STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265377	A. BUILDING _____ B. WING _____	C 03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON HEALTH CARE	615 SW OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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) COMPLETION DATE
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one sampled resident (Resident #3) was protected from verbal abuse when on 2/27/24 Certified Medication Technician (CMT) A was witnessed screaming in the resident's face telling him/her they were "acting fucking stupid," and disrespectful when the resident refused to take his/her medications crushed in pudding and wanted his/her medications whole with water out of six sampled residents. The facility census was 52 residents. Review of the facility's undated Abuse and Neglect Policy showed: -The residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical of chemical restraint	F 600		

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

Matthew Woods, Admin 4/4/24

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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F 600	Continued From page 1	F 600		

not required to treat the resident's symptoms.
-The facility will not condone any form of resident abuse or neglect.
-To aid in abuse prevention, all personal are to report any sings and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately.
-Protect the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.
-Abuse is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

1. Review of Resident #3's Face Sheet showed he/she admitted to the facility on 12/18/23 and readmitted on 12/20/23 with the following diagnoses:
-Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome).
-Depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act).
-Schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder - a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).
-Dysphagia, oropharyngeal phase (is characterized by the dysfunction of one or more parts of the swallowing apparatus (begins with the mouth and includes the lips, tongue, oral cavity, pharynx, airway, esophagus, and both upper and

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F 600	Continued From page 2 lower sphincters). Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 12/27/23 showed: -He/she was cognitively intact. -No swallowing problems. -Physical behaviors occurred four to six days a week. -Verbal behaviors occurred daily. -Other behaviors occurred one to three days a week. -Rejected cares daily. Review of the resident's care plan dated 2/9/24 showed: -He/she had been receiving his/her medications crushed or one pill at a time due to recent difficulty in swallowing medications. -He/she will be able to successfully take his/her medications. -Supervise the resident with taking medications. -He/she will request medications to be left at bedside, do not leave medications at bedside. -Speech Therapy (ST) to evaluate and treat as indicated. -Crush appropriate medications and provide in pudding or applesauce. -2/21/24, ST continues to work with him/her on swallowing medications. -He/she has no difficulty swallowing foods or drinking liquids. -Becomes easily agitated at times. -Make his/her needs known and avoid yelling at others. -Remind to speak calmly as needed. -Do not argue with him/her. -Return later and allow him/her to calm down as	F 600		

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F 600	Continued From page 3 needed. -Provide a quite place to calm down when irritated. -Becomes easily agitated and begin to focus on negative thoughts. -He/she is not easily directed. -When he/she refuses care, return later, and re-offer. -Help him/her understand the reasoning behind a difference of opinion. -Identify staff that he/she might have a better connection to. -Altered thought process at times. Do not argue with resident, ensure he/she remains safe. Review of Housekeeping Manager's written statement on 2/27/24 at 10:48 A.M., showed: -He/she was walking by the resident's room and heard CMT A yelling at the resident. -Maintenance went into the resident's room and separated CMT A and the resident. -Maintenance told CMT A to leave the room. Review of the facility's undated investigation summary showed: -Director of Regional Consulting was informed of the incident on 2/28/24 at approximately 1:30 P.M. -Statements were obtained and the resident was interviewed. -Through interview and discussion, the resident as well as the direct witness felt the incident was not abusive, resident felt and expressed that he/she felt safe, however both the resident and CMT A felt it was inappropriate. -New Administrator was informed of this incident, to schedule all staff in-service review customer service, dignity and abuse and neglect with all facility staff members and include a copy of	F 600		

