| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26E084 | A. Building<br>B. Wing | 10/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Myers Nursing & Convalescent Center | 2315 Walrond Avenue<br>Kansas City, MO 64127 |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to maintain the cleanliness in the kitchen there was dust build up on the overhead piping systems and exit sign that were over the preparation serving area, dust built up on the two big blue and black fans, the floor and wall behind the gray grease trap box under the three compartment sink had dirt and debris, the stove knobs that turn the burners on had residue built up on them, and the walk-in cooler had dust on the fan and there was debris on the floors. The floors under the refrigerators, eye was station, and stove had missing tiles and needed to be repaired. The ice machine tray that collects the overflow of ice and water had brownish/reddish debris all over it potentially mold and where the ice and water come out there was black spots on the inside and out of it potentially mold and there were some black spots in the white plastic reservoir at the top of the machine. This practice potentially affected all 78 residents. The facility census was 78 residents.Observations and interview during the initial walk-through 10/7/25 9:55 A.M., showed:-Food debris and debris on the floor of the walk-in cooler under the shelves. -Dust on the fans of the walk-in cooler. -The Dietary Supervisor said the walk-in cooler was cleaned every Tuesday before the truck comes in on Wednesday. Observations and interview during the lunch meal preparation on 10/8/25 from 10:00 A.M. through 1:00 P.M., showed:-Dust on the pipes and exit sign above preparation serving area.-Dust on the two blue and black fans.-Dirt and debris on the floor and wall behind the gray grease trap box under the three-compartment sink.-The stove knobs that turn the burners on had residue built up on them. -The floors under the refrigerators, eye was station, stove, had missing tiles.-Dietary Supervisor said they are cleaned daily.Observation on 10/9/25 at 9:00 A.M. showed the ice machine in the South Hall ice machine tray that collects the overflow of ice and water had brownish/reddish debris on it. During an interview on 10/9/25 at 9:45 A.M. the Dietary Supervisor said housekeeping was responsible for the ice machines in the halls.During an observation and interview on 10/9/25 at 10:03 A.M., the Housekeeping Supervisor and Corporate Maintenance Person said:-Housekeeping oversees the outside of the ice machine and they would wipe it down daily.-Maintenance oversees the inside of the ice machine and it would be cleaned quarterly.-Maintenance opened the ice machine and the appearance of a black substance was on the plastic spout where the ice and water come out and in the white plastic reservoir above. |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to do the following: maintain a fan in the activity area free from a heavy buildup of dust; failed to maintain one ceiling tile free of a black colored stain; failed to maintain the climate control unit in North resident room [ROOM NUMBER]-6 free from a dust buildup; failed to maintain the light fixture in North resident room free from a buildup of debris on the fixture; failed to maintain the handles of a shower chair in the North east Shower Room free from cracks which rendered those handles not easily cleanable; failed to maintain the ceiling vent in the restroom of resident room [ROOM NUMBER]-40, from a heavy buildup of dust; failed to maintain two sprinkler heads in the dining room free from a dust; failed to maintain a stand -up lift in the South [NAME] shower room free from a buildup of grime; failed to implement a system to monitor hot water temperatures to ensure that hot water in south resident rooms 11--12, 29-32, 15-16, and 19-20, would remain above 105 degrees F (degrees Fahrenheit) ; failed to maintain the floors in resident rooms South 29-32, South 19-20, and South 21-24, free of a grime buildup. This practice potentially affected at least 40 resident s who resided in or used those areas. The facility census was 76 residents.1. Observation on 10/7/25 at 11:51 A.M., with the Activity Director and the Corporate Maintenance Person, showed a heavy buildup of dust on the fan which blew air and dust across the main sitting area of the activity area in the basement.During an interview on 10/7/25 at 11:56 A.M., the Activity Director said he/she has been in the Activity Department since 6/24, and he/she has never seen the fan cleaned.2. Observation on 10/7/25 at 11:53 A.M., with the Corporate Maintenance Person and the Housekeeping Supervisor, showed the presence of a black substance on one ceiling tile in the room next to the pool table room.During an interview on 10/7/25 at 11:57 A.M., the Corporate Maintenance Person said the ceiling tile needed to be changed and there used be a leak at that location in the past.3. Observation on 10/7/25 at 12:13 P.M., with the Corporate Maintenance Person and the Administrator, showed a buildup of dust the climate control unit in North resident room [ROOM NUMBER]-6.During an interview on 10/7/25 at 12:13 P.M., the Administrator said the facility's plan was to replace the climate control units.4. Observation on10/7/25 at 1:08 P.M., with the Corporate Maintenance Person and the Housekeeping Supervisor, showed a buildup of dust and debris on the light fixture above one of the beds in resident room North 9-10.During an interview on 10/7/25 at 1:10 P.M., the Housekeeping Supervisor said the housekeeping staff was not cleaning on top of the light fixtures very well. 5. Observation on 10/7/25 at 1:20 P.M., with the Corporate Maintenance Person and the Housekeeping Supervisor showed the presence of cracked handles on the shower chair in the Northeast Shower room.6. Observation on 10/7/23 at 1:23 P.M., with the Housekeeping Supervisor showed a heavy buildup of dust inside of the ceiling vent in North resident room [ROOM NUMBER]-40.During an interview on 10/7/23 at 1:23 P.M., the Housekeeping Supervisor said he/she has only worked as a Housekeeping Supervisor for 3 months and the reason why the vents have not been cleaned, was related the absence of a regular maintenance person in 1 year and 3 months. 7. Observation on 10/7/25 at 2:59 P.M., with the Housekeeping Supervisor showed a buildup of dust on two sprinkler heads in the dining room.During an interview on 10/7/25 at 3:00 P.M., the Housekeeping Supervisor said the housekeepers have never cleaned the sprinkler heads.8. Observation on 10/7/25 at 3:22 P.M., with the Housekeeping Supervisor and the Administrator showed a buildup of grime on the base of the stand-up lift (a specialized medical devices designed to assist individuals with limited mobility in transitioning from a seated to a standing position) in the Southwest shower room.During an interview on 10/7/25 at 3:22 P.M., the Administrator said that the night shift staff members are mostly responsible for cleaning the lifts.9. Observations on 10/8/25 of the hot water temperatures showed the following: after the hot water was allowed to flow for 2 minutes or more:At 10:07 A.M., the hot water temperature in resident room South 11-12 was 91.9 FAt 10:15 A.M., the hot water<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | temperature in resident room South 29-32. was 95.0 FAt 10:36 A.M., the hot water temperature in resident room South 15-16, was 82.4 FAt 10:46 A.M., the hot water temperature in resident room South 19--20, was 70.1 FAt 10:54 A.M., the hot water temperature in resident room South 19--20, was 98.8 FDuring an interview on 10/8/25 at 11:02 A.M. the Corporate Maintenance Person said there was a hot water pipe that was not turned off at a janitor's closet close to the smoke room and the constant flowing of the hot water caused less hot water to go to those rooms. During an interview on 10/9/25 at 11:19 A.M., the Housekeeping Supervisor said he/she had not heard of checking water temperatures until that survey.During an interview on 10/9/25 at 11:20 A.M., the Corporate Maintenance Person said he/she checked water temperatures about 3 months prior to the survey10. Observation on 10/8/25 At 10:15 A.M., with the Housekeeping Supervisor, showed the floor in south resident room [ROOM NUMBER]-32 had a buildup of grime and debris and the presence of a heavy buildup of dust on the blades of two fans in that room.During an interview on 10/9/25 at 2:07 P.M., the Housekeeping Supervisor said he/she had not thought about cleaning the fans before this survey. 