DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265869	A. BUILDING _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCRITE PLAZA AT BRIARCLIFF SKILLED FACILITY	1301 TULLISON RD KANSAS CITY, MO 64116

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F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578	**Preparation, submission, and implementation of the POC does not constitute admission or agreement by McCrite Plaza to the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared, submitted and implemented in accordance with the provisions of the state of law. McCrite Plaza maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit McCrite Plaza's capacity to render reasonable and adequate care.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/16/25

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.

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the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to ensure an invoked (activated by verifying incapacity of the resident to make decisions) Durable Power of Attorney (DPOA) was in place prior to allowing the designated agent to sign Outside of Hospital Do Not Resuscitate (OHDNR, it instructs health care providers not to begin cardiopulmonary resuscitation, or CPR, if the resident's breathing stops or if a resident's heart stops beating) forms which affected two of the 12 sampled residents, (Resident #22 and #18). Additionally they facility failed to ensure Resident #295's code status matched his/her's care plan. The facility census was 40.

Review of the facility's undated policy for advance directives, showed:
- It is the policy of the facility to comply with applicable law and to promote the right of self-determination by encouraging the use of Advance Directives (a legal document which allows your to plan and make your own end-of-life wishes known in the event your are unable to communicate)and honoring treatment preferences expressed by the resident and/or the resident's representative and their Advance Directives, if those preferences are allowed by law;
- Prior to or on admission, the Social Worker or designee will ask the resident or resident's representative, if they have a a Living Will (a written, legal document that spells out medical treatments you wound not want to be used to keep you alive, as well as your preferences for

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other medical decisions) or DPOA for health care decisions;
- All residents will be given written information concerning an individual's rights under state law, to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives;
- If the resident has any of these Advance Directives, a copy of the documents will be placed in the resident's medical record and reviewed quarterly, annually and as needed with the resident;
- If the resident becomes incapacitated, the resident's representative will be contacted quarterly, annually and as needed;
- If the resident is in a coma or incapacitated, the information about Advance Directives shall be given to the family or resident's representative.

1. Review of Resident #22's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/8/24 showed:
- Long and short term memory problems;
- Lower extremities impaired on both sides;
- Dependent on the assistance of staff for toilet use, showers, dressing, personal hygiene and transfers;
- Diagnoses included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), progressive neurological disorder (condition where there is a progressive deterioration in functioning), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and dementia (inability to think).

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Review of the resident's care plan, revised 10/22/24 directed staff the resident's code status was a do not resuscitate and the resident wanted to have his/her wishes honored.

Review of the resident's face sheet showed the responsible party was the resident's spouse.

Review of the resident's medical record showed:
- The resident's spouse signed the purple OHDNR form on 6/6/24 and the physician signed it on 6/5/24;
- Unable to locate the resident's incapacitation letter in the resident's medial record.

During an interview on 12/11/24 at 2:53 P.M., the Social Services Director (SSD) said he/she was looking for the resident's advance directives and the incapacitation letter.

During an interview on 12/12/24 at 9:41 A.M., the SSD said she found the resident's advance directive but was unable to locate the resident's incapacitation letter.

During an interview on 12/13/24 at 10:52 A.M., the Director of Nursing (DON) said if a resident was not their own person and had a DPOA in place, she would expect there to be an incapacitation letter in the residents medical record.

2. Review of Resident #18's Quarterly Minimum Data Set, dated 11/26/24, showed:
- Severe cognitive impairment;
- Dependent on staff for activities of daily living (ADLs);
- Frequently incontinent of bowel and bladder;

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- Diagnoses included Alzheimer's disease, aphasia (disorder that makes it difficult to communicate), and high blood pressure.

A review of the resident's care plan dated 12/2/24 showed:
- The resident has an ADL self care performance deficit related to limited mobility;
- DNR (Do Not Resuscitate) code status.

Review of the resident's medical record showed:
- Physician's order dated 12/25/22: DNR code status;
-OHDNR (Out of Hospital Do Not Resuscitate) signed by the resident's husband and physician on 12/3/22;
-No DPOA paper work was found;
-No letter of incapacitation was found.

During an interview on 12/12/24 at 11:45 A.M., the SSD said:
-The resident should have a letter of incapacity;
-If a resident is deemed incapacitated there should be a letter with that information;
-DPOA and incapacitation information should be obtained at admission and placed in the resident's chart;
-He/she could not locate the resident's DPOA or incapacity letter.

3. Review of Resident #295's Face Sheet (a document meant to be a quick summary of a resident's essential information) showed:
-The resident is his/her own person (there is no other person assigned by the resident or the courts that would be responsible for making the resident's healthcare and/or end-of-life decisions).
-The resident's Code Status is listed as

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"unknown."
-The Advanced Directive reads the resident's code status is listed as DNR.

Review of Resident #295's medical record showed:
-The resident had a Basic Interview for Mental Status (BIMS) score of 14, indicating the resident is cognitively intact and capable of making his/her needs and desires known.
-The resident signed a Code Status Form dated 12/04/24 and checked the DO NOT RESUSCITATE box. The form was witnessed by LPN C.
-The resident's New Admission Report Sheet, completed by an unknown staff member, lists the resident's code status as "Full Code."
-The resident's Medication Administration Record lists the resident's Advance Directive status as both a Full Code and a DNR.

Review of Resident #295's care plan updated 12/04/2024 directed staff the resident was to be a FULL CODE.

Review of Resident #295's Physician Orders showed a DNR, order dated 12/04/24.

During an interview on 12/10/24 at 2:34 P.M., Resident #295 said he/she has a DNR and he/she expects his/her wishes to be honored.

During an interview on 12/11/24 at 8:25 A.M., LPN C said:
-If a resident is a DNR, there would be a butterfly sticker on the back of their door. Plus, they would have a purple DNR sheet in the book at the desk.
-Resident's Advance Directive paperwork can be found on the computer.

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F 578	Continued From page 6 -A resident's code status is listed in their care plan, on their face sheet, in provider orders. -The code status listed in all these places are the same. During an interview on 12/13/24 at 7:55 A.M., LPN B said: -If a resident is a DNR, it would be in the binder at the desk or "all over in their chart." -A resident's code status "should be the same" in each place in their chart. During an interview on 12/13/24 at 10:52 A.M. the Director of Nursing (DON) said: -If a resident is a DNR status, they would have a physicians order in the computer as well as a DNR form completed in the binder located at each nurse's station. -A resident's advanced directive can be found in the computer on the physician's order sheet, on the face sheet, and when the Medication Administration Record (MAR) is pulled up. -A resident's code status is listed in their care plan. -The code status in the care plan should match the code status in the provider's orders. During an interview on 12/13/24 at 10:52 A.M., the Administrator said: -A resident's code status is expected to be the same throughout their chart. -Whatever code status is listed in the provider's orders should be the code status in the care plan.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		

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comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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Based on observation and interviews, the facility failed to maintain a clean, comfortable, and homelike environment when the facility failed to maintain and replace holes in carpet, vacuum and sweep floors, clean stained furniture, repair scraped and missing paint from walls, clean and maintain food and medication carts, replace stained ceiling tiles, and clean facility windows. The facility census was 40.

Review of facility policy, Cleaning and Infection Control of Non-Critical, Reusable Resident Care Equipment, undated, showed:
-Cleaning-the physical removal of foreign material, e.g. dust, oil, organic material such as blood, secretions, excretions, and micro-organisms
-Cleaning reduces or eliminates the reservoirs of potential pathogenic organisms
-Cleaning is accomplished with water, detergents/sanitizers, and mechanical action;
-Cleaning is a shared responsibility between nursing and housekeeping departments;
-All equipment must be cleaned immediately if visibly soiled, and immediately after use on elders with contact precautions regardless of cleaning schedule;
-All neighborhoods will set up a schedule for cleaning with specific assignments to ensure tasks are completed;
-All horizontal and frequently touched surfaces will be cleaned daily and immediately when soiled;
-The Housekeeping manager and the Infection Practitioner must approve all products used for the stages of cleaning/disinfection process;

Review of facility policy, quality of care, undated, showed:

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-Facility is committed to providing high quality of care and services to residents in a safe, respectful, and person-centered environment.
-Safety and Security
-Ensuring the safety and security of residents is paramount;
-Facility adheres to all relevant safety protocols, infection control measures, and emergency procedures to maintain a secure environment.

Observation in the dining room on 12/10/24 at 11:29 A.M., showed several areas on all walls where the paint had been scrapped off and was missing from the walls showing white through the dark gray colored paint. One 8 inch by 3 inch area was noted on the back wall by the windows.

Observation on 12/10/24 at 12:14 P.M. showed a three tiered metal cart was being used to deliver resident meal trays. The cart was observed to have sticky food like substance caked to the bottom rim of the metal cart unit. The wheels on cart were also observed to be caked in dirt.

Observation on 12/11/24 at 8:29 A.M. showed sitting area by patio on east hall had food crumbs located under all four chairs in seating area and the end tables.

Observation on 12/11/24 at 8:33 A.M. showed the floor on east hall nurses station had food crumbs, pieces of torn paper, paper clips, and other particles laying on floor.

Observation on 12/11/24 at 8:34 A.M. of medication cart on east hall showed the wheels on medication cart were covered and wrapped with appeared to be human hair. The ledges of the bottom of the medication cart also had grime

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and dirt built up.

Observation on 12/11/24 at 8:35 A.M. showed a discolored ceiling tile above sitting area on east hall by patio.

Observation on 12/11/24 at 8:37 A.M. showed on east hall there was a 4 inch by 1 inch area that was missing carpet where the blue carpet met white carpet. Areas of frayed carpet were also sticking up where the area of carpet was missing.

Observation on 12/11/24 at 8:40 A.M. showed windows on east hall between room 2018 and 2017 had dirt built up between the screens.

Observation on 12/11/24 at 8:43 A.M. showed the stairwell exit door between resident rooms 2018 and 2017 had a spilled sticky substance on it.

Observation on 12/11/24 at 8:45 A.M. showed the pillar in the dining area across from room 2004 had a spilled brown sticky substance on it.

Observation on 12/11/24 at 8:49 A.M. showed the white portions of the carpet in the living room area had stains on it.

Observation on 12/12/24 at 9:00 A.M. showed crumbs remained under chairs and end tables in on carpeted seating area by the patio on the east hall.

Observation on 12/11/24 at 2:23 P.M., showed a PTAC (packaged terminal air conditioner) unit with a black mold-like substance on the fins of the heating/cooling unit in the janitor's closet by room 1006.

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Observation on 12/10/24 at 9:59 A.M. showed:
-A window at the end of the rehab hallway, between resident #294's room and the room across the hall, with grime and debris cracked around its edges.
-Resident #296 walking in the rehab hallway with a therapy staff member . The resident was overhead saying, "That window needs to be cleaned, it looks disgusting!"

Observation on 12/10/24 at 9:59 A.M. showed:
-A chair at the end of the rehab hallway, between resident #294's room and the room across the hall, with stains on the seat.

Observation on 12/11/24 at 2:19 P.M. showed a hole in the carpet in resident #21's room. The hole measured approximately one (1) inch by six (6) inches. The hole had frayed carpet around the edges and was directly in the walking path in front of the bathroom door and posed a trip hazard.

During an interview on 12/12/24 at 9:59 A.M., Housekeeping Supervisor said:
-Maintenance was responsible to fix and repair walls;
-The facility was currently understaffed with only four staff members in housekeeping for whole building;
-The floor technician was responsible for vacuuming, maintaining floors, windows, and furniture in facility;
-Due to the vacant position of floor technician the facility vacuuming and maintenance of the floors had been overlooked by his/her staff;
-His/Her staff was primarily responsible for cleaning of the resident rooms;
-The facility floor technician quit and facility had

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been without a floor technician for approximately a week;
-He/She had her staff assist with the floor technician duties following completion of resident rooms;
-If residents complained about the noise of the vacuum then he/she expected his/her staff to wait until resident was out of their room to vacuum or respect resident wishes and desires to keep the area quiet and not vacuum but try to hit the area with a broom;
-He/She expected his/her staff to deep clean every day;
-He/She expected his/her staff to respect resident wishes, if a resident did not want housekeeping in their room he/she expected staff to listen;
-Housekeeping staff were expected to clean areas that floor technician missed and furniture in main areas;
-The materials found on chairs in halls were cleaned with a steam cleaners;
-Housekeeping staff were not allowed to clean the chairs due to risk of spotting the furniture;
-He/She communicated with maintenance staff and floor technicians via email if he/she found area that needed addressed;
-Resident rooms that were occupied by residents were cleaned daily;
-If a room did not get cleaned one day then it was scheduled to be cleaned first the next day;
-He/She expected his/her staff to clean resident's bathrooms first and then work their way out of the room by dusting, wiping down furniture items, and attending to the floor;

During an interview on 12/13/24 at 9:06 A.M., Assistant Director of Nursing (ADON) B said:
-The facility used a website for communication needs that were to be addressed by

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maintenance;
-Nurses and facility administration had access to communicate maintenance needs via the website;
-Certified nurses aids are to communicate any maintenance requests to nursing staff and nursing staff are to log the request for maintenance on the website.

During an interview on 12/13/24 at 9:10 A.M., Maintenance Technician said:
-He/She received work orders through the website work hub;
-He/She was able to obtain supplies needed really quickly if did not have them in facility;
-He/She was aware of holes in carpet, there is current plans to replace carpet in main areas;
-He/She was currently working on resident room needs as first priority;
-Facility had a floor technician responsible for cleaning and maintaining facility floors;
-The floor technician position had been vacant for approximately one week;
-He/She was responsible for wall repairs;
-He/She was aware of repair needs required in dining room;
-He/She had to get painters from other facility building to come in and paint in dining room.