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F 600	Continued From page 4 signed acknowledgments. -CMT A received corrective action on 3/1/24, his/her first day back to work following the incident about dignity, abuse, and neglect as well as customer service. Review of the Nutritionist's written statement dated 2/28/24 at 10:48 A.M., showed: -He/she witnessed CMT A yelling at the resident. -He/she heard the statement "fucking stupid", which he/she could not say if it was CMT A calling the resident that or his/her behavior. -But he/she does know that CMT A was yelling at the resident and being very loud. -Maintenance came in and separated CMT A and the resident. Review of Licensed Practical Nurse (LPN) A's dated 2/28/24 at 11:20 A.M., showed: -He/she was called to the resident's room due to CMT A yelling at the resident. -As he/she entered the resident's room, CMT A was coming out of the room continuously yelling at the resident saying, "You do not disrespect other people, if you want respect, you have to give respect". -He/she told CMT A that is the resident's room and if he/she does not want you in his/her room, he/she can tell you to get out. -He/she told CMT A that the resident can be disrespectful, and he/she just has to take it and CMT A stated, "No I will not be disrespected, that is why nobody wants to work with the resident." Review of the resident's written statement dated 2/28/24 at 3:15 P.M., showed: -CMT A had a mean streak and a terrible foul mouth. -If he/she would turn on the call light typically	F 600		

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F 600	Continued From page 5 CMT A would say "quit turning your light on." -Today he/she asked CMT A "why are you such a dumb ass?" -He/she feels safe at the facility a lot of the time. -Some of the staff feel like they do not want to be bothered. Review of Maintenance Manager's written statement dated 2/28/24 at 3:30 P.M., showed: -During call light inspections he/she heard voices getting louder down the hall. -He/she heard the nutritionist say CMT A needed to get out of the resident's face. -He/she entered the resident's room and CMT A and the resident were face to face screaming at each other. -CMT A said something like "you're acting fucking stupid." -He/she pulled the privacy curtain and told CMT A to leave the room. -He/she informed the previous Administrator about the incident. Review of CMT A's written statement dated 2/28/24, showed: -He/she went to give the resident his/her morning medications. -The resident's Medication Administration Record (MAR) showed the resident received his/her medications crushed in pudding. -He/she went to take the resident's blood pressure and the resident told him/her that he/she hates taking his/her medications in pudding because he/she hates the taste. He/she does not like the taste of his/her medications crushed and mixed in pudding or applesauce. -The resident told him/her that he/she can take his/her medications whole, but it would take 10 minutes to do so.	F 600		

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F 600	Continued From page 6 -He/she told the resident the order on the MAR said the medications had to be crushed, and it was not worth his/her license to give him/her whole medications. -He/she started the blood pressure cuff and asked the resident to stop talking until after his/her blood pressure was taken. -The resident asked why no other staff had asked him/her to be quiet before. -He/she explained to the resident that talking could cause the blood pressure to read wrong. -The resident said that is a lie, and he/she responded it was not a lie and left it at that. -The resident kept talking and he/she again asked the resident to stop talking until the blood pressure machine was done, and he/she argued that he/she was dumb. -He/she was stirring the resident's medications and the resident starting yelling at him/her because the resident thought he/she was going to feed him/her the medications. -He/she explained that he/she was just stirring the medication and passed the medications to the resident for him/her to take him/herself. -The resident kept repeating his/her statement that it would only take 10 minutes to take his/her medications whole with water. -By this time the nutritionist was outside the resident's door. -After some time, the resident finally took his/her medications. -He/she did raise his/her voice to talk over the resident as he/she was repeating his/her statement over and over. -As he/she was closing the resident's door, the resident said, "I am tired of this dumb ass bitch, he/she knows nothing." -The Maintenance Director and Nutritionist were in the room at this time and told both the resident	F 600		

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F 600	Continued From page 7	F 600		

and him/her to calm down.
-He/she told the Maintenance Director and Nutritionist that he/she was calm, the resident needed to learn some respect.
-If he/she was not disrespecting the resident what gave the resident the right to disrespect him/her.
-Everything he/she said was in a raised voice and was not yelling.
-He/she left the resident's room and went to his/her medication cart to continue to pass medications.
-LPN A was coming down the hall and he/she explained what happened with the resident.
-He/she told LPN A that he/she never disrespected the resident and that he/she felt very disrespected and that was not okay.