11. Observation on 10/8/25 At 10:37 A.M., with the Housekeeping Supervisor, showed the presence of grime on the floor of South resident room [ROOM NUMBER]-28. 12. Observation on 10/8/25 At 10:46 A.M., with the Housekeeping Supervisor, showed the presence of grime and dust behind the beds in South resident room [ROOM NUMBER]-20. 13. Observation on 10/8/25 At 10:54 A.M., with the Housekeeping Supervisor, showed the presence of grime on the floor of South resident room [ROOM NUMBER]-24. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly store respiratory continuous positive airway pressure (C-PAP is a machine that uses mild air pressure to keep breathing airways open while you sleep) mask when not in use for one sampled resident (Resident #13) and failed to ensure oxygen equipment, nasal cannulas nasal cannula (a device used to deliver supplemental oxygen through a plastic tube into the nose in a sanitary manner; a lightweight tube which on one end splits into two prongs which are placed in the nostrils and from which a mixture of air and oxygen flows) and tubing was kept covered when not in use for two sampled residents (Resident #45 and #72) out of 18 sampled residents. The facility census was 76 residents. Review of the facility Respiratory Care policy and procedure dated 2006, showed the purpose was to maintain the proper infection control technique when providing respiratory care to the residents. The policy showed:-All respiratory equipment shall be checked and cleaned daily/weekly and as needed.-There was documentation in the policy showing how respiratory equipment should be stored when not in use. 1.Review of Resident #45's Face Sheet showed the resident was admitted with diagnoses including chronic obstructive pulmonary disease (COPD-a group of lung diseases that cause ongoing airflow obstruction and breathing problems). and emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness). 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 5/19/25, showed the resident:-Was alert and oriented but had cognitive loss.-Had shortness of breath when sitting, lying flat and any exacerbation.-Did not receive oxygen therapy during the lookback period. Review of the resident's Physician Order Sheet (POS) dated 10/2025 showed physician's orders for Oxygen 2 liters per nasal canula, as needed for shortness of breath. Observation on 10/7/25 at 10:38 A.M., showed the resident was laying on his/her bed. He/she was not wearing oxygen. There was an oxygen concentrator that was against the wall beside the resident's bed, and the nasal cannula and tubing was coiled around the concentrator, uncovered. Observation on 10/9/25 at 8:15 A.M., showed the resident was outside in his/her wheelchair without oxygen on. In his/her room was his/her oxygen concentrator with the nasal cannula coiled around the concentrator, uncovered. Observation and interview on 10/9/25 at 9:20 A.M., showed the resident was laying down on his/her bed reading a book. He/she was not wearing oxygen. His/her oxygen concentrator was against the wall beside his/her bed. The nasal canula and tubing were coiled around the concentrator, uncovered. The resident said:-He/She used his/her oxygen at night most of the time, but he/she sometimes used it during the day.-He/She had a plastic bag for his/her breathing treatment machine, but he/she did not have anything to put her oxygen tubing in. During an interview on 10/9/25 at 9:26 A.M., Certified Nursing Assistant (CNA) B said:-They are supposed to check for any resident who has a respiratory device to ensure the device was covered.-They have residents who have oxygen and use masks and nasal cannulas.-The masks and tubing are supposed to remain covered when it's not in use. During an interview on 10/10/25 at 10:46 A.M., Licensed Practical Nurse (LPN) A said:-Usually the resident used his/her oxygen at night, and he/she would remove the nasal cannula himself/herself and put it up.-There should be a plastic bag for the nasal cannula and tubing to go into.-The nasal cannula and tubing should be covered when it is not in use, and the nursing staff should be observing during the day to ensure it is in a bag and covered. 2.Review of Resident #72's Face Sheet showed the resident was admitted with diagnoses including COPD. Review of the resident's quarterly MDS dated [DATE], showed the resident:-Was alert, oriented and cognitively intact.-Needed moderate assistance with toileting and dressing and maximum assistance with bathing.-Had no oxygen therapy during the look back period. Review of the resident's POS dated 10/2025, showed physician's orders for Oxygen at 2 liters per minute as needed for shortness of breath (5/15/25). Review of the residents Medication Administration Record (MAR) showed: -9/2025<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | showed resident did not use oxygen during the month.-10/2025 showed the resident did not use oxygen during the month. Observation on 10/07/25 at 11:29 A.M., showed the resident was not in his/her room. There was an oxygen concentrator that was sitting across from his/her bed, against the wall. It was not on, and the nasal cannula and tubing were coiled around it, uncovered. The resident was in his/her wheelchair in the hallway and was not wearing oxygen. Observation on 10/8/25 at 8:32 A.M., showed the resident was sitting in his/her wheelchair in the hallway outside of his/her room. He/she was not wearing oxygen. His/her oxygen concentrator was sitting across from his/her bed with the nasal canula and tubing coiled around it, uncovered. The oxygen concentrator was not on. Observation on 10/9/25 at 8:18 A.M., showed the resident was in his/her room standing up adjusting his/her pants before transferring himself/herself to his/her wheelchair. He/she was not wearing oxygen. His Her oxygen concentrator was sitting across from his/her bed with the nasal cannula and tubing coiled around the concentrator, uncovered. LPN B went into the room to check the resident's blood sugar and then came out of the resident's room without covering the resident's oxygen tubing. Observation and interview on 10/9/25 at 9:32 A.M., showed the resident was in his/her bed with his/her eyes closed, resting comfortably without oxygen on. The oxygen concentrator was across from the resident's bed, and the nasal cannula and tubing were wrapped around the concentrator, uncovered. CNA B said:-He/She saw his/her oxygen concentrator, but the resident rarely used his oxygen, in fact he/she never had seen the resident use oxygen.-If the resident has oxygen in his/her room, the nasal cannula and tubing should be covered. During an interview on 10/9/25 at 9:58 A.M., LPN B said:-The resident has not had to use his/her oxygen that he/she is aware of.-If the resident does not use oxygen, the concentrator should not be in his/her room.-If the resident used oxygen at night, the tubing should be covered.-At this time LPN B instructed the nursing staff to remove the nasal cannula and tubing from the oxygen concentrator and discard it.-He/She said the resident's order was for oxygen as needed. During an interview on 10/10/25 at 1:57 P.M. the Director of Nursing (DON) said:-The oxygen nasal cannulas, tubing and face masks should be in a bag labeled and dated.