During an interview on 12/13/24 at 10:52 A.M., Administrator said:
-She expected to provide a safe, clean, and home like environment for residents;
-She expected food carts for room trays to be cleaned and sanitized;
-She did not expect food carts to have food and other substances caked to bottom of carts;
-She expected floors to be free from holes in carpets and trip hazards;

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F 584	Continued From page 14 -She expected facility floors to be free from debris, crumbs, and stains; -She expected facility floors to be vacuumed; -She expected walls to be maintained with dry wall patches made and walls painted; -She expected furniture to be free from stains and break down.	F 584		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and	F 607		

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F 607	Continued From page 15 (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a criminal background check for for five of 10 sampled employees prior to employment start date and evaluate for history of abuse, neglect, exploitation, or misappropriation of resident property in order to prohibit and prevent such abuse, consistent with the applicable requirements at subsection §483.12(a)(3). The facility census was 40. The facility's Abuse, Neglect, and Exploitation Policy stated: - McCrite Plaza at Briarcliff has developed and implemented this policy and procedure to prohibit abuse, neglect, exploitation, or misappropriation of property by any perpetrator including but not exclusive to any staff member or volunteer of this facility or any contracted agency staff, vendors, another resident, family member, or visitors of the resident or other residents. - The purpose of the components of this policy is to ensure that all residents of this facility will be free of physical, emotional, and sexual abuse, neglectful treatment and misappropriation of funds and resources. -The accompanying procedures are employed to assure total staff adherence to this policy. -The objective of the Abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. -Overview of seven components: Screening, Training, Prevention, Identification, Investigation, Protection, Reporting and Response. -It is the policy of McCrite Plaza at Briarcliff to screen residents prior to moving into the facility as well as employees and volunteers prior to	F 607		

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working with residents.
-Screening of employee and volunteer components include verification of references, certification and verification of license, criminal background checks, and query of the Family Care Safety Registry.
-All potential employees' names will be submitted to Validity Background Checks prior to their employment.

Review of the facility's New Hire employee packets reviewed for Employee Disqualification List (EDL), Criminal Background Check (CBC) and Federal Indicator Checks showed:
-Five of the 10 employees randomly selected had a date of hire prior to the date CBC results were received.
-Maintenance Employee A was hired on 11/07/24. His/Her CBC results were received by the facility on 11/21/24.
-Cook C was hired on 10/03/24. His/Her CBC results were received by the facility on 10/07/24.
-CNA G was hired on 08/08/24. His/Her CBC results were received by the facility on 08/15/24.
-Housekeeper A was hired on 07/11/24. His/Her CBC results were received by the facility on 07/15/24.
-Activity Assistant A was hired on 10/11/24. His/Her CBC results were received by the facility on 06/03/24.

During an interview on 12/13/24 at 10:52 A.M., the DON said:
-An employee's hire date is their first day of orientation.
-All background checks are completed by HR/Staffing Coordinator.

During an interview on 12/13/24 at 10:52 A.M.,

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F 607	Continued From page 17 the Administrator said: -An employee's hire date is their first day of orientation. -HR ensures all new employees have ben through the EDL, Nurse Aid Certification Check, and runs background checks.	F 607		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to provide services that met professional standards of quality when staff failed to recognize and report significant weight loss and/or gain. This affected four of the 12 sampled residents (Resident #28, Resident #295, Resident #244, and Resident #294). Facility census was 40. The facility's policy for Monitoring Weights stated: -All residents will be evaluated for weight stabilization and timely identification of weight loss. -Significant weight loss will be defined as: 3% loss in one week, 5% loss in 30 days, 7.5% loss in 90 days, and/or 10% loss in 180 days. -The physician, resident, and/or legal representative will be notified immediately (within 24 hours) of any resident meeting the definition of significant weight loss in this policy and informed on the interventions implemented. -Any resident with significant weight loss will be	F 658		

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referred to the Registered Dietician Nutritionist (RDN) for recommendations.
-The recommendations of the RDN will be communicated to the resident's primary care physician and family upon receipt of the recommendations.
- The policy does not address significant weight gain.

The facility's Role of Registered Dietician policy showed the Registered Dietician (RD) will be notified of weight changes weekly either in person, by phone conference, or by fax with a specific request for individualized recommendations.

The facility's Preventive Maintenance and Inspection policy stated:
-Resident weight scales will be calibrated by a licensed outside contractor quarterly and as needed due to use, wear, and tear.
-The facility did not provide the requested scale calibration/inspection logs.

1. Review of Resident # 28's undated Care Plan showed:
- The resident requires extensive assistance from staff for most activities of daily living (ADLs) including toileting and transfers.
- The resident has a diagnosis of Diabetes. Staff are expected to monitor for signs and symptoms of hyperglycemia (elevated blood sugar), one of which is weight loss.
- The resident is taking an antibiotic, which puts him/her at risk for experiencing anorexia (a lack of interest in food and/or eating). Staff are expected to monitor for side effects of this medication every shift.
- The resident has a nutritional problem related to

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moderate malnutrition, diabetes, and Parkinson's disease. Staff are expected to monitor/record/report to the doctor (MD), signs and symptoms of malnutrition, including significant weight loss.
- The resident is at risk for dehydration or potential fluid deficit related to diuretic use. Staff are expected to monitor/record/report to the MD, signs and symptoms of dehydration, including recent/sudden weight loss.

Review of Resident #28's medical record showed:
- On 11/04/24, Resident #28 weighed 173.1 lbs.
- On 11/20/24, he/she weighed 142.0 lbs. This calculated to a loss of 31.1 lbs., or 18% in 16 days.
- On 11/24/24, Resident #28 weighed 136.2 lbs. This calculated to a loss of another 5.8 lbs., or 4.1% in four days.
- On 11/25/24, Resident #28 weighed 139.0 lbs.
- On 12/02/24, Resident #28 weighed 138.6 lbs.
- On 12/09/24, Resident #28 weighed 137.6 lbs.
- In total, Resident #28 lost 35.5 lbs. between 11/04/24 and 12/09/24, or 20.5% in 35 days.
- The percentage of weight lost was calculated by the facility's electronic medical record program and the resulting calculation was visible to staff reviewing the resident's weights.
- No documentation of notification made to Resident #28's Primary Care Provider related to significant weight loss.
- No documentation of notification made to the RD related to specific request for individualized recommendations.

2. Review of Resident #295's Care Plan, revised 12/04/24 showed:
- The Resident had a diagnosis of Diabetes and

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staff are expected to monitor for signs and symptoms of hyperglycemia (elevated blood sugar), one of which is weight loss.
- He/She has a potential for nutritional problems related to immobility due to fractures/pain. Staff are expected to monitor/report to the doctor (MD) as needed, signs and symptoms of malnutrition, including significant weight loss.
- Is taking two antidepressant medications, Venlafaxine and Mirtazapine. Staff are expected to monitor/document/report to the MD, signs and symptoms of on going depression unaltered by the prescribed medications, which include changes in weight.

Review of Resident #295's December Physician Orders showed:
- Order Date: 12/04/24, Monitor for side effects, adverse reactions, and behaviors related to antidepressants, anxiolytics (anti-anxiety medications), hypnotic (sleeping medication), and psychotropic medications (medications used for some mental health conditions). Notify Practitioner of and chart any adverse reaction, side effect, or behavior.
- Order Date: 12/04/24, Weigh weekly on Monday, change to daily if Congestive Heart Failure (CHF), new diuretic, etc. Notify provider for loss or gain five lbs. or more in seven days. Every day shift every Monday.

Review of Resident #295's medical record showed:
- On 12/04/24, Resident #295 weighed 188.0 lbs.
- On 12/04/24, a Nutritional Assessment was completed on Resident #295. In this assessment staff documented that Resident #295 was at risk for malnutrition.
- On 12/05/24, a second Nutritional Assessment

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was completed on Resident #295. Again, staff documented that the resident was at risk for malnutrition.
- On 12/09/24, Resident #295 weighed 176.2 lbs. This calculated to a loss of 11.8 lbs., or 6.2% in five days.
- On 12/10/24, a third Nutritional Assessment was completed on Resident #295. In this assessment staff documented that they did not know if the Resident had any weight loss in the last three months and left the assessment incomplete, failing to document a completed nutritional status on the resident.
- The percentage of weight gained and lost was calculated by the facility's electronic medical record program and the resulting calculation was visible to staff reviewing the resident's weights.
- No documentation of notification made to Resident #295's Primary Care Provider related to significant weight loss.
- No documentation of notification made to the RD related to specific request for individualized recommendations.

3. Review of Resident #244's undated Care Plan showed:
- The resident is receiving the antidepressant medication duloxetine relating to depression. Staff are expected to monitor/document/report to the doctor (MD), signs and symptoms of depression unaltered by the prescribed medication, one of which is changes in weight.
- The resident is at risk for psychosocial well-being problems related to social isolation. Staff are expected to monitor/document/report to the MD, signs and symptoms of depression.
- The resident is at risk for nutritional problems related to impaired mobility and risk for malnutrition. Staff are expected to

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monitor/document/report to the MD, signs and symptoms of malnutrition, including significant weight loss.

Review of Resident #244's medical record showed:
- On 11/12/24, Resident #244 weighed 146.0 lbs.
- On 11/20/24, Resident #244 weighed 139.1 lbs. This calculated to a loss of 6.9 lbs., or 4.7% in seven days.
- On 11/27/24, Resident #244 weighed 140.0 lbs.
- On 11/27/24, a Nutritional Assessment was completed on Resident #244. In this assessment staff documented that Resident #244 had a normal nutritional status, with no weight loss during the last three months.
- On 11/28/24, a Comprehensive Nutritional Assessment was completed on Resident #244. In this assessment staff documented that Resident #244's weight history was not applicable, the resident had no weight change, and that the RD had no recommendations at this time.
- On 12/02/24, Resident #244 weighed 146.2 lbs. This calculated to a gain of 6.2 lbs., or 4.4% in five days.
- The percentage of weight gained and lost was calculated by the facility's electronic medical record program and the resulting calculation was visible to staff reviewing the resident's weights.
- No documentation notification was made to Resident #18's Primary Care Provider related to significant weight fluctuations.
- No documentation notification was made to the RD related to specific request for individualized recommendations.

4. Review of Resident #294's undated Care Plan showed:
- Resident had potential for nutritional problem

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related to impaired balance and mobility. Staff are expected to monitor/record/report to the doctor (MD), signs and symptoms of malnutrition including significant weight loss.
- Resident had potential for fluid deficit related to diuretic (a medication used to flush fluids from the body) use. Staff are expected to monitor/record/report to the MD, signs and symptoms of dehydration including recent/sudden weight loss.
- Resident had a diagnosis of Diabetes and staff are expected to monitor for signs and symptoms of hyperglycemia (elevated blood sugar), one of which is weight loss.

Review of December Physician Orders showed:
- Start Date: 12/07/24 Torsemide Oral Tablet 20 milligrams (mg) Give one tablet by mouth every 24 hours as needed for diuretic related to unspecified diastolic congestive heart failure (a chronic condition that causes the heart to pump blood less effectively than it used to) administer an additional 20 mg for weight gain of two-three lbs. in one day or five lbs. in one week.
- Start Date: 12/07/24 Torsemide Oral Tablet 20 mg Give one tablet by mouth in the morning related to unspecified diastolic congestive heart failure.

Review of December's Medication Administration record showed:
- The resident was not administered any "as needed" doses of Torsemide for weight gain between 12/01/24 to 12/13/24
- On 12/08/24 a "one time only" dose of Torsemide 20 mg was administered to the resident for shortness of air (SOA)/congestion.

Review of the medical record showed:

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F 658	Continued From page 24 - On 12/06/24, Resident #294 weighed 211.4 lbs. - On 12/08/24, Resident #294 weighed 208.4 lbs. This calculated to a loss of 3.0 lbs. in two days. - On 12/10/24, Resident #294 weighed 200.2 lbs. This calculated to a loss of 8.2 lbs., or 3.9% in two days. - In total, Resident #294 lost 11.2 lbs., or 5.29% in four days. - The percentage of weight loss was calculated by the facility's electronic medical record program and the resulting calculation was visible to staff reviewing the resident's weights. - No documentation notification was made to Resident #294's Primary Care Provider related to significant weight loss. - No documentation the provider was made aware of the resident's 3.0 lbs. weight loss prior to administration of the ordered onetime only dose of Torsemide. - No documentation notification was made to the RD related to specific request for individualized recommendations. During an interview on 12/11/24 at 8:25 A.M., LPN C said: - Residents are weighed before breakfast. - If a resident has to be weighed in their wheelchairs, the weight of the wheelchair and whether or not the wheelchair should have the peddles on or off while weight is being obtained, is written on the back of the wheelchair. The weight of the wheelchair is then subtracted from the total weight obtained with the resident in the wheelchair on the scale. -Scales are checked and calibrated regularly but he/she's not sure by whom. He/She thinks it's done by an outside company. -He/She is unaware of any residents currently on the floor with weight loss or weight gain concerns.	F 658		

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-If a resident gains or loses three lbs. in 24 hours or five lbs. in one week, staff is supposed to call the doctor.
-If staff contacts the doctor it is charted in PCC (the facility's electronic medical record program)
-Residents taking diuretics are supposed to be weighed daily.

During an interview on 12/11/24 at 9:12 A.M., Speech Language Pathologist A said:
-Speech works with the facility's nutritionist and follows the resident's weight.
-He/She is not aware of any residents with a weight gain or weight loss concerns.

During an interview on 12/11/24 at 8:44 A.M., Maintenance Technician said:
-The Maintenance department checks and calibrates scales annually.
-Scale checks and calibrations are documented in the maintenance log/compliance book.
-He/She doesn't know when scales were last calibrated.

During an interview on 12/13/24 at 7:52 A.M. DM A said:
-Nutritional Assessments are completed by him/her or another dietary manager.
-Comprehensive Nutritional Assessments are completed by the RD.
-He/She isn't sure if nutritional assessments are reviewed by nurses or doctors.

During an interview on 12/13/24 at 10:52 A.M. the DON said:
-There are two Dietary Managers employed with the facility and each of them has a food manager's certification.
-Dietary Manager Assessments are completed by

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F 658	Continued From page 26 the Registered Dietician (RD). -Nutritional Assessments are reviewed by nurses during risk meetings. -If a resident's nutritional assessments or weight shows a decline over time, it would be expected that the dietician and a dietary manager would discuss different processes to be put in place. -Both CNAs and Nurses weigh residents. -Scales are checked and calibrated quarterly. -A total of three pounds gained or lost in one day or five pounds gained or lost in one week would require a call to the Provider. -When a resident is identified as having a significant weight gain or loss they are discussed each week. -An order for a diuretic would not change the parameters laid out in the facility's policy for what would be considered significant weight gain or loss and if those parameters are met, it is expected that staff would contact the provider. During an interview on 12/13/24 at 10:52 A.M. the Administrator said: -Dietary Managers are expected to complete Nutritional Assessments and the RD is expected to complete Comprehensive Nutritional Assessments weekly. -Nutritional Assessments are expected to be completed with 24-48 hours after admission. -Scales are checked and calibrated by an outside company. -Wheelchairs are expected to be weighed each time residents requiring wheelchairs are weighed.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		

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services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene when staff did not provide complete perineal care which affected four of 12 sampled residents, (Resident #18, #27, #22 and #14). The facility census was 40.

Review of the facility's undated Perineal Care Protocol Policy showed:
-Perineal care is very important in maintaining the resident's comfort and should be completed after each incontinent episode;
-Provide privacy;
-Perform hand hygiene;
-Separate all skin folds and cleanse all perineal areas;
-Turn resident to the side and wash perineal area buttocks cleaning all areas;
-Reposition the resident;
-Perform hand hygiene.

