 7:30 A.M. Review of the resident's MAR on 6/13/24, showed: -One documented administration of Lorazepam at 6:14 A.M. by LPN B. -A documented administration of Carbidopa-Levodopa at 7:32 A.M. by CMT A. During an interview on 6/13/24 at 8:30 A.M., the Director of nursing (DON) said: -Night shift may pick and choose some medications to administer for the day shift. -He/She expected any medications given by the night shift to be documented by the staff administering the medication. -He/She would not expect the day shift to have to guess who had received medications. -He/she expected staff to only document administration of medications they had administered themselves. -The Lorazepam appeared to be given to the resident twice within a one-hour timeframe.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38452 Based on observation and interview, the facility failed to retain operable thermometers in all refrigerators and/or freezers to confirm adequate temperature ranges; failed to maintain plastic cutting boards in good condition to avoid food safety hazards (cross-contamination); and failed to separate damaged foodstuffs, in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 13 residents with a licensed capacity for 16 residents at the time of the survey. 1. Observations on 6/11/24 at 10:53 A.M., during the facility basement inspection, showed there was no thermometer in the freezer in the Food Storage room. Observations on 6/11/24 at 11:16 A.M., showed there was a 7 pound (lb.) 3 ounce (oz.) can of baked beans that was dented on one side and stored on a shelf with other various undented cans. Observations on 6/12/24 at 9:18 A.M., during the follow-up kitchen inspection showed a yellow cutting board on the food preparation table next to the 3-tub sink was heavily scored to the point that plastic bits were flaking off. During an interview on 6/12/24 at 1:31 P.M., the Dietary Manager (DM) said: -After separating damaged foodstuffs from the regular, they send them back to the food vendor for a refund. -He/She would expect food to be free of foreign substances. -Damaged food preparation items are thrown away when found, especially cutting boards. -All refrigerators and freezers should have thermometers in them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A443	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Care Center	115 East 83rd Street Kansas City, MO 64114

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive infection prevention and control program designed to help prevent the development and transmission of Legionella (a [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease), and failed to provide documented assessments for such an outbreak with accepted response protocols, in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. The facility census was 13 residents with a licensed capacity for 16 residents at the time of the survey. 1. Observations on 6/11/24 at 11:17 A.M., during the initial kitchen Life Safety Code (LSC) inspection with the Dietary Manager (DM) present, showed a three-sink area, a chemical and high heat dish-washing machine, and a hand-washing sink. Observations on 6/12/24 between 9:33 A.M. and 3:57 P.M., during the initial facility LSC room-to-room inspections with the Maintenance Manager (MM), showed the following: -There was a facility-wide fire sprinkler system. -On the lower level there was a laundry room with clothes washers, two restrooms, and the Maintenance Office where the sprinkler risers (Fire sprinkler risers are, in a sense, where the plumbing outside a building ends and a fire sprinkler system begins. Each riser taps into a permanent source of water, such as a pipe connected to the city water system, a water tank, or reservoir.) were located. -On the main level there were at least 12 resident rooms with sinks and bathrooms, two bathhouses, a Main Dining Room with an ice machine, and a janitor's closet with a mop hopper sink. Review of the facility's water-borne pathogen prevention program in a binder entitled, Water Management Program, last reviewed on 7/14/23 and provided by the MM, showed the following: -There was no facility-specific risk management plan assessment that considered all elements of the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188. -There was no completed Centers for Disease Control (CDC) toolkit including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens. -There was no facility-specific infection prevention and control program or plan to deal with outbreaks of Legionella and/or other waterborne pathogens. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A443	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Care Center	115 East 83rd Street Kansas City, MO 64114

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There was a diagram on page 6 showing possible stagnation locations throughout the facility, but no assessments of each location's individual potential risk level. -At Appendix B2: Example Log Sheets and Checklists, there were 12 blank pages of various charts, checklists, and spreadsheets to be used by the facility including, but not limited to a Program Strategy, Potable Water Services Monitoring, At-Risk Water System Monitoring, Bacterial Indicator Test, and a Program Action Log, but none were completed or used as templates. -There was no documentation of any site log book being maintained with any cleanings, sanitizings, descalings, and inspections mentioned. -The 4-page report from the water lab company, dated 6/1/23, showed no test methods listed under that same heading on pages 2 through 4. During an interview on 6/12/24 at 2:47 P.M., the MM said the following: -The blank sheets in the binder are not used. -The company that created the program was sending someone out to periodically test the water for Legionella, but they said the facility was at low risk so testing was really only needed once a year. -He/She did occasional flushings, but they were not documented anywhere. During an interview on 6/13/24 at 12:16 P.M., the Administrator said the following: -Their water-borne pathogen program was based on the regulations and created by the MM and the previous Administrator. -He/She would expect that whoever created the Legionella program would know all the requirements.