-They should not be left uncovered.-He/She expected the staff to check daily as they go in/out of resident rooms.-If the resident had oxygen that was not being used, they should not have nasal cannula and tubing attached-it should be discarded until they need it.<br><br>3. Review of Resident #13's admission Record showed was admitted to the facility on [DATE] with diagnosis of COPD.<br><br>Record review of the resident's Quarterly MDS dated [DATE], showed he/she:-Was cognitively intact.-He/She was able to understand others and make his/her needs known.<br><br>Record review of the resident's Care plan updated on 8/12/25 showed:-Diagnosis of COPD.-Requires ongoing use of C-PAP (continuous positive airway pressure) is a machine that uses mild air pressure to keep breathing airways open while you sleep) use.<br><br>Review of the resident's POS dated 10/1/25 to 10/31/25 showed:-C-PAP on at bedtime duet to sleep apnea -Change tubing to C-PAP and clean weekly on Mondays.<br><br>During an observation of the resident's room and interview with the resident on 10/7/25 at 11:18 A.M. showed his/her C-PAP machine was on the bedside table with the C-PAP mask uncovered and hung over the side rail of the resident's bed, there was no storage bag for the mask. The resident said: -He/She has a C-PAP machine on the bedside table. -The facility cleans the C-PAP machine and mask as needed.-He/She was able to apply and remove C-PAP mask by himself/herself.<br><br>Observation on 10/7/25 at 1:31 P.M., the resident room showed his/her C-PAP mask was hung<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | uncovered on the siderail.<br><br>Observation and interview on 10/9/25 at 10:04 A.M., of the resident in his/her room showed his/her C-PAP mask was not stored in plastic bag or covered; the c-pap mask was hanging over side rail. The resident did not have C-PAP storage bag in his/her room at that time. The resident said:-He/She normally has a plastic bag to store C-PAP mask in when not in use. -Nursing staff provide the storage bag as needed.<br><br>During an interview on 10/9/25 10:45 A.M., CNA B said:-The resident's C-PAP mask should be stored in plastic bag when not in us. -The resident was able to place his/her C-PAP mask on and removed by himself/herself. -CNA would monitoring during rounds to ensure the C-PAP mask was stored when not in use.<br><br>During an interview on 10/9/25 10:45 A.M., LPN B said:-The resident's C-PAP mask should be stored in a bag when not in use. -The facility night staff were responsible to ensure the resident would have new storage bag every week. -The resident was able to place C-PAP mask on and removed by himself/herself.<br><br>During an interview on 10/10/25 at 1:57 P.M., the DON said:-He/She would expect nursing staff and care staff to ensure proper storage for the resident's C-PAP mask when not in use. -The resident's C-PAP mask should be stored in a plastic bag, labeled with resident name and dated when changed, -Night nursing staff were responsible for ensure the resident have plastic storage bag for C-PAP mask. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Hospice (is a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life) physician orders were obtained and documented on the physician's order sheet for four sampled residents (Resident #52, #13, #45, and #58) out of 18 sampled residents. The facility census was 76 residents. Review of the facility's policy for Physician Order dated 2013 showed:Purpose:-To ensure the accuracy of transcribing order.-To have physician orders transcribed from the Physician Order Sheet (POS) to the appropriate administration record. Policy:-All nursing staff must follow the policy for transcribing medication, medication management and receiving physician order. All nursing staff must be compliant with this policy. Procedure:-The licensed nurse documents the complete orders on the POS. Sign name, date and the nurse practitioners and/or physician's name.-The POS will be reviewed by a licensed nurse monthly during the changeover to capture all information for the next month. -The POS will be reviewed by the physician/assistant nurse practitioners monthly to ensure the appropriate treatment and orders. -Should be documented or transcribed exactly the order upon receipt on the POS, MAR, and Treatment book.<br><br>Review of the Facility's policy for Collaborative Practice with Hospice Care and Services dated 2010 showed: Purpose:-To enhance the quality of care via collaborative services between hospice agencies and the facility.-To promote the communication between hospice and nursing staff.-To ensure the continuum of care provided to the residents.<br><br>1. Review of Resident #52's admission Record showed the resident had diagnoses:-Senile degeneration of the brain (is a decline or death of brain cells, it's a process deteriorates intellectual functions like memory, speech, and coordination, and while there is no cure, treatments can help manage symptoms). -Dementia (is used to describe the gradual deterioration of intellectual abilities and behavior that eventually interferes with customary daily living activities).-Moderate Intellectual disabilities (is a term used when there are limits to a person's ability to learn at an expected level and function in daily life).-admitted to Hospice Services.<br><br>Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 9/26/25, showed he/she:-Was cognitively impaired.-Received hospice services.<br><br>Review of the resident's POS dated September 2025, and October 2025 showed he/she had no physician orders for hospice services and care, to include when the resident was admitted to hospice, name of hospice provider and supporting diagnosis.<br><br>Review of the resident's Hospice Medical Record binder on 10/9/25 at 8:17 A.M. showed:-The resident's hospice physician order to recertify hospice services from 8/16/25 to 10/14/25 with admitting diagnosis of senile degeneration of the brain.-His/Her hospice care plan dated on 3/19/25 to include hospice aide visits on Monday and Wednesday.-He/She had a hospice bath aide sheet completed on 10/7/25 to include shower, peri care, nail care and oral care.<br><br>2. Review of Resident #13's admission Record showed he/she was admitted to the facility on [DATE] with diagnoses of:-Chronic Obstructive Pulmonary Disease (which includes chronic bronchitis and emphysema, is a long-term lung disease that makes it hard to breathe).-admitted to (continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Hospice Services.<br><br>Review of the resident's Hospice Medical Record binder showed: -The resident was recertified for Hospice services on 7/10/25. -His/Her Hospice Plan of Care was dated 7/24/25 showed, he/she was scheduled for hospice aide visits on Tuesday and Thursday. Licensed Nurse visits on Tuesday.<br><br>Review of the resident's Care Plan updated on 8/12/25 showed he/she admitted to hospice care 4/11/25 with diagnosis of COPD.<br><br>Review of the resident's Quarterly MDS dated [DATE], showed he/she:-Was cognitively intact.-Was able to understand others and make his/her needs known.-Received hospice services.<br><br>Review of the resident's POS dated 9/1/25 to 9/30/25 showed he/she had no physician orders for hospice services and care, to include when was admitted to hospice, name of hospice provider and supporting diagnosis.<br><br>Review of the resident's Nursing Note dated 9/21/25 at 4:00 P.M. showed the resident continues to be on hospice services.<br><br>Review of the resident's POS dated 10/1/25 to 10/31/25 showed he/she had no physician orders for hospice services and care, to include when was admitted to hospice, name of hospice provider and supporting diagnosis.<br><br>During an interview on 10/07/25 at 1:31 P.M., the resident said he/she was on hospice services and hospice care staff provide showers, help with basic care needs, and medication.