Review of the facility's undated policy for indwelling catheter protocol, showed:
- Procedure for care of an indwelling urinary catheter:
- Clean the perineal area and catheter tubing proximal to distal, with warm, soapy water or a disposable cleansing wipe followed by rinsing the area twice daily and after every bowel movement;
- Retract the skin fold and the area washed thoroughly, rinse well and replace the skin fold

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1. Review of Resident #18's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/26/24, showed:
- Severe cognitive impairment;
- Dependent on staff for activities of daily living (ADLs);
- Frequently incontinent of bowel and bladder;
- Diagnoses included: Alzheimer's disease, aphasia (disorder that makes it difficult to communicate), and high blood pressure.

A review of the resident's care plan dated 12/2/24 showed:
- The resident has an ADL self care performance deficit related to limited mobility;
-The resident is dependent on staff for personal hygiene and toileting.

Observation on 12/12/24 at 08:37 A.M., showed:
-The resident in bed;
- Certified Nurses Aide (CNA) A and CNA D removed the resident's brief;
- CNA A washed hands and applied clean gloves and used one wipe to clean under the resident's abdominal fold;
-CNA A used one wipe to clean down the left groin and a different wipe to clean down right groin;
-CNA A used a wipe and wiped down the front of the resident and did not spread the skin and clean all areas that urine or feces had touched;
-CNA A and CNA D turned the resident on his/her side and CNA D used a wipe and cleaned the back of the resident;
-CNA D did not clean all areas that urine or feces had touched;
-CNA A and CNA D washed hands and applied clean gloves and placed a clean brief on the

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resident;
-CNA A and CNA D failed to provide complete perineal care to the resident when they did not spread the skin and clean all areas that urine or feces had touched.

During an interview on 12/12/24 at 9:05 A.M., CNA A said:
-A different wipe should be used for each cleansing motion when doing peri care;
-All areas that urine or feces have touched need to be cleaned;
-Staff should spread and clean all areas and skin folds that urine or feces have touched.

During an interview on 12/12/24 at 9:09 A.M., CNA D said:
-One wipe one swipe is how peri care should be completed;
-Staff should spread the skin to clean the front and make sure they clean all areas of the back that urine or feces came in contact with.

2. Review of Resident #27's Quarterly MDS, dated 9/9/24, showed:
- Severe cognitive impairment;
- Substantial assistance from staff for ADLs;
- Always incontinent of bowel and bladder;
- Diagnoses included: Alzheimer's disease, depression and anxiety.

A review of the resident's care plan dated 11/22/24 showed:
-The resident requires extensive assistance with ADLs;
-The resident has bladder incontinence related to Alzheimer's disease.

Observation on 12/12/24 at 10:45 A.M., showed:

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- Registered Nurse (RN) A and CNA F transferred the resident to the toilet and removed the resident's brief;
- CNA F washed hands and applied clean gloves and cleaned the backside of the resident;
- CNA F washed hands and applied clean gloves and cleaned under the resident's abdominal fold and left and right groin, using a new wipe for each cleansing;
-CNA F cleaned the front of the resident and did not spread the skin and clean all the areas that urine or feces had touched;
- CNA F and RN A washed hands and applied clean gloves and put a clean brief on the resident;
-CNA F did not provide complete perineal care to the resident when he/she did not spread the skin and clean all areas that urine or feces had touched.

During an interview on 12/12/24 at 10:52 A.M., CNA F said staff should spread and clean all areas and skin folds that urine or feces have touched.

During an interview on 12/12/24 at 10:59 A.M., RN A said:
- A new wipe should be used each time staff clean;
- Staff should spread and clean all areas and skin folds that urine or feces have touched.

During an interview on 12/13/24 at 10:52 A.M. the Director of Nursing (DON) said:
-He/she expects staff to separate skin folds and cleanse all areas that urine or feces have touched;
-Staff should not use the same area of the wipe to clean different areas of the skin;
-He/she expects staff to use one wipe per one

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swipe.

During an interview on 12/13/24 at 10:52 A.M. the Administrator concurred with the DON.

3.Review of Resident' #22's Quarterly MDS, dated 10/8/24 showed:
- Long and short term memory problems;
- Lower extremities impaired on both sides;
- Dependent on the assistance of staff for toilet use, showers, dressing, personal hygiene and transfers;
- Had a urinary catheter (sterile tube inserted into the bladder to drain urine);
- Always incontinent of bowel;
- Diagnoses included obstructive uropathy (a condition in which the flow of urine is blocked), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), progressive neurological disorder (condition where there is a progressive deterioration in functioning), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and dementia (inability to think).

Review of the resident's care plan, revised 10/22/24 showed:
- The resident required enhanced barrier precaution (EBP, gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO, multi-drug resistant organisms, resistant to one or more classes of antibiotics), as well as those at increased risk of MDRO acquisition). Don and doff gloves and gowns during high-contact cares. Perform proper hand hygiene. Use biohazard trash receptacles for disposal of EBP refuse;

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- The resident is on antibiotic therapy related to a urinary tract infection (UTI, an infection in any part of the urinary system). Administer medication as ordered;
- The resident has an indwelling catheter related to obstructive uropathy. Provide catheter care as needed;
- The resident required extensive assistance with activities of daily living (ADL). Extensive assistance of one staff for dressing. Extensive assistance of two staff for toilet use. Dependent on the assistance of two staff for transfers;
- The resident is at risk for bladder incontinence related to Alzheimer's disease. The resident used disposable briefs and staff should change as needed. Check the resident every two hours and as required for incontinent care.

Review of the resident's urinalysis (UA, a test to analyze urine contents), dated 11/29/24, showed the presence of bacteria indicative of a possible urinary tract infection (UTI).

Review of the resident's urine culture and sensitivity (UA with C & S, identifies the amount and type of bacteria present and the medications appropriate to treat the infection), dated 12/2/24, showed the presence of organisms indicative of a possible UTI.

Review of the resident's medication administration record, (MAR) dated December 2024, showed an order for Cefdinir dated 12/2/2024 for 300 milligrams (mg) one capsule twice daily for seven days for UTI.

Observation on 12/12/24 at 7:09 A.M., showed:
- CNA E entered the res room, did not don a gown or wash his/her hands and applied gloves;

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F 677	Continued From page 33 - LPN A entered the resident's room with the mechanical lift, did not don a gown or wash his/her hands and applied gloves; - CNA E unfastened the resident's brief; - CNA E did not anchor the catheter tubing and used the same area of the wipe and wiped down the catheter tubing; - CNA E did not separate and clean all the skin folds; - CNA E and LPN A turned the resident on his/her side; - CNA E cleaned the buttocks and applied a house barrier cream to the resident's buttocks and placed a clean incontinent brief under him/her; - CNA E removed his/her gloves, did not wash his/her hands and applied gloves; - LPN A And CNA E turned the resident side to side and removed the wet incontinent brief and placed a clean incontinent brief under him/her; - LPN A removed his/her gloves and did not wash his/her hands; - CNA E removed gloves, did not wash his/her hands and applied gloves; - CNA E placed the graduate (a graduated cylinder or container used to collect and measure urine) in a gray basin, unclamped the drainage bag and emptied 250 milliliters (mls.) of urine into the toilet; - CNA E did not clean the port before or after emptying the urine; - CNA E removed gloves and did not wash his/her hands; - CNA E and LPN A used the mechanical lift and transferred the resident from his/her bed to the broda chair (a type of reclining geri-chair); - CNA E washed the resident's face and hands and combed his/her hair; - CNA E did not offer or provide oral care;	F 677		

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F 677	Continued From page 34 - LPN A and CNA E washed their hands. During an interview on 12/12/24 at 2:39 P.M., CNA E said: - The catheter tubing should be anchored close to the insertion cite; - The port of the drainage bag should be cleaned with an alcohol wipe; - Should separate and clean all areas of the skin folds; - Should not use the same area of the wipe to clean different areas of the skin; - Should wear a gown and gloves with a resident who had a wound or a catheter; - If you can't wash your hands, should sanitize when you enter the resident's room and between glove changes. Should wash your hands before you leave the room. During an interview on 12/12/24 at 2:57 P.M., LPN A said: - Should separate and clean all areas of the skin where urine or feces had touched; - Should not use the same area of the wipe to clean different areas of the skin; - Should sanitize your hands when you enter the resident's room. Wash your hands after you're done with cares. He/she thought you should wash your hands after sanitizing your hands. Should wash your hands or sanitize between glove changes and before you leave the room. During an interview on 12/13/24 at 10:52 A.M., the DON said: - When staff get the resident up in the morning, the staff should brush the resident's teeth or offer oral care, make sure their hair is brushed or combed, offer hearing aides; - Staff should separate and clean all the skin folds	F 677		

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and staff should not use the same area of the wipe to clean different areas of the skin.

4. Review of Resident #14's undated Care Plan showed:
-Staff were expected to maintain the resident's dignity at the highest level.
-The resident required extensive assistance with activities of daily living (ADLs).
-The resident required one - two staff members assistance with toileting.
-Resident had bladder and bowel incontinence related to dementia, parkinson's disease, and impaired mobility and wore disposable briefs.
-Staff were expected to check and change the resident every two hours.
-Staff were expected to wash and dry the resident's perineal area with each incontinent episode.

Observation of Resident #14's peri care performed by CMT B and CNA A on 12/11/24 at 10:31 A.M. showed:
-After removing the resident's soiled brief, staff used a wet wipe to clean a across the resident's pubic bone and down the center of the genitals. Staff failed to clean the skin folds on either side of the genitals.
-After running out of gloves, CNA A left the room to get more.
-While cleaning the resident's bottom, CNA A's gloves became soiled with fecal matter along the outer side of his/her left pinky finger. CNA A failed to remove the soiled gloves and/or complete hand hygiene.

During an interview on 12/13/24 at 10:52 A.M., the Administrator and the Director of Nursing (DON) both agreed and said:

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F 677	Continued From page 36 -Staff are expected to separate and clean skin folds during peri care. -Staff are expected to complete hand hygiene before and after all resident cares.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff provided quality of care and treatment in accordance with professional standards of practice when staff failed to reposition one resident and additionally failed to follow physician's orders for this resident to be laid down after lunch (Resident #14's). This affected one resident out of twelve sampled residents. The facility census was 40. Review of facility policy, Safe Lift, Transfer, and Repositioning Policy, undated, showed: -Transfer and mobility assistance as well as other resident handling and movement tasks will be carried out in accordance with comprehensive nursing and therapy assessments, the Minimum Data Set (MDS) (a federally mandated assessment tool completed by facility staff) and individualized comprehensive care plan, and written instructions pertaining to each individual	F 684		

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resident;
-Lifting, transferring, or repositioning assistance will be provided in accordance with the resident's care plan absent emergencies or exceptional circumstances.

1. Review of Resident #14's Annual MDS dated, 10/17/24, showed:
-He/She was severely cognitively impaired;
-He/She was dependent on a wheelchair;
-He/She required substantial/maximal assistance with personal hygiene, shower/bathing, upper body dressing, rolling to left and right mobility, sit to lying, lying to sitting, sit to stand, chair to bed transfer, toilet transfer, and tub/shower transfers;
-He/She was at risk of development of pressure ulcers;
-He/She used a pressure reducing device in chair and his/her bed;
-Care areas triggered included pressure ulcers;
-Diagnosis included dementia (a condition that causes decline in mental functioning such as ability to think, remember, and reason), Parkinson's disease (a progressive neurological disorder that causes nerve cells in the brain to die leading to movement problems), anxiety, depression, restless leg syndrome (a condition that caused an uncontrollable urge to move legs), muscle weakness, difficulty in walking, and cognitive deficit (a general term for impairments that affect a person's ability to think, learn, remember, and make decisions).

Review of care plan, revised 11/7/24, showed:
-Transfer: extensive assistance from two staff for transfers with gait belt to wheelchair; may use mechanical lift due to recent decline;
-Check him/her every two hours as required for incontinence.

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-Check and change every two hours and as needed.
-He/She had potential for pressure ulcer development due to immobility, dementia, and Parkinson's disease;

Review of physician's orders, dated 12/10/24, showed an order with a start date of 5/12/24 directing staff to lay the resident down after lunch to off load buttocks in the afternoon for skin integrity.

Review of nurses medication administration record (MAR), dated 12/11/24, showed:
-Start date 5/12/24, lay resident down after lunch to off load buttocks in the afternoon for skin integrity.
-Completed 12/1, 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10;

Observation on 12/10/24 at 10:00 A.M. showed resident was sitting up in his/her wheelchair.

Observation on 12/10/24 at 12:22 P.M. showed resident taken to his/her room. He/She was not laid down and remained up in wheelchair chair watching television in his/her room.

Observation on 12/10/24 at 2:03 P.M. showed resident remained up in his/her wheelchair.

During an interview on 12/10/24 at 2:18 P.M, Resident's representative said:
-He/She had a sore on his/her bottom;
-Resident had become stiff so facility started using a lift to transfer him/her;
-The facility staff now placed resident in a reclining wheelchair chair.

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Observation on 12/11/24 at 7:25 A.M. showed resident was up in his/her wheelchair sitting out in the living room.

Observation on 12/11/24 at 8:16 A.M. showed resident completed breakfast and was back in living room sitting in his/her wheelchair.

Observation on 12/11/24 at 10:05 A.M. showed resident remained in his/her wheelchair chair sitting in living room.

During an interview on 12/11/24 at 10:25 A.M., Certified Nurses Aide (CNA) A said Resident #14 had not been laid down since prior to going to breakfast;

Observation showed on 12/11/24 at 10:34 A.M. CNA A took resident in his/her room to be laid down and provided incontinent care.

During a continuous observation on 12/12/24 from 7:01 A.M.-11:34 A.M. showed:
-7:01 A.M., Resident up in his/her wheelchair leaning at 45 degree angle sitting in living room next to medication cart.
-8:43 A.M., Resident back in living room from going to dining room for breakfast, remained in wheelchair. He/She was sat in hallway next to nurses station in living room area.
-9:16 A.M., Resident wheeled to his/her room by Certified Medication Technician (CMT) A for medications, resident remained in his/her wheelchair chair
-9:23 A.M., Resident remained in his/her wheelchair in his/her bedroom;
-9:25 A.M., CMT A exited resident's bedroom
-10:30 A.M. Resident remained in his/her wheelchair;

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-10:52 A.M., Resident remained in his/her wheelchair;
-11:10 A.M., Hospice Registered Nurse (RN) arrived to facility to see resident, resident remained in his/her chair during hospice assessment and visit;
-11:34 A.M., Hospice RN wheeled resident to dining room for lunch;
-Staff did not provide incontinent cares or repositioned the reisdent from his/her wheelchair for three hours and thirty-three minutes.