<br><br>During an interview and review of the resident medical record on 10/09/25 at 11:15 A.M., showed review of the resident's POS with Licensed Practical Nurse (LPN) B:-The resident did not have physician orders transcribed to the facility POS for hospice services. -He/She would expect to have a physician order for a resident on hospice services to include the hospice provider name and supporting diagnosis.<br><br>3.Review of Resident #45's Face Sheet showed the resident was admitted with diagnoses including COPD, emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness), and high blood pressure.<br><br>Review of the resident's quarterly MDS dated [DATE], showed the resident:-Was alert and oriented but had cognitive loss.-Did not show hospice services during the lookback period. Review of the resident's POS showed:-The POS dated 4/2025 showed a physician's order dated 4/11/25, for a hospice evaluation and treatment.-POS's dated 5/2025, 6/2025, 7/2025, 8/2025, 9/2025 and 10/2025 showed no physician's orders for hospice services was documented. Review of the resident's Hospice Record showed:-The resident was approved for and started on hospice services on 4/11/25, was re-certified on 7/9/25 and again 10/2025.-The hospice related diagnosis was COPD.-The hospice physician's orders showed 4/11/25 (the date the order was written).-Documentation showed hospice started on 4/11/25 and has continued since that date. During an interview on 10/9/25 at 9:20 A.M., the resident said he/she was still receiving hospice services and the nurse came to visit every week to see how he/she was doing and he/she was satisfied with his/her care. During an interview on 10/10/25 at 10:46 A.M., Licensed Practical Nurse (LPN) A said:-With resident's who receive hospice services, the orders are only on the hospice order sheet. -Regarding the resident, the hospice orders (continued on next page) |

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| | 26E084 | A. Building<br>B. Wing | 10/10/2025 |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | showed on the POS dated 4/2025, that the resident was to receive a hospice evaluation and treatment.-Hospice did pick the resident up for services and so there should be an order for hospice on the POS.-The resident started hospice services on 4/11/25.-The hospice order should have been documented on the resident's POS and carried over from month to month.-When they change an order on the POS, it is picked up by pharmacy and it's supposed to be changed on the POS for the following month.-The nurse was supposed to check the POS for accuracy from month to month.-If they notice that the order did not carry over, they were supposed to change it on the POS and they should notify the pharmacy that the order needs to be changed for the following month.-He/She would make sure that the residents who are on hospice that he/she cared for have hospice orders that are documented on their POS.<br><br>4. Review of Resident #58's admission Sheet dated 3/13/15 showed the following diagnoses:-Multiple Sclerosis (MS, a neurological disease that attacks the protective covering of the nerves, leading to impaired sensory and motor nerve function, and in most cases some degree of disability).-Essential (primary) hypertension (HTN- high blood pressure).-Anxiety disorder, unspecified (a psychiatric disorder causing feelings of persistent anxiety)-Other chronic pain.-Other muscle spasm.-Dysphagia, unspecified (inability or difficulty swallowing).<br><br>Review of the resident's MDS dated [DATE] showed: -He/She was moderate cognitive impairment.-He/She was on hospice.<br><br>Review of the resident's POS dated 10/8/25 showed the resident did not have orders for hospice.<br><br>Review of hospice communication book on 10/9/25 showed that hospice had visited and communicated with staff on 9/18, 9/25, 10/1, 10/3 2025.<br><br>5.During an interview on 10/10/25 at 9:06 A.M., LPN A said he/she would expect to have a physician order for residents on hospice services to include the hospice provider name and supporting diagnosis.<br><br>During an interview on 10/10/25 at 10:46 A.M., LPN A said:-With residents on hospice, the orders were only on the hospice order sheet. -They have a list of residents who were on hospice. -There should be an order for hospice on the POS<br><br>During an interview on 10/10/25 at 1:57 P.M., the Director of Nursing (DON) said:-Residents on hospice should have hospice orders on their POS.-He/She would expect the resident's physician's order to include the hospice provider, date the order was written, associated diagnosis and physician who wrote the order.<br><br>During an interview on 10/10/25 at 1:57 P.M., the Director of Nursing (DON) said:-Residents on hospice should have hospice orders on their POS.-Typically, the order should show the hospice provider, date the order was written, associated diagnosis and physician who wrote the order. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the drainage sink in the North Hall Janitor's closet free from being clogged; failed to ensure that there was not a heavy buildup of dust on the ventilation fan and blades in the laundry above the dryers; failed to maintain the hopper (sinks in soiled utility rooms which are used for the disposal of liquid clinical waste) in the South side soiled linen room close to the nurse's station free from being clogged; and failed to ensure that grime was removed from the hopper in the soiled utility room next to South rooms 13-14. This practice potentially affected at least 30 residents who resided close to or use the corridors adjacent to these areas. The facility census was 76 residents.1.Observation on 10/7/25 at 1:16 P.M., with the Housekeeping Supervisor and the Corporate Maintenance Person, showed a clogged sink in the North Hall soiled utility room. During an interview on 10/7/25 at 1:16 P.M., the Corporate Maintenance Person said he/she did not know about it because he/she has not been at the facility in a while. 2. Observation on 10/7/25 at 1:32 P.M., with the Corporate Maintenance Person and the Housekeeping Supervisor, showed the wall mounted fan in the laundry area, was encrusted with a layer of dust. During an interview on 10/7/25 at 1:33 P.M. the Housekeeping Supervisor said he/she did not know he/she needed to remove the dust from that vent fan. 3. Observation on 10/8/25 at 9:59 A.M., with the Corporate Maintenance Person, showed a clogged hopper in the South side Soiled utility room close to the nurse's station. During an interview on 10/8/25 at 10:00 A.M., the Corporate Maintenance Person said he/she did not know how long the hopper was clogged. 4. Observation on 10/8/25 at 10:24 A.M., with the Housekeeping Supervisor showed a heavy build of grime in the hopper within the South side soiled utility room located next to resident room [ROOM NUMBER]-14 and a very pungent odor emanating into the adjoining corridor from that room. During an interview on 10/8/25 at 10:25 A.M., the Housekeeping Supervisor said he/she did not know how long the grime had existed on the hopper and that hopper was not flushing properly as well. |