During an interview on 12/13/24 at 7:36 A.M., Certified Medication Technician B said:
-He/She would expect residents to be repositioned every two hours;
-He/She expected residents in a wheelchair to be also be repositioned every two hours;
-He/She expected residents to be provided incontinent care and checked every two hours;

During an interview on 12/13/24 at 7:46 A.M., Licensed Practical Nurse (LPN) B said:
-He/She expected a resident to be repositioned every two hours or more frequently depending on resident specific surgical needs ;
-He/She expected Resident #14 to be repositioned every two hours, but if he/she is sore he/she would expect resident to be repositioned more frequently.

During an interview on 12/13/24 at 7:51 A.M., CNA B said:
-He/She expected residents to be repositioned every two hours and more frequently for residents who may be on Lasix (A diuretic that removes fluid from the body) when he/she would provide cares more frequently such as hourly;
-Resident #A should be laid down after every

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F 684	Continued From page 41 meal and repositioned every hour to alleviate pressure and prevent him/her from developing open wounds; -He/She would not expect Resident #14 to be up in the chair for four and 1/2 hours without being repositioned. During an interview on 12/13/24 at 8:18 A.M., Director of Nursing (DON) said: -He/she expected residents to be repositioned every two hours; -He/She expected Resident #14 to be repositioned; -Resident #14 helped by moving around a lot; -Resident #14 moved around a lot in his/her chair; -Staff often reposition Resident #14 when they move him/her from room to room; During an interview on 12/13/24 at 10:52 A.M., Administrator said: -He/She expected residents to be repositioned every two hours and as needed; -Some residents can reposition themselves and they will tell us when they are fine and not in need of repositioning; -When resident is not able to reposition themselves we do encourage every two hours turning or repositioning.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure staff used proper techniques when transferring four of the 12 sampled residents, (Resident #18, #27, #28, and #14) during the use of a mechanical lift, and additionally during the use of a gait belt transfer for resident #28. The facility census was 40.

Review of the facility's undated Use of Transfer Gait Belt policy showed:
- Gait belts will be used when transferring residents who are partially dependent and have some weight bearing capacity;
- Explain the procedure to the resident and place the gate belt around the resident's waist;
- Ensure the belt is securely fastened and cannot be easily undone;
- Staff members need to position one hand on either side of the gate belt with underhand grip and assist the resident forward.

Review of the facility's undated Transfer and Repositioning policy showed:
- It is the policy of the facility to provide safe and appropriate transfers of residents as to prevent injuries;
-All personnel are responsible for implementing this policy;
-Resident handling and movement tasks will be carried out in accordance with comprehensive nursing and the individualized care plans;
-Lifting equipment will be operated in accordance with manufactures instructions;
-Mechanical devices require two staff at all times.

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Review of the manufactures instructions for the sit to stand mechanical lift dated 2/16/16, showed:
-Transfer from the wheel chair:
-Push mechanical lift toward the resident;
-Open the base of the lift to go around the chair;
-Apply the brakes in both rear castors;
-Position the resident;
-Release the brakes, close the legs of the lift and transfer resident;
-Reverse the above procedure when lowering the resident to bed or chair.

Review of the undated manufacturer's guidelines for the mechanical lift showed:
- Do not lift a resident with the caster brakes on. Always let the lift find the correct center of gravity;
- Never perform a lift/transfer with the legs in the closed /transport position (front casters touching);
- When lifting, the casters should be left free and un-braked, so that the lift will then be able to move to the center of gravity of the lift. Do not apply the brakes unless parking the lift.

1. Review of Resident #18's Quarterly Minimum Data Set (MDS), A federally mandated assessment instrument completed by facility staff, dated 11/26/24, showed:
- Severe cognitive impairment;
- Dependent on staff for activities of daily living (ADLs);
- Diagnoses included Alzheimer's disease, aphasia (disorder that makes it difficult to communicate), and high blood pressure.

A review of the resident's care plan dated 12/2/24 showed:
- The resident has an ADL self care performance deficit related to limited mobility;

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- The resident is dependent on staff for transfers;
-The resident is dependent on staff for personal hygiene and toileting.

Observation on 12/12/24 at 08:37 A.M., showed:
-The resident was in bed;
-Certified Nurses Aide (CNA) A brought the mechanical lift into the resident's room;
-CNA A pushed the lift to the resident's bed;
-The legs of the lift were not spread and the breaks remained unlocked;
-CNA A and CNA D hooked the resident up to the sling pad;
-CNA A used the control and raised the resident off the bed;
-CNA D left the resident and went into the bathroom while CNA A was at the head of the lift opposite the resident;
-The resident was suspended in the lift with no staff stabilizing him/her;
-The resident was swinging back and forth in the lift;
-The staff failed to safely stabilize the resident while he/she was suspended in the lift.

During an interview on 12/12/24 at 9:05 A.M., CNA A said:
-There should be two nursing staff using the lift at all times;
-One staff member operates the controls of the lift and the other stabilizes the resident as they are raised by the lift and while being transferred.
-He/She should have stabilized the resident the entire time the resident was up in the lift.

During an interview on 12/12/24 at 9:09 A.M., CNA D said:
-It takes two staff to use the mechanical lift lift;
-One staff runs the control and one staff stabilizes

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the resident;
-He/she should not have left the resident unsupported in the lift.

During an interview on 12/12/24 at, 10:43 A.M., Licensed Practical Nurse (LPN) A said when a resident is suspended in the mechanical lift, staff should be stabilizing the resident by guiding the resident in the sling along with the lift.

2. Review of Resident #27's Quarterly MDS, dated 9/9/24, showed:
- Severe cognitive impairment;
- Substantial assistance from staff for mobility and transfers
- Diagnoses included: Alzheimer's disease, depression and anxiety.

Review of the resident's care plan dated 11/22/24 showed:
-The resident requires extensive assistance with ADLs;
- The resident requires extensive assistance with transfers;
-The resident has bladder incontinence related to Alzheimer's disease.

Observation on 12/12/24 at 10:45 A.M., showed:
-The resident was in his/her room in a wheelchair;
-CNA F locked both brakes of the resident's wheel chair;
-CNA F brought the sit-to-stand mechanical lift into the resident's room;
-CNA F spread the legs of the lift around the resident's wheel chair and locked the brake of the left rear castor;
-The right rear castor remained unlocked;
-Registered Nurse (RN) A and CNA F hooked the resident up to the lift pad;

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F 689	Continued From page 46 -CNA F raised the resident up in the lift and unlocked the left rear castor; -CNA F and RN A transferred the resident to the bathroom; -RN A locked the right rear castor on the lift; -The left rear castor remained unlocked; -RN A lowered the resident to the toilet; -CNA F provided peri care; -CNA F and RN A hooked the resident back up to the lift; -RN A unlocked the right rear castor; -The resident was moved back to the living room to his/her wheel chair; -RN A spread the legs of the lift and lowered the resident to the wheel chair; -RN A left both brakes of the rear castors unlocked while lowering the resident to the wheel chair; -CNA F and RN A unhooked the resident from the lift pad. During an interview on 12/12/24 at 10:52 A.M., CNA F said: -The only time time the brakes are to be locked is when the lift is parked; -He/she did not realize he/she only left one of the rear brakes unlocked; -Staff should leave the brakes of the lift unlocked while raising or lowering the resident. During an interview on 12/12/24 at 10:59 A.M., RN A said: -The brakes should be locked on the lift when raising or lowering a resident; -He/she did not realized he/she had only locked one break on the lift. 3. Review of Resident #28's Quarterly MDS dated 9/17/24, showed:	F 689		

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F 689	Continued From page 47 - Moderate cognitive impairment. - Required substantial assistance from staff with dressing and toileting; - Diagnoses included Parkinson 's Disease (a chronic brain disorder that causes movement problems, mental health issues, and other health concerns), high blood pressure, anxiety and depression. Review of the resident's care plan dated 9/20/24 showed: - The resident requires extensive ADL assistance; - The resident is at risk for falls related to Parkinson 's Disease. Observation on 12/13/24 at 8:45 A.M., showed: -The resident was in his/room setting in a wheelchair; -CNA C locked the wheelchair and placed the gait belt around the resident's waist; -CMT D and CNA A stood on each side of the wheelchair; -CNA C grabbed the front of the gait belt with his/her left hand and hooked his/her right arm under the residents left arm; -CMT D grabbed the front of the gait belt with his/her right hand and hooked his/her left arm under the residents right arm; -CNA A and CMT D lifted the resident and transferred him/her to the bed; -CNA A and CMT D failed to do a safe gait belt transfer when they hooked their arms under the resident's arms instead of grabbing the back of the residents gait belt. During an interview on 12/13/24 at 9:32 A.M., CMT D said he/she should have grabbed the back of the resident's gait belt instead of hooking the resident under his/her arm during the transfer.	F 689		

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During an interview on 12/13/24 at 9:40 A.M., CNA C said he/she should have grabbed the back of the resident's gait belt instead of hooking the reisdent under his/her arm during the transfer.

During an interview on 12/13/24 9:53 A.M., LPN A said:
- The gate belt should be placed around the resident's waist;
- Staff should grab the gait belt and not the resident when doing a gait belt transfer;
- Staff should never grab or put their arm under the resident's shoulder to transfer.

During an interview on 12/13/24 at 10:52 A.M. the Director of Nursing (DON) said:
-He/she expects staff to have two hands on the gait belt;
-No staff should be lifting underneath the arms of the resident;
-He/she expects the manufactures guidelines to be followed when using a mechanical lift;
-He/she expects the brakes to be unlocked while a resident is in the lift;
-He/she would expect staff to ensure they are stabilizing the resident who is up in the lift.

During an interview on 12/13/24 at 10:52 A.M. the Administrator concurred with the DON.

4. Review of Resident #14's Medical Record showed:
-Resident required extensive assistance from two staff members with all transfers. Staff are to use the mechanical lift for transfers due to the resident's recent decline.
-The resident is receiving hospice services due to

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end-stage Parkinson's disease (a disorder of the nervous system that affects movement and worsens over time).
-The resident's diagnoses include Unspecified Dementia (a general term for loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) Generalized Muscle Weakness
-The resident is at risk for falls due to deconditioning, It is the goal of the resident/resident's representative and the facility, that the resident remains free of falls.

Observation on 12/11/24 at 10:31 A.M. showed:
-Mechanical lift transfer of Resident #14 from his/her wheelchair chair to the bed, performed by CMT B and CNA A.
The residents bottom was hanging partially over the edge of the sling 's edge and the top edge of the sling was well above the resident's head, forcing his/her chin against his/her chest. This improper sling placement left the resident vulnerable to falling from the sling while in the air.
-Staff did not correctly position the resident in the sling prior to raising the sling with the mechanical lift. The resident's arms dangled from either side of the sling, leaving the resident vulnerable to potential impact injury during transfer.

During an interview following the transfer on 12/11/24 at 10:31 A.M., CNA A said he/she realized the resident was improperly placed in the sling but they had already begun moving the mechanical lift to the bed and he/she thought it was "just better to get him/her there quick."

During an interview on 12/13/24 at 10:52 A.M., the Director of Nursing (DON) and Administrator agreed:

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F 689	Continued From page 50 -Staff are expected to follow manufacturer guidelines when using mechanical lifts. -When staff use a mechanical lift to lift a resident in a sling, the staff are expected to position the resident correctly in the sling and keep the resident stable during the transfer.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff provided proper respiratory care when staff failed to date when oxygen tubing and water humidification bottles were exchanged out, and oxygen filters where changed (Resident #244, #28 and #11). This affected three of the 12 sampled residents. The facility census was 40. Review of the facility's Cleaning and Infection Control of Non-Critical, Reusable Resident Care Equipment policy, undated, showed: - Non-Critical Equipment are those items that either touch only intact skin but not mucous membranes or do not directly touch the elder; - Reusable Equipment is a device designed and tested by the manufacturer, that is suitable for reprocessing prior to use on a elder;	F 695		

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- All equipment must be cleaned immediately if visibly soiled;

Review of the facility's Oxygen Administration policy, undated, showed:
- Oxygen concentrators, cylinders and equipment will be kept and maintained in such a way as to be compliant with all relevant health and safety guidelines;
- Every shift check and clean oxygen equipment, masks, tubing and canulas;
Procedures:
- Display warning signs;
Care and use of oxygen concentrators:
- This equipment is supplied and maintained by the Durable Medical Equipment provider of the facility;
- No cleaning or documentation requirements were listed in the policy for this specific equipment;

1. Review of Resident #244's Admission Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 11/18/24, showed:
- Cognitive skills moderately impaired;
- Supervision for toileting, upper/lower body dressing, footwear, personal hygiene, and transfers;
- Diagnosis: Chronic Lung Disease, Cancer, Anemia (blood disorder), Atrial fibrillation (heart condition), Coronary artery disease (heart disease), Deep venous thrombosis (deep vein blood clots), Hypertension (high blood pressure), Cirrhosis (liver disease), Ulcerative Colitis (inflammatory bowel disease):

Review of the resident's care plan, revised 11/29/24, showed:

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- Resident has altered respiratory status/difficulty breathing, COPD (lung disease), emphysema, acute respiratory failure and asthma;
- Oxygen per physician order 12/2/24

Review of the resident's POS, dated December 2024 showed the resident did not have an order for oxygen therapy.

Observation on 12/11/24 at 7:45 A.M. showed:
- There is no date to indicate the last time that the oxygen tubing was cleaned or changed;
- The date next to the water canister on the oxygen concentrator reads 11/11/24 (greater than 30 days ago);

During an interview on 12/11/24 at 7:45 A.M., the resident said:
- While in the room they have not seen anyone clean or change out any of the oxygen equipment;
- Resident uses the oxygen concentrator continuously and gets light headed when not in use;

During an interview on 12/12/24 at 3:15 P.M., LPN B said the staff change out tubing and the humidifier canister on oxygen concentrators weekly and indicate the date on the tubing;
2. Review of Resident #11's Quarterly MDS, dated 11/22/24 showed:
- Cognitive skills severely impaired;
- Substantial to maximal assist with showers, dressing, personal hygiene and transfers;
- Always incontinent of bowel and bladder;
- Diagnoses included cancer, congestive heart failure (accumulation of fluid in the lungs and other areas of the body) and dementia (inability to think).

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Review of the resident's care plan, revised 12/10/24 showed:
- The resident had oxygen therapy related to shortness of air. If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (change from mask to nasal cannula). Return resident to usual oxygen delivery method after the meal;
- The resident is at risk for altered respiratory status, difficulty breathing related to respiratory failure, recent pneumonia and heart failure. Provide oxygen as ordered.