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| F 0923<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have enough outside ventilation via a window or mechanical ventilation, or both.<br><br>Based on observation and interview, the facility failed to ensure there was adequate ventilation in the following areas: North resident rooms 21-24, 25-28, 15-16, 13-14, 29-32, 33-36, 9-10, South resident rooms 37-40, 1, 13-14, the soiled utility room close to South 13-14, and South 17-18. This practice potentially affected at least 20 residents who resided in those rooms or used corridors close to those areas. The facility census was 76 residents.**Note: Air flow was tested by holding one piece of tissue paper to the ceiling vent. If the paper was drawn to the vent, then negative air flow was present; if the paper fell, then negative airflow was absent.1. Observations on 10/7/25 with the Corporate Maintenance Person and the Housekeeping Supervisor, showed:At 12:41 P.M., there was the absence of negative airflow in the ceiling vent of Resident room North 21-24.At 12:50 P.M., there was the absence of negative airflow in the ceiling vent of Resident room North 25-28.At 12:52 P.M., there was the absence of negative airflow in the ceiling vent of Resident room North 15-16.At 12:54 P.M., there was the absence of negative airflow in the ceiling vent of Resident room North 13-14.At 12:56 P.M., there was the absence of negative airflow in the ceiling vent of Resident room North 29-32.At 1:01 P.M., there was the absence of negative airflow in the ceiling vent of Resident room North 11-12.At 1:04 P.M., there was the absence of negative airflow in the ceiling vent of Resident room North 33-36.At 1:06 P.M., there was the absence of negative airflow in the ceiling vent of Resident room North 29-32.At 3:20 P.M., there was the absence of negative airflow in the ceiling vent of Resident room South 37-40.At 3:29 P.M., there was the absence of negative airflow in the ceiling vent of Resident room South 37-40.At 3:36 P.M., there was the absence of negative airflow in the ceiling vent of Resident room South 7-8.During an interview on 10/7/25 at 1:04 P.M., the Corporate Maintenance Person said a motor on the roof of the facility, which controlled the negative airflow may not have worked at that time. Observations on 10/8/25 with the Corporate Maintenance Person and the Housekeeping Supervisor, showed: -At 10:22 A.M., there was the absence of negative airflow in the ceiling vent of Resident room South 13-14.-At 10:23 A.M. there was the absence of negative airflow and the presence of a strong odor in the soiled utility room next to South 13-14.During an interview on 10/8/25 at 10:23 A.M., the Housekeeping Supervisor said he/she did not know how long that soiled utility room had been like that.-At 10:44A.M., there was the absence of negative airflow in the ceiling vent of Resident room South 17--18.-At 10:46A.M., there was the absence of negative airflow in the ceiling vent of Resident room South 21--24.During an interview on 10/9/25 at 11:11 A.M., the Housekeeping Supervisor said he/she did not know how to check for negative airflow, until that survey.During an interview on 10/9/25 at 11:12 A.M., the Corporate Maintenance Person said he/she was not always at that facility but did try to get to that facility 3-4 times per month, if there were not emergencies at the other facilities, that he/she served for the corporation. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to obtain and transcribe a physician order for self-administration of medication and failed to ensure nursing staff documented and completed a self-administration medication assessment for the resident's ability to store medication safely at bedside and to administer medication by himself/herself, for one sampled resident (Resident #13) out of 18 sampled residents. The facility resident census of 76 residents. Review of the facility's Self-Administration of medication dated 8/16/07 showed:-All bedside medication must be approved and ordered by the resident attending physician. -Each resident who desires to self-administer their own medication will be provided education about medication with return demonstration on proper administering or are adequately trained in the techniques of the medication. -Nursing staff are responsible to monitor and ensure the prescribed medication are properly administrated by the resident. -Nursing staff are responsible to ensure the safety on of bedside medication by checking storage regularly. 1.Review of Resident #13's admission Record showed was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (which includes chronic bronchitis and emphysema, is a long-term lung disease that makes it hard to breathe).Review of the resident's Care Plan updated on 8/12/25 showed:-He/She has diagnosis of COPD.NOTE: no care plan for self-medication administration of inhaler. Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 9/9/25, showed he/she:-Was cognitively intact.-He/She was able to understand others and make his/her needs known.Review of the resident's Physician Order Sheet (POS) dated 10/1/25 to 10/31/25 showed:-Albuterol HFA 90 Micrograms (mcg) (inhaler used to treat shortness of breath) inhale one puff orally every six hours as needed for shortness of air.-NOTE: did not have physician order to keep medication at bedside or self-administer any medication. Review of the resident Medication Administration Record (MAR) dated 10/1/25 to 10/31/25 showed:-Albuterol solution HFA 90 MCG (Ventolin) inhale one puff orally every six hours for shortness of air.NOTE: There was no physician order to keep medication at bedside or self-administer any medication. During an and observation and interview with the resident on 10/07/25 at 1:31 P.M., showed: -Observed the resident had a red and white medication box with an albuterol inhaler laid at the foot of his/her bed. -He/She had been instructed on how to administer the inhaler medication by facility nursing staff and kept the inhaler at bedside due to his/her breathing issue. Observation on 10/9/25 at 10:04 A.M., of the resident in his/her room showed he/he had an Albuterol HFA inhaler in a red and white box at the foot of his/her bed. The prescription label was dated refilled on 7/29/25. Observation on 10/9/25 at 10:10 A.M., of the Certified Medication Technician (CMT) medication cart showed the resident had an Albuterol inhaler HFA in a box with a pharmacy label refilled in June 2025. During an interview on 10/9/25 at 10:10 A.M., CMT A said:-The resident should have a physician order for self-administration and a licensed nursing assessment for self-administration of inhaler be completed to keep any medication at bedside. -He/She was not aware the resident had the inhaler medication left at bedside. -The resident did not have physician order for self-administration of inhaler or any other medication. -He/She removed the inhaler medication from the resident room. During an interview on 10/9/25 10:45 A.M., Licensed Practical Nurse (LPN) B said: -Residents were not allowed to keep prescribed or over-the-counter medication at bedside.-He/She would expect the resident to have a physician order for self-administration of medication and nursing assessment for the ability to self-administration medication safely. During an interview on 10/10/25 at 1:57 P.M., Director of Nursing (DON) said:-He/she would expect to have physician orders for self-administration of medication and completed nursing assessment for the resident ability to keep and administer medication safely.-The facility did not have any residents with physician orders for self-administration of medication and able to keep medication at bedside. -The<br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility CMT and licensed nursing staff would be responsible for ensuring resident's medication were stored safely and no medication left in resident room. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>Based on observation, interview and record review, the facility failed to ensure the correct code status (a medical designation that communicates a patient's wishes regarding resuscitation if their heart stops or they stop breathing) was documented on the resident physician's order sheet and was consistent throughout the resident's medical record for one sampled resident (Resident #43) out of 18 sampled residents. The facility census was 76 residents.Review of the Physician's Orders policy and procedure dated 2013, showed the purpose was to ensure the accuracy of the order and to have the physician's orders transcribed to the appropriate administration record. The procedure showed:-The physician dictated the order through phone or fax.-The nurse will document the exact order on the physician's order sheet (POS) and transcribe the order to the medication administration record (MAR)/treatment administration record (TAR).-The POS will be reviewed by the nurse monthly during the changeover to capture all of the information for the next month.-The POS will be reviewed by the physician monthly to ensure the appropriate treatment orders.-All necessary information related to code status, allergy, specialized diets, and care instructions must be transcribed to the medical record. 1.Review of Resident #43's Face Sheet showed the resident was admitted on e 2/10/22, with diagnoses including dementia, hypokalemia (low levels of potassium in the blood), schizophrenia (a chronic mental health condition characterized by significant disturbances in thought, perception, emotion, and behavior), insomnia (a sleeping disorder), (COPD-a group of lung diseases that cause ongoing airflow obstruction and breathing problems), diabetes, movement disorder, hypothyroidism, high blood pressure and history of breast cancer. Review of the resident's Hospice (end of life) records showed the resident was a do not resuscitate (DNR) and there was a DNR form in the record dated 4/24/25.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 5/28/25, showed the resident:-Was alert with significant confusion.-Received Hospice services. Review of the resident's Physician's Order Sheets (POS) showed:-The POS dated 4/2025, showed on 4/22/25 the resident had an order for hospice to evaluate and treat the resident.-A physician's telephone order dated 4/24/25 showed the resident's code status showed DNR.-The POS dated 4/2025, 5/2025 and 6/2025 showed the resident's code status was DNR.-The POSs dated 7/2025, 8/2025, 9/2025, and 10/2025 showed the resident's code status was full code. Review of the resident's Physician's Note dated 8/12/25, showed:-The resident was on Hospice services and was declining.-Regarding his/her code status the physician documented do not resuscitate? Review of the resident's Care Plan dated 9/11/25, showed the resident chose to be DNR.Review of the resident's medical record showed there was no documentation showing the resident had changed his/her code status from DNR back to full code since 7/2025. During an interview on 10/9/25 at 9:20 A.M., the resident said:-He/She was on hospice services and was content with the services he/she received.-He/She did not want to be resuscitated if he/she was no longer breathing. During an interview on 10/10/25 at 10:46 A.M., Licensed Practical Nurse (LPN) A said:-If they have a resident who is on hospice and they were full code but are now DNR, then the order should be changed to show they are no longer full code on the POS.-The resident's code status changed when he/she started receiving hospice services.-(After looking at the resident's medical record) the resident determined he/she did not want to be a full code and started hospice on 4/24/25 the resident signed the DNR form.-The resident's POS showed the code status changed from full code to do not resuscitate in April and seemed to have dropped off of the POS in July.-The POS was incorrect and should have showed the code status as DNR.-When they put changed orders on the POS, the POS goes to the pharmacy and it should have been changed for the following month, but sometimes it's not.-This had been a continuous problem with the pharmacy.<br>-They try to ensure the orders are current and correct on the POS from month to month, but they must have missed it. During an interview on 10/10/25 at 1:57 P.M., with the Director of Nursing (DON) and<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administrator, the DON said:-The resident should have an advanced directive that is current.-They have had issues with the pharmacy not updating the POS and orders falling off of the POS, but the advance directive for the resident should be current and, on the POS.-The Administrator said the issues with the pharmacy dropping orders off the POS occurs monthly. They are in process of transferring their orders to the electronic record as of November and hopefully this issue will be resolved. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review the facility failed to ensure the area next to the bed was clear of clutter including a siderail for one sampled resident (Resident #22) out of 18 sampled residents. The facility census was 76 residents. An Accident Hazards policy was requested but not provided by the exit date.1. Review of Resident 22's undated face sheet showed he/she admitted to the facility with diagnoses that included:-Left below knee amputation (left BKA a surgical procedure to remove the leg below the knee joint, keeping the knee intact).-Alcohol use, unspecified with intoxication.-Polyneuropathy (a disease affecting many peripheral nerves, causing symptoms like numbness, tingling, and weakness).Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 9/9/25 showed:-Activities of Daily Living (ADL dressing, grooming, bathing, eating, and toileting) assistance necessary for health and well-being had been rejected previously.-Had lower extremity impairment on one side.-Required substantial/maximal assistance transferring from a sit to stand position.-Required substantial/maximal assistance transferring from bed/chair-to-chair.Review of the resident's care plan dated 9/18/25 showed:-The resident was a high risk for falls related to recent fall, left leg amputation, refusal of care, altered mobility status and self-transferring to bed, wheels unlocked.-The resident had ADL, self-care performance deficits related to left below knee amputation, continually refusing to let staff assist with toileting and continuing to refuse to let staff assist with ADL'S.-The resident had limited physical mobility related to below knee left leg amputation, has ongoing use of wheelchair for mobility and continues to be non-compliant with assistance with transfers from wheelchair with staff.Observation on 10/7/25 at 9:49 A.M. showed:-The resident was sitting in the wheelchair in his/her room at bedside watching television.-The resident's bed was positioned on the left side of room, his/her BKA was on his/her left side.-The bed was positioned with a curtain separating the room on the right side of the bed with less than one foot between the edge of the bed and the curtain. -Left side bed rail was lying on the floor partially under bed between the resident and the left side of the bed.Observation on 10/7/25 at 1:14 P.M., 10/8/25 at 9:05 A.M., and 10/9/25 at 2:10 P.M. showed the left side bed rail was lying on the floor partially under bed between the resident and the left side of the bed.During an interview on 10/10/25 at 1:30 P.M., Certified Nursing Assistant (CNA) A said:-He/She knew what a resident's interventions, assistance requirements, and/or mobility needs were based on experience and working with the residents.-He/She was not aware if the resident had fallen in the past.-The resident required assistance but preferred to do everything for himself/herself and liked to be independent.-The resident's room should be free of clutter.-He/She did not know there was a side rail on the floor, the siderail was put back in place recently and thought it was still attached.-The bed side rail should not be on floor or under the resident's bed.-The right side would be the best side for the resident to get in and out of bed.During an interview on 10/10/25 at 1:52 P.M., Licensed Practical Nurse (LPN) B said:-He/She knew what the resident's interventions, assistance requirements and/or mobility needs were by looking at the resident's chart.-The resident had a fall in the past but not recently.-The resident did everything on his/her own but should be getting standby assistance from staff.-The resident frequently refused assistance from staff.-The resident should be reminded to ask for help with transfers and to use the call light for assistance.-The resident's room was free from clutter and was safe.-He/She was not aware that the resident's bed rail was on the floor.-The resident's room should be free of clutter.-The bed rail should not be on the floor.-The right side would be the best side for the resident to get in and out of bed.During an interview on 10/10/25 at 3:00 P.M., the Director of Nursing (DON) said:-He/She would expect the staff to encourage the resident to wait for assistance before transferring.-He/She would not expect for a bed's side rail to be on the floor or under bed.-He/She would expect staff to remove a non-working or broken piece of equipment when<br>(continued on next page) |