Review of the resident's POS, dated December 2024 showed the resident did not have an order for oxygen therapy.

Observation 12/10/24 at 10:44 A.M., showed:
- The resident did not have the nasal cannula in his/her nose;
- The filters on both sides of the oxygen concentrator was covered in gray lint.

Observation on 12/11/24 at 3:35 P.M., showed the filters on both sides of the oxygen concentrator were covered in gray lint.

During an interview on 12/11/24 at 2:51 P.M., Registered Nurse (RN) A said he/she only worked one day a week and was not for sure how often staff were supposed to clean the oxygen filters or when it was supposed to be done.

During an interview on 12/12/24 at 2:57 P.M., LPN A said:
- He/she did not know there were filters on the oxygen concentrator;
- He/she did not know how often the filters should

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be cleaned.

3. Review of Resident #28's Quarterly MDS dated 9/17/24, showed:
- Cognitive skills moderately impaired;
- Diagnoses included Parkinson 's Disease (a chronic brain disorder that causes movement problems, mental health issues, and other health concerns), high blood pressure, anxiety and depression.

Review of the resident's care plan dated 9/20/24 showed:
- The resident requires extensive ADL assistance;
- The resident is on oxygen therapy related to shortness of breath;
- The resident is at risk for altered respiratory status and difficulty in breathing related to sleep apnea and pulmonary fibrosis (a chronic lung disease that causes scarring in the lungs, making it difficult to breathe);
- Monitor for signs and symptoms of respiratory distress.

Review of the resident's POS dated 12/1/24 through 12/31/24 showed:
-Order start date: 10/31/24 Change oxygen tubing weekly and as needed every night shift on Sunday;
-The resident's POS did not address the cleaning of the oxygen filters.

Review of the resident MAR dated 12/1/24 through 12/31/24 showed to change oxygen tubing weekly as needed every night shift on Sunday.

Observation on 12/10/24 at 11:30 A.M. showed:
-The resident's oxygen concentrator covered with

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F 695	Continued From page 55 dust; -The resident's oxygen concentrator filter caked in dust. Observation and interview on 12/11/24 at 3:08 P.M., showed: -The resident's oxygen concentrator covered with dust; -The resident's oxygen concentrator filter caked in dust; - CMT F said he/she is not sure who changes the filters on the oxygen filters; - CMT F said the oxygen concentrators should be clean and the filters should be clean. During an interview on 12/11/24 at 3:10 P.M., CMT E said: -He/she is not sure who is responsible for cleaning the oxygen filters; -Oxygen filters and the concentrator should be free from dust. During an interview on 12/13/24 at 10:52 A.M. the Director of Nursing (DON) said: -The oxygen filters should be changed weekly; -There are no logs to document that the filters have been changed.	F 695		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 759		

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review, the facility failed to ensure staff administered medications with a medication rate of less than five percent when facility staff made two medication errors out of 25 opportunities for error resulting in a medication error rate of eight percent which affected two of the 12 sampled residents (Resident #19 and #16). The facility census was 40.

Review of the facility's undated policy for medication administration showed, all medications will be administered to every resident by a licensed nurse or a Certified Medication Technician (CMT) and as ordered by a physician in a safe and sanitary manner.

The facility did not provide a policy for administration of eye drops.

Review of the website, https://webmd.com, for refresh eye drops showed:
- To avoid contamination, do not touch the dropper tip to the eye or or any other surface;
- Tilt your head back, look up, and pull down the lower eyelid to make a pouch;
- Place the dropper directly over the eye and squeeze out one or two drops as needed;
- Look down and gently close your eye for one or two minutes. Place one finger at the corner of the eye near the nose and apply gentle pressure. This will prevent the medication from draining away from the eye.

Review of manufacturer guidelines for Systane Ultra Ophthalmic Solution 0.4-0.3 % (used to treat dry eye), dated 2023 showed:
-Tilt head back and look up;
-Pull down lower eyelid and create pocket;
-Administer drop into pocket of eyelid;

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-Apply gentle pressure to the inner corner of the eye for two minutes.

1. Review of Resident #19's Physician's Order Sheet (POS) dated December 2024 showed a start date of 8/11/24 for Refresh Ophthalmic solution 1.4-0.6%, instill one drop in both eyes every morning and at bed time for dry eyes.

Review of the resident's medication administration record (MAR) dated December 2024 showed Refresh Ophthalmic solution 1.4-0.6%, instill one drop in both eyes every morning and at bed time for dry eyes.

Observation on 12/12/24 at 7:50 A.M., showed:
- CMT A washed his/her hands, applied gloves and cleaned the resident's eye lids, removed gloves and washed his/her hands and applied new gloves;
- CMT A placed one drop in the resident's left and the tip of the eye dropper touched the resident's eye lid and eye lashes. CMT A applied lacrimal pressure (gentle pressure applied to the inner eye by the nose) for 20 seconds;
- CMT A placed one drop in the resident's right eye and the tip of the eye dropper touched the resident's eye lid and eye lashes. CMT A applied lacrimal pressure for 25 seconds.

During an interview on 12/12/24 at 9:00 A.M., CMT A said:
- The tip of the eye dropper should not touch the resident's eye lid or eye lash;
- Lacrimal pressure should be applied for one to two minutes.

During an interview on 12/13/24 at 10:52 A.M., the Director of Nursing (DON) said:

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- The tip of the eye dropper should not touch the resident's eye lashes or eye lids;
- Staff should apply lacrimal pressure for one minute.

2. Review of Resident #16's POS, dated December 2024 showed a start date of 11/10/23 - Systane Ultra Ophthalmic Solution 0.4-0.3 %, give one drop in each eye every morning and at bed time for dry eye.

Review of the resident's MAR, dated December 2024, showed Systane Ultra Ophthalmic Solution 0.4-0.3 %, give one drop in each eye every morning and at bed time for dry eye.

Observation and interview on 12/12/24 at 6:59 A.M., showed:
-CMT C administered one eye drop to the resident's left eye and wiped the resident's face with a tissue;
-The tip of the applicator touched the resident's upper eye lashes;
-CMT C administered one eye drop to the resident's right eye;
-The tip of the applicator touched the resident's upper eye lashes;
-CMT C did not apply pressure to the inner corner of the resident's left eye after administering the medication;
-CMT C did not apply pressure to the inner corner of the resident's right eye after administering the medication;
-CMT C said he/she should have applied pressure for two minutes to the inner corner of the resident's right eye and the resident's left eye after administering the medication;
-CMT C said the dropper should not have touched any part of the resident's eye.

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F 759	Continued From page 59 During an interview on 12/13/24 10:43 AM LPN A said: -Staff should apply pressure for two minutes to the inner corner of the resident's eye after administering eye drops. -The dropper should not touch any part of the eye.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		

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Based on observation, interview and record review, the facility failed to store and label drugs and biological's in accordance with current accepted professional principles for three (Resident #12, #28, and #193) out of the 12 sampled residents when the facility failed to store medications in a locked storage area for Resident #28 and Resident #193. Additionally, the facilty failed to supervise Resident #12 while taking medications. The facility census was 40.

Review of facility policy, right to self-administer medications, undated, showed:
-A resident may self-administer medications only if approved in writing by the resident's physician and a licensed nurse has determined that the resident can perform the task safely and accurately.
-A licensed nurse will assess the resident to determine the resident's ability to self-administer their medications. The findings of the assessment will be documented in the resident's medical record.
-The medications that the resident self-administers, will be stored in the resident's room in a locked drawer. The resident, nurse, and certified medication technician (CMT) will have a key to the drawer.

Review of the facilty's undated Medication Administration policy showed:
-All medications will be administered to every resident by a licensed nurse or CMT as ordered by a physician;
-All medications will be administered in a safe and sanitary manner.

1. Review of Resident #12's medical record showed:

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-Admission date 7/30/21;
-No assessment for self administration of medications was found.

Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/17/24, showed:
- Cognitive skills moderately impaired;
- Substantial assistance with dressing and toileting;
- Diagnoses included Parkinson 's Disease (a chronic brain disorder that causes movement problems, mental health issues, and other health concerns), high blood pressure, anxiety and depression.

Observation and interview on 12/11/24, at 08:39 A.M., showed:
-The resident laying in bed;
- No staff present in the resident's room;
- A medication cup containing two pills sat on the bedside table;
-The resident picked the pills out of the medication cup with his/her fingers and put the pills in his/her mouth;
-The resident kept the pills in his/her mouth for approximately two minutes before taking a drink of water;
-The resident said he/she did not need supervision to take his/her medication.

During an interview on 12/12/24, at 09:10 A.M., CMT C said:
- The resident should not have pills setting in his/her room;
- Staff should watch residents take all of their medications before leaving the room.

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During an interview on 12/12/24 10:43 AM Licensed Practical Nurse (LPN) A said:
-The resident needs to be supervised while taking medications;
-Medications should not be left in the resident's room.

2. Review of Resident #28's medical record showed:
-Admission date 9/20/24;
-No assessment for self administration of medications was found.

Review of the resident's admission MDS, dated 9/26/24, showed:
- No cognitive impairment;
- Extensive assistance of one with dressing, toileting and bathing;
- Diagnoses included Parkinson 's Disease, diabetes (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly), and arthritis.

Observation on 12/10/24 at 08:18 A.M., showed:
-The door to the resident's room was open;
-The resident laying in bed and a bottle of decongestant nose spray setting on the window.

Observation on 12/11/24 at 08:44 A.M., showed:
-The door to the resident's room was open;
-The resident laying in bed and a bottle of decongestant nose spray setting on the window.

Observation on 12/12/24 at 08:10 A.M., showed:
-The door to the resident's room was open;
- CMT D and CNA C walked in the resident's room and asked the resident how he/she was doing;
- The resident laying in bed and a bottle of

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decongestant nose spray setting on the window.

During an interview on 12/12/24 at 09:32 A.M., CMT D said:
-The family brings medication in that we do not know about;
- The resident does not use this medication;
- The nose spray should be kept in the medication cart.

During an interview on 12/12/24 10:43 AM LPN A said medications should not be left unsecured in the resident's room.

During an interview on 12/13/24 at 10:52 A.M. the Director of Nursing (DON) said:
-Medications should not be left unsecured in the resident's room;
-Staff should watch residents take their medications.

During an interview on 12/13/24 at 10:52 A.M. the Administrator concurred with the DON.

3. Review of Resident #193's return MDS., dated 12/5/24, showed he/she entered from a short term general hospital stay.

Review of admission record, dated 12/11/24, showed:
-He/She admitted to facility 12/5/24;
-Diagnoses included fracture of right femur (bone fracture in right leg), delirium due to known physiological condition (a sudden change in mental state that causes confusion, disorientation, and inability to think clearly), urinary tract infection, and chronic kidney disease.

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Review of physician's orders, dated 12/11/24, showed:
-Start date 12/5/24, monitor right hip surgical site for signs and symptoms of infection (redness/pain), directions every morning and at bedtime.;
-Start date 12/6/24, Monitor skin tear to left outer hand. Clean with wound cleanser, apply xeroform, and dry dressing until healed. Directions: in the morning.

Review of electronic medical record showed:
-No assessment for self administration of medications.
-12/6/24, admission packet progress note showed patient presented to hospital on 11/11 following a fall with acute onset right hip pain. Resident had a right interchanteric femur fracture. He/She underwent surgery 11/15.

Observation on 12/10/24 at 10:10 A.M. of resident room showed an 8 oz (236 milliliter (ml)) bottle of wound cleanser non-ionic disinfectant and 4oz skin-preparation protective spray was sitting in resident's bedroom window.

During an interview on 12/13/24 at 7:36 A.M., Certified Medication Technician (CMT) said wound cleansers and medications should be stored in medication room or medication cart.

During an interview on 12/13/24 at 7:46 A.M., Licensed Practical Nurse (LPN) B said:
-Resident's wound cleansers should be stored in the medication cart;
-Resident medications could be left at bedside if they had orders for medications to be left at bedside;
-Resident wound cleansers could be stored in

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F 761	Continued From page 65 resident room in a baggy and should be dated; -Resident #193 could have wound cleansers in his/her room if it was bagged and dated; -If residents wound cleansers were not going to be left in room they should be stored in the medication cart. During an interview on 12/13/24 at 7:59 AM, Assistant Director of Nursing (ADON) B said: -Wound cleansers should not be stored at bedside but the facility did allow storage in resident's bathroom storage closet; -Resident's wound cleansers should not be stored on resident's windowsill; -Wound cleansers should be stored in a baggy in the closet bathroom. During an interview on 12/13/24 at 8:18 A.M., Director of Nursing (DON) said: -He/She expected wound cleansers not be stored in windowsills; -He/She expected residents wound cleansers to be stored in the pantries in the resident bathrooms out of sight or in the medication carts. During an interview on 12/13/24 at 10:52 A.M., Administrator said she did not expect wound cleansers to be left in window sill of a residents room.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		

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	265869	A. BUILDING _____ B. WING _____	12/13/2024

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F 812	Continued From page 66 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store, prepare and serve food in accordance with professional standards of food service safety when staff failed to date the receipt of incoming products in the dry storeroom, label and date used products in the freezer and refrigerator, label and date leftovers in the refrigerator, discard expired leftovers, and monitor refrigerator, freezer and dishwasher temperatures on a daily basis. This had the potential to impact all residents by placing them at risk for food born illnesses. The facility census was 40. Review of the facility's policy Dietary Procedures, undated, showed the evening staff members will check the dates on containers of leftovers and dispose of food found to have been refrigerated for more than four days; A policy on temperature checks in the kitchen was requested and not provided; Observation at 9:00 A.M on 12/10/24 showed:	F 812		

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F 812	Continued From page 67 Dry Kitchen Storage Room located on the 1st floor: - Box of pancake mix opened and no opening date written on package; - Seven loose juice cocktail containers sitting out of case package with no date written; - Thickened Orange Juice opened box with no date written; Refrigerator 1st Floor: - Two plastic bags of tortillas opened and not dated; - Raw strawberries in plastic container not dated; - Leftover chicken soup in facility plastic container not dated; - Multiple containers of pudding and yogurt not dated; - Pulpy unknown food in bag dated 10/13 (57 days old); - Raw pickles, Jalapenos, green peppers, onions and squash bagged and undated; - Romaine lettuce dated 12/4 (6 days old) not discarded; - Sharp cheese open bad not sealed, not dated; - Opened hot dogs bagged, no date or label; - Seven unknown condiments stored in facility plastic bottles no dates, not labeled; - Open Jello container not dated; Observation at 9:35 A.M. on 12/10/24 showed: Main Kitchen Dry Storeroom Ground Floor - No received dates on multiple unopened packages of cake mixes and double chocolate cake; - Eight bags of chocolate chip cookie mix undated; - Four rack levels of unopened bread with no received date; - Extra heavy mayonnaise plastic container not dated;	F 812		

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F 812	Continued From page 68	F 812		

- Opened caramel topping Smuckers brand not dated;
Freezer
- Chicken patties opened and not sealed with no date;
- Frozen peas opened box with no date;
- Fillets not labeled and not dated;
- Dry noodles unsealed and not dated;
- Otis Spunkmeyer cookie dough opened and uncovered;
- Review of dishwashing log shows no temperatures taken on the dishwasher from 12/8 to 12/11 (morning);

Observation at 10:02 on 12/11/24 showed:
Main Prep Area Kitchen Ground Floor
- Refrigerator and Freezer temperature log missing temperature checks from 12/9 to 12/11
- Refrigerator/Freezer checks for 12/12 already entered into the log one day early;
Refrigerator Ground Floor
- Swiss cheese repackaged undated in a soiled bag;
- Sauce unlabeled in facility container with no date;
- Lettuce rewrapped with unreadable date on package;
- Large unlabeled container of lettuce no date;

Interview conducted on 12/10/24 at 9:20 A.M., Cook A said:
-He has one and a half years' experience working at the facility.
- The purpose of the refrigerator on the 1st floor kitchen area is to hold ingredients for cooking.
- Policy directs staff to date opened products in bags and containers and store in the refrigerator for later use.
- The date on the package is the first use date

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F 812	Continued From page 69	F 812		

when opened.
- He believes the policy is that after three days any item not used should be discarded.

Interview conducted on 12/10/24 at 9:25 A.M., Cook B said the reason for all of the undated items in the refrigerator is that with the dishwasher down they have not had time to review the contents of the refrigerator on a daily basis.

In an interview on 12/11/24 at 2:33 P.M., DM A said:
- The leftover policy is 3-5 days which is mostly for vegetables.
- All items need to be labeled and dated with first use date.
- Incoming shipments need to have items annotated with receipt date, opened cases need date of when they were opened and expiration is in accordance with the item label.
- The staff are to follow milk expiration dates on the package.
- Condiments in jugs need to be discarded after 30 days and condiments in facility serving bottles need to be discarded after seven days.
- Open items should be labeled and dated.
- Temperature logs and dishwasher logs need to be done daily.

In an interview on 12/12/24 at 1:30 P.M., RD (Registered Dietician)said the expectation is that leftovers are labeled and dated. Beef could be kept for three to four days and everything else is expected to be discarded sooner than that. Bags with no labels and no dates would be annotated on his/her inspection report for the facility staff to take action.

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F 812	Continued From page 70 In an interview on 12/13/24 at 10:20 A.M., Administrator said she would expect temperature logs to be maintained daily in the kitchen and leftovers to be sealed, labeled and dated.	F 812		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents had a means of directly contacting caregivers when staff failed to identify and correct bathroom call light pull cords that had been wrapped around the handrail on the wall, leaving them inoperable and inaccessible to residents. The facility census was 40. The facility's Call Light, Bed Alarm System policy showed: -Call lights are to be present in all resident rooms and bathrooms. -The policy fails to address the issue of call lights being operable and accessible to a resident lying on the floor in need of help. The facility's Accident Prevention policy showed all staff members will ensure that each resident's environment remains as free from accident	F 919		

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F 919	Continued From page 71	F 919		

hazards as possible.

The facility's Incident and/or Accident Protocol showed staff are to assess the environment for safety modifications, clear pathways and ensure the call light was within the resident's reach.

The facility's Preventive Maintenance and Inspection policy showed:
-Alarms which include personal protective devices such as bed alarms and/or chair alarms, will be calendared for a routine weekly inspection to verify their working order.
-Nurses are responsible for any component of alarm verification, such as alert bracelets, the scheduling and documentation correspond to the same standards set for all preventive maintenance of weekly monitoring.

Observations on 12/11/24 at 2:19 P.M., 12/12/24 at 9:24 A.M. and 12/13/24 at 9:09 A.M. showed:
- In Resident #294, and Resident #21's room and room #2015, bathroom call light pull cords were wrapped around the handrail on the wall leaving the call light inoperable and inaccessible.
- In three common area bathrooms, call light pulls were observed wrapped around the handrail on the wall leaving the call light inoperable and inaccessible.

During an interview on 12/13/24 at 10:52 A.M., the Director of Nursing (DON) said:
-Call lights should always be within reach and residents should be able to use the call light easily.
-Approximately every 30 days, the online call light system checks every room at least once to be sure the light can alert at the desk.
-Common area bathrooms are left unlocked and

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F 919	Continued From page 72 do not require staff assistance to access. -Residents are allowed to use the common area bathrooms and the call light should be within reach. During an interview on 12/13/24 at 10:52 A.M., the Administrator said it is her expectation for call lights to be accessible to residents.	F 919		

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A3026	19 CSR 30-85.032(27) Call System Requirements The facility shall be equipped with a call system that consists of an electrical intercommunication system, a wireless pager system, a buzzer system, or hand bells for each resident bed, toilet room, and bathroom. The call system shall be audible in the attendant's work area and be in compliance with 19 CSR 30-85.012(124). II/III This regulation is not met as evidenced by: Class II 1. Refer to F919 * The higher classification merited due to the extent of the violation.	A3026		
A3038	19 CSR 30-85.032(38) Furniture/Equip, Provide Comfort & Safety The facility shall maintain furniture and equipment in good condition and shall replace it if broken, torn, heavily soiled or damaged. Rooms shall be designed and furnished so that the comfort and safety of the residents are provided for at all times. II/III This regulation is not met as evidenced by: Class II 1. Refer to F584 *The higher classification merited due to the extent of the violation.	A3038	**Preparation, submission, and implementation of the POC does not constitute admission or agreement by McCrite Plaza to the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared, submitted and implemented in accordance with the provisions of the state of law. McCrite Plaza maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit McCrite Plaza's capacity to render reasonable and adequate care.**	
A4017	19 CSR 30-85.042(17) Criminal Background Check Request	A4017		

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A4017	Continued From page 1 Effective August 28, 1997, each facility shall, not later than two (2) working days of the date an applicant for a position to have contact with residents is hired, request a criminal background check, as provided in sections 43.530, 43.540 and 610.120, RSMo. Each facility must maintain in its record documents verifying that the background checks were requested and the nature of the response received for each such request. The facility must ensure that any applicant who discloses prior to the check of his/her criminal records that he/she has been convicted of, plead guilty or nolo contendere to, or has been found guilty of any A or B felony violation of Chapter 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or of section 568.020, RSMo, will not be allowed to work in contact with patients or residents until and unless a check of the applicant ' s criminal record shows that no such conviction occurred. II/III This regulation is not met as evidenced by: Class II 1. Refer to F607 * The higher classification merited due to the extent of the violation.	A4017		
A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and	A4031		

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A4031	Continued From page 2 procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Class II 1. Refer to F607	A4031		
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II 1. Refer to F759	A4055		
A4059	19 CSR 30-85.042(50) Self-Administration of Medication Self-administration of medication is permitted only if approved in writing by the resident's physician, and it is in accordance with the facility's policy and procedures. II This regulation is not met as evidenced by: Class II 1. Refer to F761	A4059		
A4062	19 CSR 30-85.042(53) Medication Labeling	A4062		

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A4062	Continued From page 3 All prescription medications shall be supplied as individual prescriptions. All medications, including over-the-counter medications, shall be packaged and labeled in accordance with applicable professional pharmacy standards and state and federal drug laws and regulations. The United States Pharmacopoeia (USP) labeling shall include accessory and cautionary instructions as well as the expiration date, when applicable, and the name of the medication as specified in the physician's order. Over-the-counter medications for individual residents shall be labeled with at least the resident's name. II/III This regulation is not met as evidenced by: Class II 1. Refer to F761 *The higher classification merited due to the extent of the violation.	A4062		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Class II Please refer to F761	A4064		

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A4064	Continued From page 4 *The higher classification merited due to the extent of the violation.	A4064		
A4067	19 CSR 30-85.042(58) Meds Destroyed Within 30 Days All non-unit doses and all controlled substances which have been discontinued must be destroyed on the premises within thirty (30) days. Outdated, contaminated, or deteriorated medications and non-unit dose medications of deceased residents shall be destroyed within thirty (30) days. Unit dose medications returnable to the pharmacy shall be returned within thirty (30) days. II/III This regulation is not met as evidenced by: Class III 1. Refer to F761	A4067		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II 1. Refer to F677 and F695	A4075		
A4078	19 CSR 30-85.042(69) Reposition Every 2 hr/Maintain Body Alignment Residents who are physically or mentally incapable, or both, of changing their own positions shall have their positions changed at	A4078		

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A4078	Continued From page 5 least every two (2) hours and shall be provided supportive devices to maintain good body alignment. I/II This regulation is not met as evidenced by: Class II 1. Refer to F684	A4078		
A4087	19 CSR 30-85.042(78) Dr Notification-Change in Condition In the event of accident, injury, or significant change in the resident's condition, facility staff shall notify the resident's physician in accordance with the facility's emergency treatment policies which have been approved by the supervising physician. I/II This regulation is not met as evidenced by: Class II 1. Refer to F658	A4087		
A7016	19 CSR 30-87.030(14) Food-Clean Containers, Storage, Covers Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be stored in a clean covered container except during necessary periods of preparation or service. Container covers shall be impervious and nonabsorbent except that linens or napkins may be used for lining or covering bread or roll containers. III This regulation is not met as evidenced by: Class III	A7016		

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A7016	Continued From page 6 1. Refer to F812	A7016		
A7019	19 CSR 30-87.030(17) Food Stored in Identifying Containers Unless its identity is unmistakable, bulk food, such as cooking oil, syrup, salt, sugar or flour not stored in the product container or package in which it was obtained, shall be stored in a container identifying the food by common name. III This regulation is not met as evidenced by: Class III 1. Refer to F812	A7019		
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record	A8010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29084A	A. BUILDING: _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCRITE PLAZA AT BRIARCLIFF SKILLED FACILITY	1301 TULLISON RD KANSAS CITY, MO 64116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8010	Continued From page 7 and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by: Class II 1. Refer to F578 * The higher classification merited due to the extent of the violation.	A8010		

PLAN OF CORRECTION (F Tags)

Provider/Supplier Name:	McCrite Plaza at Briarcliff SNF
Street Address, City, Zip:	1301 NW Tullison Road, KCMO
Date of Survey:	12/13/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F578	**Preparation, submission, and implementation of the POC does not constitute admission or agreement by McCrite Plaza to the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared, submitted and implemented in accordance with the provisions of the state of law. McCrite Plaza maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit McCrite Plaza's capacity to render reasonable and adequate care.** **F578: Request/Refuse/Discontinue Trmt; Formulate Advanced Directives** Immediate Correction: • Resident #22 Incapacitation Letter verified, DPOA verified, physician order updated and care plan updated. • Resident # 18 Incapacitation Letter verified, DPOA verified, physician order updated and care plan updated. • Resident #295 no longer in facility. • Administrator or Designee provide education by 1/25/25 to Admissions, Social Worker, Clinical	1/25/25

	Team and Administrative Team regarding Advanced Directive policy and procedure. Plan: • Social Worker or Designee will audit resident charts using audit tool that includes: Code Status; order of Code Status; Advanced Directives; DPOA paperwork; Incapacitation Letter; door sign reflected correctly to be completed by 1/25/25. • Upon admission during morning IDT meeting on working business days Monday through Friday; Clinical Team and Social Worker will review new resident admission for Advanced Directives, Code Status; DPOA Paperwork and Incapacitation Letter if applicable and ensure orders and care plans are correct. Monitoring: • Social Worker or Designee will audit monthly for three months beginning February 1, 2025 and then ongoing using audit tool for Code Status; order of Code Status; Advanced Directives; DPOA paperwork; Incapacitation Letter; door sign reflected correctly and take results to QAPI.	
F584	**F584 Safe/Clean/Comfortable/Homelike Environment** Immediate Correction: • Director of Nursing or Designee will ensure carts will be cleaned from top to bottom including wheels by 1/15/25.	1/25/25

	• Dietary Manager or Designee will ensure metal carts used for food delivery are cleaned from top to bottom including wheels by 1/25/25. • Housekeeping Director or Designee will ensure carpets are vacuumed and free of crumbs by 1/17/25 and windows sills are dusted and free of debris by 1/25/25. • Maintenance Director or Designee will ensure PTAC unit is cleaned by 1/15/25. Plan: • Director of Nursing or Designee will make a schedule for clinical team to clean carts weekly with a sign off. • Director of Nursing or Designee will do weekly cleaning checks for four weeks on medication carts. • Director of Nursing or Designee will in-service clinical staff on the new policy on or before 1/25/25. • Maintenance Director or Designee will paint scraped area of paint no later than 1/25/25. • Dietary Manager or Designee will make a schedule for cart cleaning with check off by 1/25/25. • Dietary Manager or Designee will audit cart cleaning weekly for 4 weeks beginning in February to ensure carts are being cleaned. • Maintenance Director or Designee will repair or replace holes in carpet. • Housekeeping Supervisor or designee will in-service staff on cleaning policy and schedule on	

	or before 1/25/25 to ensure common areas and windows are cleaned. • Housekeeping Supervisor or Designee will prepare cleaning schedule for common areas and windows on or before 1/25/25. Monitoring: • Director of Nursing or Designee will complete monthly checks of medication carts to confirm cleanings are completed as scheduled and will report findings to QAPI. The facility will be in substantial compliance by 1/25/25. • Dietary Manager or Designee will audit meal carts monthly for 3 months beginning in February and report findings to QAPI. • Housekeeping Supervisor or Designee will complete weekly audits for 3 months beginning in February to ensure common areas and window sills are clean and report finding to QAPI.	
F607	**F607 Develop/Implement Abuse/Neglect Policies** Immediate Correction: • Complete education with Human Resources and Payroll regarding facility policy of background checks needed prior to start of employee no later than 1/25/25. Plan • Human Resources or Designee will not allow employees to begin training/employment until background checks are completed and on file. • Human Resources or Designee will audit new employee files for appropriate pre-employment	1/25/25

	screening prior to employee starting training to remain in compliance starting immediately and weekly for four weeks. Results of audits will be taken to QAPI. Monitoring • Human Resources or Designee will complete pre-employment screening/background checks and have results prior to employee starting training at facility. • Human Resources or Designee will audit new employee files for appropriate pre-employment screening prior to employee starting training to remain in compliance monthly beginning 1/16/2025 for three months and then ongoing as needed. Results of audits will be taken to QAPI.	
F658	**F658 Services Provided to Meet Professional Standards** Immediate Correction • Patient 28, 295, 244, 294 no longer at facility. • Scales will be calibrated on or before 1/25/25 by outside contractor. • Director of Nursing or Designee will review all resident weights for weight gain and loss and ensure care plans are updated, interventions are in place and notifications are made. This will be completed by 1/25/25 • Director of Nursing or Designee will amend Weight Management Policy to reflect significant weight gain to the existing weight management policy. Significant weight gain will be considered	1/25/25

	3% in 1 week, 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. • Clinical staff will be in-serviced on or before 1/25/25 on appropriate use of PRN medication to ensure that medication ordered is appropriate for the symptom/diagnosis and that appropriate clinical information is provided to medical practitioner and documented in resident chart. Plan • Maintenance Director or Designee will have weight scales calibrated by an outside contractor every 3 months and as needed and keep log of services being completed. • Administrator or Designee will in-service maintenance staff on new policy and procedure by 1/25/25. • Director of Nursing or Designee will in-service clinical staff on weight loss/gain policy and documentation expectations on or before 1/25/25. • Clinical staff will be in-serviced on or before 1/25/25 on appropriate use of PRN medication to ensure that medication ordered is appropriate for the symptom/diagnosis and that appropriate clinical information is provided to medical practitioner and documented in resident chart. • Facility will be in substantial compliance by 1/25/25. Monitoring • Maintenance Director or Designee will provide report to QAPI monthly on status of calibration and documentation of scales.	