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|---|---|---|---|
| | 26E084 | A. Building<br>B. Wing | 10/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Myers Nursing & Convalescent Center | 2315 Walrond Avenue<br>Kansas City, MO 64127 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | discovered.-He/She would expect the resident's room to be free of clutter.-If the resident was being non-compliant, he/she would expect staff to encourage the resident to ask for assistance, notify the nurse, tell him/her, notify physician, and do a care plan review and follow up. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on observation, interview and record review, the facility failed to ensure a physician ordered dietary supplement for weight loss was provided to one sampled resident (Resident #45) who had gradual weight loss out of 18 sampled residents. The facility census was 76 residents.1.Review of Resident #45's Face Sheet showed the resident was admitted with diagnoses including chronic obstructive pulmonary disease (COPD-a group of lung diseases that cause ongoing airflow obstruction and breathing problems) emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness). 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 5/19/25, showed the resident:-Was alert and oriented but had cognitive loss.-Was independent with eating and needed moderate assistance with bathing, hygiene and supervision with transfers.-Had no chewing or swallowing problems.-Had no significant weight loss during the lookback period. Review of the resident's Weight Record showed:-On 5/14/25 the resident weighed 100.4 pounds.-On 6/20/25 the resident weighed 94.6 pounds (represented a significant weight loss within a month).-On 7/22/25 the resident weighed 95 pounds (there was no significant weight loss within 3 months).Review of the resident's Dietary Progress Notes dated 7/25/25, showed the Registered Dietician (RD) assessment noted the resident had a 6-pound weight loss in 30 days, the resident's weight was down significantly.-The resident was placed on hospice (end of life care).-The resident received a regular diet and was eating well at meals.-The resident was ordered health shakes three times daily or magic cup three times daily.-He/She suspected the resident's pain would have an effect on his/her weight loss.-The resident would benefit from Isosource (a nutritionally complete liquid formula, designed to meet the dietary needs of patients who are unable to meet their nutritional requirements through normal food intake) 8 ounces, twice daily. Review of the resident's Weight Record showed Weight Record showed the resident's weight on 9/3/25 was 94.2 pounds. Review of the resident's Care Plan updated on 9/4/25, showed the resident:-Was admitted with a history of malnutrition and weighed 94.2 pounds.-Was to receive a house supplement with all meals and weight monitoring.-Received hospice services.-Interventions included provide and serve the diet as ordered, offer house supplement with meals and snacks. Review of the resident's Weight Record showed Weight Record showed the resident's weight on 10/2/25=92.9 pounds. The resident's weight loss was gradual but was not a significant weight loss over a 6-month period. Review of the resident's Physician Order Sheet (POS) dated 10/2025 showed:-A Regular diet.-Give health shakes three times daily with meals, substitute for magic cup (a fortified frozen dessert that serves as a nutritious and calorie-dense snack, ideal for individuals with involuntary weight loss or those on special textured diets) as needed.-There was no response to the Registered Dietician's recommendation on 9/25/25 for Isosource twice daily. Observation on 10/7/25 at 8:15 A.M., showed the resident was served a regular diet of a boiled egg with toast and cold cereal with milk, juice and coffee. He/she was not served a magic cup or health shake. The resident was eating without assistance or an assistive device. When he/she finished eating, he/she self-propelled from the dining room to his/her room. The resident did not receive a house supplement or magic cup. Observation on 10/9/25 at 8:16 A.M., showed the resident was sitting in his/her wheelchair at the dining table eating an egg sandwich with cold cereal and there was a magic cup with juice, coffee and water at his/her place setting. He/she was eating without assistance and ate 100 percent of his/her meal. When he/she was done, he/she self-propelled out of the dining room back to his/her room. During an interview on 10/9/25 at 9:20 A.M., the resident said:-He/She had a good appetite and has been eating.-He/She received the ice cream like cup this morning, but he/she had not been receiving it before yesterday.-Yesterday he/she received one at lunch and then again, this morning.-He/She did not know how often he/she was supposed to receive the magic cup.-He/She thought the staff were trying to get him/her to gain weight. During an interview on 10/10/25 at 10:46 A.M., Licensed Practical Nurse (LPN) A said:-The<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident was supposed to receive magic cup or a supplement with every meal for weight gain/maintenance.-The resident does eat well, but he/she was not sure about what his/her weight currently was.-Usually the dietary staff were responsible for providing the magic cup and/or supplements to the resident.-They have not been documenting whether the resident received the supplement/magic cup daily and they have not been documenting how much of the magic cup/supplement he/she eats.-The resident usually eats everything on his/her plate that is given to him/her so he/she knew that if the resident received the magic cup, he/she ate it.-He/She would start documenting the amount of magic cup the resident consumed in his/her medical record. During an interview on 10/10/25 at 11:22 A.M., the Dietary Manager said:-The dietary staff was responsible for providing the magic cup and supplements.-The supplement/magic cup was on the resident's meal ticket.-The dietary staff are aware of the residents who receive supplements and magic cups, and they have the supplements and magic cups available in the kitchen.-He/She did not know why the resident did not receive the magic cup, but he/she should have received it and should receive it with every meal.-Dietary staff should read the ticket and ensure the supplement is on the resident's tray when they serve it to the resident. During an interview on 10/10/25 at 1:57 P.M., the Director of Nursing (DON) said he/she expected residents who receive health shakes to be given them as ordered and they should probably monitor the resident's intake if the resident is at risk for weight loss. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain and transcribe physician orders for dialysis (is a treatment used to remove waste products and excess fluid from the blood when the kidneys are not functioning properly) services to include name of dialysis clinic, days of treatment, and failed to obtain physician orders for daily monitoring of the resident's dialysis shunt site (is a surgical connection between an artery and a vein that allows for the flow of blood during dialysis treatment) to assess the thrill (a vibration) and bruit (a whooshing sound) that indicates proper blood flow of the access site and to assess for bleeding at shunt site for one sampled resident (Resident #2) out 18 sampled resident. The facility resident census of 76 residents. A policy for dialysis was requested and not received at the time of exit. Review of the facility's Policy for Physician Order dated 2013 showed: -The licensed nurse documents the complete physician order onto the resident's Physician's Order Sheet (POS) administration record. -Transcribe physician orders to the POS, Medication Administration Record (MAR) and Treatment Administration Record (TAR). -The POS will be reviewed by licensed nursing staff monthly during the changeover to capture all information for the next month of physician orders. 1. Review of Resident #2's admission Record showed the resident admitted to the facility on [DATE] with diagnosis of:-Chronic Kidney Disease Stage 4 (Very poor kidney function; your kidneys are severely damaged and close to not working).-End Stage Renal Disease (ESRD, is when you have permanent kidney failure that requires a regular course of dialysis or a kidney transplant).-Received services at a dialysis center.Review of the resident's Dialysis Care Plan updated 9/11/25 showed: -Receives hemodialysis treatment for ESRD, three times a week on Monday, Wednesday and Friday. --Encourage resident to go for the scheduled dialysis appointments. Monitors vital signs and notify the resident's physician any changes. -NOTE: did not have intervention documented to monitoring and care the resident dialysis shunt daily, before and after dialysis treatments. Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 9/24/25 showed he/she:-Was cognitively intact.-He/She was able to understand others and make his/her needs known.-Required dialysis treatment and services. Review of the Resident's Dialysis Catheter/Fistula/Shunt Care & Monitoring Sheet for September 2025 showed: -Nursing staff documented daily findings of the monitoring of the resident's shunt for bruit and thrill.-NOTE: Nursing staff were providing and documenting the resident's dialysis shunt assessment and care without physician orders. Review of the resident's POS dated 9/1/25 to 9/30/25 showed he/she did not have physician orders for dialysis services or daily monitoring and care of the resident's dialysis shunt. Review of the resident's MAR and TAR dated 9/1/25 to 9/30/25 showed no physician order for the dialysis services and monitoring of the resident dialysis shunt daily and before and after dialysis treatment.Review of the resident's POS dated 10/1/25 to 10/31/25 showed he/she did not have physician orders for dialysis services/treatment or daily monitoring and care of the resident's dialysis shunt. Review of the resident's MAR and TAR dated 10/1/25 to 10/31/25 showed no physician order for the dialysis services and monitoring of the resident dialysis shunt daily and before and after dialysis treatment. Review of the Resident's Dialysis Catheter/Fistula/Shunt Care & Monitoring Sheet for October 2025 showed: -Nursing staff documented daily findings of the monitoring of the resident shunt for bruit and thrill.-NOTE: Nursing staff were providing and documenting the resident's dialysis shunt daily assessment and care without physician orders. During an interview on 10/7/25 at 10:47 A.M. the resident said:-He/She does leave the facility for dialysis three days a week.-He/She goes to dialysis clinic on Monday, Wednesday and Friday.Review on 10/9/25 at 9:00 A.M., of the resident's Dialysis Communication binder showed:-Had documentation of the name of the dialysis clinic.-Was scheduled for dialysis on Monday, Wednesday and Friday.-He/She had a dialysis chair time of 12:15 P.M. -He/She did not have any completed dialysis communication sheet (completed before and after<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dialysis for assessment performed by facility nursing staff and the dialysis clinic staff) placed in the binder for past dialysis visits. During an interview on 10/9/25 at 9:05 A.M., Licensed Practical Nurse (LPN) B said:-The facility nursing staff would send the dialysis communication form with the resident.-The resident's dialysis communication form has not been completed or returned after dialysis. -The facility nursing staff would be responsible for contacting the resident's dialysis clinic to obtain a copy of the completed form. -He/She was not sure where the facility had filed any of the resident's completed dialysis communication form. Requested the resident's dialysis communication documentation and had not received as of 10/9/25 at 1:31 PM.Observation and interview on 10/10/25 at 8:44 A.M., of the resident's dialysis shunt by LPN B showed the resident dialysis shunt located on his/her right upper arm, with no redness noted. LPN B said:-Nursing staff were to check the resident's dialysis shunt every shift, before and after dialysis.-Nursing staff would assess for any bleeding, the bruit and thrill of the dialysis shunt. -The facility nursing staff would complete a special dialysis site monitoring form and placed it in a separate nursing TAR binder.During an interview and review of the resident's medical record on 10/10/25 at 8:46 A.M., LPN B said:-Review of the resident medical chart with LPN B, he/she did not find documentation of physician's orders for the resident's dialysis services and treatment. -The resident should have orders for dialysis to include the dialysis clinic name, days scheduled, and chair times. -Had no documentation of a physician order for the monitoring of the resident's dialysis shunt for bruit and thrill, check for bleeding from the site, report to dialysis and physician any concern with dialysis shunt or any changes in the resident condition. -Licensed nursing staff would be responsible for ensuring to have physician orders for the Resident #2 dialysis treatment and monitoring of the dialysis site daily, before and after dialysis treatment. -There should have been a communication form for the facility and the dialysis facility to fill out and add to the Dialysis Communication Binder, but it was not being done.During an interview on 10/10/25 at 9:06 A.M., LPN A said: -The resident should have dialysis order transcribed onto the resident's POS, to include dialysis provider name, chair time and days at dialysis. -He/She would expect to have a physician order for monitoring the resident dialysis shunt every shift, before and after dialysis. -Nursing staff should be monitoring the resident's dialysis shunt site for any bleeding after dialysis, to monitor the shunt for bruit and thrill every shift and after dialysis treatment. -Nursing staff would be responsible for documenting assessment of the resident dialysis shunt finding on the resident special dialysis flow sheet. -There should have been a communication form for the facility and the dialysis facility to fill out and add to the Dialysis Communication Binder, but it was not being done. During an interview on 10/10/25 at 1:57 P.M., Director of Nursing (DON) said:-He/She would expect to have physician's orders for the resident's dialysis services to include, name dialysis clinic, days schedule and chair times. -He/She would expect to have physician orders for the monitoring of the resident dialysis shunt daily and before and after dialysis treatment. -The facility has chart checks completed by night shift nursing staff. -The facility nursing staff would be responsible for check the resident vital signs and shunt for thrill and bruit before and after dialysis. -He/She would expect nursing staff to document assessment on the resident's dialysis communication sheet before and after dialysis treatment. -He/She would expect nursing staff to call the dialysis clinic to obtain the resident's dialysis communication sheet after dialysis treatment. |