	• Director of Nursing or Designee will review resident weights weekly beginning immediately to ensure policy is being followed and documentation is present and report to QAPI monthly any findings. • Director of Nursing or Designee will review documentation and orders the next business day. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
F677	**F677 ADL Care Provided for Dependent Residents** Immediate Correction • Care plan updated 1/8/25 for resident 18- separate skin folds and cleanse, clean all areas that urine or feces touch when providing perineal care. • Care plan updated 1/8/25 for resident 27- separate skin folds and cleanse, clean all areas that urine or feces touch when providing perineal care. • Care plan updated 1/8/25 for resident 22- don/doff PPE before providing care, wash hands before glove application and after glove removal, secure catheter tubing prior to providing catheter care, separate skin folds and cleanse when providing perineal care, provide oral care when providing morning cares. • Care plan updated 1/8/25 for resident 14- separate skin folds and cleanse, clean all areas	1/25/25

	that urine or feces touch when providing perineal care. Plan • Director of Nursing or Designee will in-service clinical staff on or before 1/25/25 on perineal care to include cleansing all areas that touch urine/feces, skin folds and genital folds to be spread and cleansed thoroughly during peri care, using one swipe per perineal cleansing wipe, don/doff PPE for residents on isolation, washing hands prior to/and after providing resident care, catheter care, anchoring catheter tubing, cleaning catheter port, changing gloves/washing hands when gloves soiled with feces, repositioning, and providing oral care when providing routine morning care for resident. • Director of Nursing or Designee will complete a total of 48 staff observations weekly x 4 weeks (8 each of peri care, catheter care, PPE application, hand washing, repositioning, and oral care). Monitoring • Director of Nursing or Designee will complete 24 observations monthly ongoing (4 each of peri care, catheter care, PPE application, hand washing, repositioning, and oral care). Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
F684	**F684 Quality of Care** Immediate Correction	1/25/25

	• Care plan updated 1/8/25 for resident 14- offer to lay resident down between meals, provide perineal care approximately every two hours, reposition resident approximately every two hours. Plan • Director of Nursing or Designee will in-service on or before 1/25/25 regarding repositioning resident at approximately every 2 hours, providing incontinent care approximately every 2 hours, and laying resident down per order. • Director of Nursing or Designee will complete a total of 10 staff observations weekly x 4 weeks (5 each of repositioning, monitoring to ensure laid down per physician order). Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25. Monitoring • Director of Nursing or Designee will complete 10 observations monthly (5 each repositioning, monitoring to ensure laid down per physician order) and report findings to monthly QAPI.	
F689	**F689 Free of Accident Hazards/Supervision/Devices** Immediate Correction: • Resident 18 care plan updated 1/8/25- transfer resident with mechanical lift/sling using proper technique per facility policy.	1/25/25

	• Resident 27 care plan updated 1/8/25- transfer resident with mechanical lift/sling using proper technique per facility policy. • Resident 28 no longer at facility. • Resident 14 care plan updated 1/8/25 - transfer resident with mechanical lift/sling using proper technique per facility policy. Plan • Director of Nursing or Designee will in-service staff on or before 1/25/25 regarding proper use of mechanical lifts, when lift leg should be spread or closed, when castors should locked and unlocked (both castors should be locked at the same time when resident not in lift or when lift is parked, castors unlocked all other times when patient is in it), and that there must be two staff present during entire time resident is in mechanical lift. • Director of Nursing or Designee will in-service staff on or before 1/25/25 regarding proper use of gait belt, proper placement of gait belt, proper hand position of staff when using gait belt, do not reach or hold under patient arms/hook patient arms when transferring, use cup position when holding gait belt, proper mechanical lift sling placement. • Director of Nursing or Designee will complete a total of 10 staff observations weekly x 4 weeks (5 each of gait belt transfers, mechanical lift transfers). Monitoring • Director of Nursing or Designee will complete10 observations monthly ongoing (5 each of gait belt transfers, mechanical lift	

	transfers). Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
F695	**F695 Respiratory/Tracheostomy Care and Suctioning** Immediate Correction • Resident 244 care plan updated 1/8/25 to include oxygen filter cleaning, concentrator cleaning, tubing/humidifier container changes on Sundays. • Resident 28 no longer at facility. • Order entered for resident 244 to have oxygen. Plan • Policy will be updated to have all oxygen concentrators and oxygen concentrator filters cleaned by nursing staff weekly on Sundays. • TARS for residents with oxygen use will be updated to have filters cleaned, oxygen tubing to be changed/dated, oxygen humidifier containers to be changed and dated, and nebulizer tubing/mask sets to be changed weekly on Sunday. • Audit will be completed for all residents to ensure residents with oxygen use have an order for oxygen. • Director of Nursing or Designee will review new orders next business day to ensure oxygen/tubing/cleaning of oxygen concentrator/filters are scheduled on nurse TAR. • Staff will be in-serviced by Director of Nursing or Designee on or before 1/25/25 regarding the oxygen tubing/nebulizer set changing/dating,	1/25/25

	concentrator cleaning, and entry of order for oxygen. The facility will be in substantial compliance by 1/25/25. • Director of Nursing or Designee will complete weekly visual audits for 4 weeks beginning 1/27/25 to ensure policy is being followed and items dated correctly. Findings will be reported at the monthly QAPI meeting. Monitoring • Director of Nursing or Designee will complete an audit monthly for 3 months on residents with oxygen and nebulizer treatments to ensure there is an order for oxygen use as well as orders for tubing/nebulizer charges. Findings will be reported at the monthly QAPI meeting. • Director of Nursing or Designee will complete monthly audits for three months beginning in February to ensure items in room are being changed out and dated. Findings will be reported at the monthly QAPI meeting.	
F759	**F759 Free of Medication Error Rates 5% or More** Immediate Correction • Staff will be in-serviced by Director of Nursing or Designee on or before 1/25/25 regarding updated policy for proper medication administration of eye drops. • Eye drop administration policy will be reviewed and updated by 1/25/25. Plan • Director of Nursing or Designee will complete competency checks with staff who administer	1/25//25

	eye drops in the facility to be completed by 1/25/25. Monitoring • Director of Nursing or Designee will complete 3 observations of eye drop administrations weekly for 4 weeks then 3 observations monthly to ensure proper administration. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
F761	**F761 Label/Store Drugs and Biologicals** Immediate Correction • Resident 28 care plan updated 1/8/25-medications are not to be left bedside, meds will be observed while being administered to resident. • Resident 193 care plan updated 1/8/25-no medication is to be left bedside. Plan • Director of Nursing or Designee will in-service staff on or before 1/25/25 regarding medication being observed at time of administration to resident, meds are not to be left bedside without self-administration assessment, medications are to be stored in medication carts that are locked, medications are to be labeled for specific resident. • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per week for 4 weeks. Monitoring	1/25/25

	• Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per month ongoing. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
A7019 F812	**F812 Food Procurement, Store/Prepare/Serve-Sanitary** Immediate Correction: • Dietary Manager or Designee will provide education to staff no later than 1/25/25 regarding policy on food storage which will include but is not limited to labeling and dating food, appropriate time food can be kept and when to throw away and how to properly store food as well as policy on recording and taking temperatures. • Dietary Manager or Designee will audit dry storage and remove any items with expiration or not dated, or date if open date is known by 1/25/25. • Dietary Manager or Designee will audit walk in cooler and freezer remove any items with expiration or not dated, or date if open date is known by 1/25/25. • Dietary Manager or Designee will audit kitchen refrigerators and freezers and remove any items with expiration or not dated, or date if open date is known by 1/25/25. Plan • Dietary Manager or Designee will audit dry storage walk-in cooler and freezer and any	1/25/25

	dietary refrigerators weekly for four weeks beginning 1/27/25 for food that is not dated and/or expired and ensure food is thrown out. • Dietary Manager or designee will audit temp logs daily M-F for four weeks beginning 1/27/25 for temperature recordings. • Dietician or Designee will complete full kitchen audit by 1/25/25 and provide results to Dietary Manager and Administrator for further action. Monitoring • Dietary Manager or Designee will audit dry storage walk-in cooler and freezer and any dietary refrigerators monthly for three months beginning February 1 2025 and then as needed, for food that is not dated and/or expired and ensure food is thrown out. Results will be taken to QAPI.	
F919	**F919 Resident Call System** Immediate Correction • Care plan updated 1/8/25 for resident 294- ensure restroom call light is hanging freely in restroom/not wrapped around handrail • Care plan updated 1/8/25 for resident 21- ensure restroom call light is hanging freely in restroom/not wrapped around handrail • Room 2015 not occupied to update care plan • Director of Nursing or Designee will audit all rooms/bathrooms to ensure call lights are not wrapped around handrails.	1/25/25

	Plan • Resident call system policy will be updated to include maintenance creating log and inspecting bed/chair alarms for proper functioning weekly. • Clinical staff will be in-serviced by Director of Nursing or Designee on or before 1/25/25 on proper call light placement/do not wrap around handrails. • Director of Nursing or Designee will perform call light audits to ensure call lights are not wrapped around handrails 5 times weekly for 30 days. Monitoring • Director of Nursing or designee will then perform call light audits to ensure call lights are not wrapped around handrails five times monthly going forward. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	

The Administrator signing and dating the first page of the CMS-2567/5tate Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	McCrite Plaza at Briarcliff
Street Address, City, Zip:	1301 NW Tullison Road, KCMO 64116
Date of Survey:	12/13/24

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A3026	**Preparation, submission, and implementation of the POC does not constitute admission or agreement by McCrite Plaza to the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared, submitted and implemented in accordance with the provisions of the state of law. McCrite Plaza maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit McCrite Plaza's capacity to render reasonable and adequate care.** **10 CSR 30-85.032(27)** **Resident Call System** Immediate Correction • Care plan updated 1/8/25 for resident 294- ensure restroom call light is hanging freely in restroom/not wrapped around handrail. • Care plan updated 1/8/25 for resident 21- ensure restroom call light is hanging freely in restroom/not wrapped around handrail. • Room 2015 not occupied to update care plan. • Director of Nursing or Designee will audit all rooms/bathrooms to ensure call lights are not wrapped around handrails.	1/25/25

	Plan • Resident call system policy will be updated to include Maintenance creating log and inspecting bed/chair alarms for proper functioning weekly. • Clinical staff will be in-serviced by Director of Nursing or Designee on or before 1/25/25 on proper call light placement/do not wrap around handrails. • Director of Nursing or Designee will perform call light audits to ensure call lights are not wrapped around handrails 5 times weekly for 30 days. Monitoring • Director of Nursing or Designee will then perform call light audits to ensure call lights are not wrapped around handrails five times monthly going forward. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
A3038	**19 CSR 30-85.032(38)** **Safe/Clean/Comfortable/Homelike Environment** Immediate Correction: • Director of Nursing or Designee will ensure carts will be cleaned from top to bottom including wheels by 1/15/25. • Dietary Manager or Designee will ensure metal carts used for food delivery are cleaned from top to bottom including wheels by 1/25/25. • Housekeeping Director or Designee will ensure carpets are vacuumed and free of crumbs by 1/17/25 and windows sills are dusted and free of debris by 1/25/25.	1/25/25

	• Maintenance Director or Designee will ensure PTAC unit is cleaned by 1/15/25. Plan: • Director of Nursing or Designee will make a schedule for clinical team to clean carts weekly with a sign off. • Director of Nursing or Designee will do weekly cleaning checks for four weeks on medication carts. • Director of Nursing or Designee will in-service clinical staff on the new policy on or before 1/25/25. • Maintenance Director or Designee will paint scraped area of paint on or before 1/25/25. • Dietary Manager or Designee will make a schedule for cart cleaning with check off for when cleaned by 1/25/25. • Dietary Manager or Designee will audit cart cleaning weekly for 4 weeks beginning February to ensure carts are being cleaned. • Maintenance Director or Designee will repair or replace holes in carpet. • Housekeeping Supervisor or Designee will in-service staff on cleaning policy and schedule on or before 1/25/25 to ensure common areas and windows are cleaned. • Housekeeping Supervisor or Designee will prepare cleaning schedule for common areas and windows on or before 1/25/25. Monitoring:	

	• Director of Nursing or Designee will then perform monthly checks of medication carts to confirm cleanings are completed as scheduled and will report findings to QAPI. The facility will be in substantial compliance by 1/25/25 • Dietary Manager or Designee will audit meal carts monthly for 3 months beginning in February and then ongoing as needed and report findings to QAPI. • Housekeeping Supervisor or Designee will complete weekly audits for 3 months beginning in February and then ongoing as needed to ensure common areas and window sills are clean and report finding to QAPI.	
A4017	**19 CSR 30-85.042(17)** **Develop/Implement Abuse/Neglect Policies** Immediate Correction: • Complete education with Human Resources and Payroll regarding facility policy of background checks needed prior to start of employee no later than 1/25/25. Plan • Human Resources or Designee will not allow employees to begin training/employment until background checks are completed and on file. • Human Resources or Designee will audit new employee files for appropriate pre-employment screening prior to employee starting training to remain in compliance starting immediately and weekly for four weeks. Results of audits will be taken to QAPI.	1/25/25

	Monitoring • Human Resources or Designee will complete pre-employment screening/background checks and have results prior to employee starting training at facility. • Human Resources or Designee will audit new employee files for appropriate pre-employment screening prior to employee starting training to remain in compliance monthly beginning 1/16/2025 for three months, and then ongoing as needed. Results of audits will be taken to QAPI.	
A4031		
A4055	**19 CSR 30-85.042(46)** **Free of Medication Error Rts 5% or More** Immediate Correction • Staff will be in-serviced by Director of Nursing or Designee on or before 1/25/25 regarding updated policy for proper medication administration of eye drops. • Eye drop administration policy will be reviewed and updated by 1/25/25. Plan • Director of Nursing or Designee will complete competency checks with staff who administer eye drops in the facility on or before 1/25/25. Monitoring • Director of Nursing or Designee will complete 3 observations of eye drop administrations weekly for 4 weeks then 3 observations monthly to ensure proper administration. Findings will be reported at the monthly QAPI meeting. The	1/25/25

	facility will be in substantial compliance by 1/25/25.	
A4059	**19 CSR 30-85.042(50)** **Label/Store Drugs and Biologicals** Immediate Correction • Resident 28 care plan updated 1/8/25-medications are not to be left bedside, medications will be observed while being administered to resident. • Resident 193 care plan updated 1/8/25-no medication is to be left bedside. Plan • Director of Nursing or Designee will in-service staff on or before 1/25/25 regarding medication being observed at time of administration to resident, medications are not to be left bedside without self-administration assessment, medications are to be stored in medication carts that are locked, medications are to be labeled for specific resident. • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per week for 4 weeks. Monitoring • Director of Nursing or designee will complete 5 medication administration audits and 5 room audits per month ongoing. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	1/25/25

A4062	**19 CSR 30-85.042(50)** **Self-Administration of Medication** Immediate Correction • Resident 28 care plan updated 1/8/25-medications are not to be left bedside, medications will be observed while being administered to resident. • Resident 193 care plan updated 1/8/25-no medication is to be left bedside. Plan • Director of Nursing or Designee will in-service staff on or before 1/25/25 regarding medication being observed at time of administration to resident, medications are not to be left bedside without self-administration assessment, medications are to be stored in medication carts that are locked, medications are to be labeled for specific resident. • Director of nursing or designee will complete 5 medication administration audits and 5 room audits per week for 4 weeks. Monitoring • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per month ongoing. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
A4064	**19 CSR 30-85.042(53)** **Medication Labeling** Immediate Correction	

	• Resident 28 care plan updated 1/8/25-medications are not to be left bedside, medications will be observed while being administered to resident. • Resident 193 care plan updated 1/8/25-no medication is to be left bedside. Plan • Director of Nursing or Designee will in-service staff on or before 1/25/25 regarding medication being observed at time of administration to resident, medications are not to be left bedside without self-administration assessment, medications are to be stored in medication carts that are locked, medications are to be labeled for specific resident. • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per week for 4 weeks. Monitoring • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per month ongoing. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
A4067	**19 CSR 30-85.042(55)** **Medication Storage** Immediate Correction • Resident 28 care plan updated 1/8/25-medications are not to be left bedside,	

	medications will be observed while being administered to resident. • Resident 193 care plan updated 1/8/25-no medication is to be left bedside. Plan • Director of Nursing or Designee will in-service staff on or before 1/25/25 regarding medication being observed at time of administration to resident, medications are not to be left bedside without self-administration assessment, medications are to be stored in medication carts that are locked, medications are to be labeled for specific resident. • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per week for 4 weeks. Monitoring • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per month ongoing. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
A4075	**19 CSR 30-85.042(66) Nursing Care per Res Condition** Immediate Correction • Resident 244 care plan updated 1/8/25 to include oxygen filter cleaning, concentrator cleaning, tubing/humidifier container changes on Sundays. • Resident 28 no longer at facility.	

	• Order will be entered for resident 244 to have oxygen. Plan • Policy will be updated to have all oxygen concentrators and oxygen concentrator filters cleaned by nursing staff weekly on Sundays. • TARS for residents with oxygen use will be updated to have filters cleaned, oxygen tubing to be changed/dated, oxygen humidifier containers to be changed and dated, and nebulizer tubing/mask sets to be changed weekly on Sunday. • Audit will be completed for all residents to ensure residents with oxygen use have an order for oxygen. • Director of Nursing or Designee will review new orders next business day to ensure oxygen/tubing/cleaning of oxygen concentrator/filters are scheduled on Nurse TAR. • Staff will be in-serviced by Director of Nursing or Designee on or before 1/25/25 regarding the oxygen tubing/nebulizer set changing/dating, concentrator cleaning, and entry of order for oxygen. The facility will be in substantial compliance by 1/25/25. • Director of Nursing or Designee will complete weekly visual audits for 4 weeks beginning 1/27/25 to ensure policy is being followed and items dated correctly. Findings will be reported at the monthly QAPI meeting. Monitoring	

	• Director of Nursing or Designee will complete an audit monthly for 3 months on residents with oxygen and nebulizer treatments to ensure there is an order for oxygen use as well as orders for tubing/nebulizer charges. Findings will be reported at the monthly QAPI meeting. • Director of Nursing or Designee will complete monthly audits for three months beginning in February to ensure items in room are being changed out and dated. Findings will be reported at the monthly QAPI meeting.	
A4075	**19 CSR 30-85.042(66) Nursing Care per Res Condition** Immediate Correction • Care plan updated 1/8/25 for resident 18- separate skin folds and cleanse, clean all areas that urine or feces touch when providing perineal care. • Care plan updated 1/8/25 for resident 27- separate skin folds and cleanse, clean all areas that urine or feces touch when providing perineal care. • Care plan updated 1/8/25 for resident 22- don/doff PPE before providing care, wash hands before glove application and after glove removal, secure catheter tubing prior to providing catheter care, separate skin folds and cleanse when providing perineal care, provide oral care when providing morning cares. • Care plan updated 1/8/25 for resident 14- separate skin folds and cleanse, clean all areas	

	that urine or feces touch when providing perineal care. Plan • Director of Nursing or Designee will in-service clinical staff on or before 1/25/25 on perineal care to include cleansing all areas that touch urine/feces, skin folds and genital folds to be spread and cleansed thoroughly during peri care, using one swipe per perineal cleansing wipe, don/doff PPE for residents on isolation, washing hands prior to/and after providing resident care, catheter care, anchoring catheter tubing, cleaning catheter port, changing gloves/washing hands when gloves soiled with feces, repositioning, and providing oral care when providing routine morning care for resident. • Director of Nursing or Designee will complete a total of 48 staff observations weekly x 4 weeks (8 each of peri care, catheter care, PPE application, hand washing, repositioning, and oral care). Monitoring • Director of Nursing or Designee will complete 24 observations monthly ongoing (4 each of peri care, catheter care, PPE application, hand washing, repositioning, and oral care). Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
A4067	**19 CSR 30-85.042(58)** **Meds destroyed within 30 days** Immediate Correction	

	• Resident 28 care plan updated 1/8/25-medications are not to be left bedside, medications will be observed while being administered to resident. • Resident 193 care plan updated 1/8/25-no medication is to be left bedside. Plan • Director of Nursing or Designee will in-service staff on or before 1/25/25 regarding medication being observed at time of administration to resident, medications are not to be left bedside without self-administration assessment, medications are to be stored in medication carts that are locked, medications are to be labeled for specific resident. • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per week for 4 weeks. Monitoring • Director of Nursing or Designee will complete 5 medication administration audits and 5 room audits per month ongoing. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
A4078	**19 CSR 30-85.042(69) Reposition every 2 hrs/ maintain body alignment** Immediate Correction • Care plan updated 1/8/25 for resident 14-offer to lay resident down between meals, provide perineal care approximately every	

	two hours, reposition resident approximately every two hours. Plan • Director of Nursing or Designee will in-service on or before 1/25/25 regarding repositioning resident approximately every 2 hours, providing incontinent care approximately every 2 hours, and laying resident down per order. • Director of Nursing or Designee will complete a total of 10 staff observations weekly x 4 weeks (5 each repositioning, monitoring to ensure laid down per physician order). Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25. Monitoring • Director of Nursing or Designee will complete 10 observations monthly (5 each: repositioning, monitoring to ensure laid down per physician order) and report findings to monthly QAPI.	
A4087	**19 CSR 30-85.042(78) Dr notification-change of condition** Immediate Correction • Patient 28, 295, 244, 294 no longer at facility. • Scales will be calibrated on or before 1/25/25 by outside contractor. • Director of Nursing or Designee will review all resident weights for weight gain and loss and ensure care plans are updated, interventions are	

	in place and notifications are made. This will be completed by 1/25/25. • Director of Nursing or Designee will amend Weight Management Policy to reflect significant weight gain to the existing weight management policy. Significant weight gain will be considered 3% in 1 week, 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. • Clinical staff will be in-serviced on or before 1/25/25 on appropriate use of PRN medication to ensure that medication ordered is appropriate for the symptom/diagnosis and that appropriate clinical information is provided to medical practitioner and documented in resident chart. Plan • Maintenance Director or Designee will have weight scales calibrated by an outside contractor every 3 months and as needed and keep log of services being completed. • Administrator or Designee will in-service maintenance staff on new policy and procedure by 1/25/25. • Director of Nursing or Designee will in-service clinical staff on weight loss/gain policy and documentation expectations on or before 1/25/25. • Clinical staff will be in-serviced on or before 1/25/25 on appropriate use of PRN medication to ensure that medication ordered is appropriate for the symptom/diagnosis and that appropriate clinical information is provided to medical practitioner and documented in resident chart.	

	• Facility will be in substantial compliance by 1/25/25. Monitoring • Maintenance Director or Designee will provide report to QAPI monthly on status of calibration and documentation of scales. • Director of Nursing or Designee will review resident weights weekly beginning immediately to ensure policy is being followed and documentation is present and report to QAPI monthly any findings. • Director of Nursing or Designee will review documentation and orders the next business day. Findings will be reported at the monthly QAPI meeting. The facility will be in substantial compliance by 1/25/25.	
A7016	**19 CSR 30-87.030(17) Food Stored in Identifying Containers** Immediate Correction: • Dietary Manager or Designee will provide education to staff no later than 1/25/25 regarding policy on food storage which will include but is not limited to labeling and dating food, appropriate time food can be kept, and when to throw away and how to properly store food as well as policy on recording and taking temperatures. • Dietary Manager or Designee will audit dry storage and remove any items with expiration or not dated, or date if open date is known by 1/25/25.	

	• Dietary Manager or Designee will audit walk in cooler and freezer and remove any items with expiration or not dated, or date if open date is known by 1/25/25. • Dietary Manager or Designee will audit kitchen refrigerators and freezers and remove any items with expiration or not dated, or date if open date is known by 1/25/25. Plan • Dietary Manager or Designee will audit dry storage walk-in cooler and freezer and any dietary refrigerators weekly for four weeks beginning 1/27/25 for food that is not dated and/or expired and ensure food is thrown out. • Dietary Manager or Designee will audit temp logs daily M-F for four weeks beginning 1/27/25 for temperature recordings. • Dietician or Designee will complete full kitchen audit by 1/25/25 and provide results to Dietary Manager and Administrator for further action. Monitoring • Dietary Manager or Designee will audit dry storage, walk-in cooler, freezer, and any dietary refrigerators monthly for three months beginning February 1 2025, and then as needed for food that is not dated and/or expired and ensure food is thrown out. Results will be taken to QAPI.	
A8010	**19 CSR 30-88.010(10) Advanced Directive Requirements** Immediate Correction:	

	• Resident #22 incapacitation letter verified, DPOA verified, physician order updated and care plan updated. • Resident # 18 incapacitation letter verified, DPOA verified, physician order updated and care plan updated. • Resident #295 no longer in facility. • Administrator or Designee will provide education by 1/25/25 to Admissions, Social Worker, Clinical Team and Administrative Team regarding Advanced Directive policy and procedure. Plan: • Social Worker or Designee will audit resident charts using audit tool that includes: Code Status; order of Code Status; Advanced Directives; DPOA paperwork; Incapacitation Letter; door sign reflected correctly to be completed by 1/25/25. • Upon admission during morning IDT meeting each working business day Monday through Friday; Clinical Team and Social Worker will review new resident admission for Advanced Directives, Code Status; DPOA Paperwork and Incapacitation Letter if applicable and ensure orders and care plans are correct. Monitoring: • Social Worker or Designee will audit monthly for three months beginning February 1, 2025 and then as needed using audit tool for Code Status; order of Code Status; Advanced Directives; DPOA paperwork; Incapacitation Letter; door sign reflected correctly and take results to QAPI.	

	F584 Safe/Clean/Comfortable/Homelike Environment Immediate Correction: • Director of Nursing or Designee will ensure carts will be cleaned from top to bottom including wheels by 1/15/25. • Dietary Manager or Designee will ensure metal carts used for food delivery are cleaned from top to bottom including wheels by 1/25/25. • Housekeeping Director or Designee will ensure carpets are vacuumed and free of crumbs by 1/17/25 and windows sills are dusted and free of debris by 1/25/25. • Maintenance Director or Designee will ensure PTAC unit is cleaned by 1/15/25. Plan: • Director of Nursing or Designee will make a schedule for clinical team to clean carts weekly with a sign off. • Director of Nursing or Designee will do weekly cleaning checks for four weeks on medication carts. • Director of Nursing or Designee will in-service clinical staff on the new policy on or before 1/25/25. • Maintenance Director or Designee will paint scraped area of paint no later than 1/25/25. • Dietary Manager or Designee will make a schedule for cart cleaning with check off for when cleaned by 1/25/25.	

	• Dietary Manager or Designee will audit cart cleaning weekly for 4 weeks beginning February to ensure carts are being cleaned. • Maintenance Director or Designee will repair or replace holes in carpet. • Housekeeping Supervisor or Designee will in-service staff on cleaning policy and schedule on or before 1/25/25 to ensure common areas and windows are cleaned. • Housekeeping Supervisor or Designee will prepare cleaning schedule for common areas and windows on or before 1/25/25. Monitoring: • Director of Nursing or Designee will then complete monthly checks of medication carts to confirm cleanings are completed as scheduled and will report findings to QAPI. The facility will be in substantial compliance by 1/25/25. • Dietary Manager or Designee will audit meal carts monthly for 3 months beginning in February and then as needed and report findings to QAPI. • Housekeeping Supervisor or Designee will complete weekly audits for 3 months beginning in February and then as needed to ensure common areas and window sills are clean and report finding to QAPI.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.