During an interview on 3/7/24 at 11:21 A.M., Maintenance Director said:
-He/she was checking call lights when he/she heard yelling coming from a resident's room.
-As he/she walked up to the room, the Housekeeping Director was saying the CMT A needed to get out of the resident's face.
-CMT A was about six inches from the resident's face yelling "are you fucking stupid", and "you are acting fucking ignorant."
-He/she asked CMT A to leave the resident's room and he/she pulled the resident's privacy curtain and stayed with the resident until he/she calmed down.
-He/she notified the LPN A of the incident.

During an interview on 3/7/24 at 11:33 A.M., Nutrition Director said:
-He/she was coming up the hall when he/she heard the resident ask CMT A about his/her medications being crushed.
-CMT A said "that is how it is" and said the

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F 600	Continued From page 8 resident was "fucking stupid." -He/she told CMT A and the resident to stop yelling and told CMT A to leave the resident's room, that this was his/her home. -Maintenance Director went into the resident's room and separated CMT A from the resident and made CMT A leave the room. During an interview on 3/7/24 at 11:52 A.M., Housekeeping Supervisor said: -He/she heard the yelling in his/her office and went to see where the yelling was coming from. -Maintenance Director and Nutritionist were also going to see what the yelling was about and found CMT A in the resident's room screaming at the resident saying he/she was "fucking stupid" and telling the resident he/she could not talk to him/her like that. -Maintenance Director entered the room and made CMT A leave the room. During an interview on 3/7/24 at 1:03 P.M., LPN A said: -He/she did not see or hear the incident but was notified of the incident by Maintenance Director. -He/she had a talk with CMT A about resident's rights, dignity, and respect and how this is the resident's home. -He/she notified the Administrator of the incident. -He/she went to talk to the resident and the resident told him/her to get out of his/her room. During an interview on 3/7/24 at 2:07 P.M., the Administrator said: -He/she was new to the facility and the incident happened before he/she arrived at the facility. -He/she did have to terminate CMT A due to poor performance on 3/6/24. -He/she will not tolerate anyone disrespecting the	F 600		

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F 600	Continued From page 9 residents in their home. During an interview on 3/11/24 at 9:41 A.M., CMT A said: -He/she did not tell the resident that he/she was "fucking stupid." -The resident wanted to take his/her medications whole, but the physician's order said to crush the medications and give in applesauce or pudding. -He/she tried to explain this to the resident, but he/she would not listen. -The resident is very difficult to work with and is always cussing or yelling at staff. -He/she does not have the time to wait for the resident to take 10 minutes to take medications like he/she wants. -The resident said he/she was "dumb" and call him/her out and this upset him/her. He/she was talking to the resident in a raised voice but not yelling. -He/she did not disrespect the resident when trying to get the resident to take his/her medications, but the resident was disrespectful to him/her, and he/she does not have to be treated that way. During an interview on 3/11/24 at 1:26 P.M., the resident said: -CMT A was being rude and disrespectful to him/her when he/she asked for his/her medication to be whole and not crushed. -He/she told CMT A that the nurse lets him/her take the medications whole. -CMT A was yelling at him/her because he/she kept trying to explain how he/she wanted to take the medications. -He/she did become upset and was yelling back at CMT A, when CMT A said he/she was "fucking stupid" and "acting fucking ignorant."	F 600		

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F 600	Continued From page 10 -Maintenance Director came into his/her room and made CMT A leave the room. -The Maintenance Director stayed and talked to him/her to make sure he/she was good. MO00232324 MO00232505	F 600		

Missouri Department of Health and Senior Services

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A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: *Class II *The higher classification merited due the violation's effect on the resident. 1. Refer to F600.	A8023		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Matthew J Woods, Admin | 4/4/24

PLAN OF CORRECTION

Provider Name:	Jefferson Health Care
Street Address, City, Zip:	615 SW Oldham Parkway, Lee's Summit, Mo. 64081
Date of Survey:	3/11/2024
Provider number:	265377

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Jefferson Health Care agrees with the allegations and citations listed on the statement of deficiencies. Jefferson Health Care maintains that the alleged deficient practices do not, individually and collectively, jeopardize the health and safety of the residents nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Jefferson Health Care's written credible allegation of compliance. By submitting this plan of correction, Jefferson Health Care does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Jefferson Health Care reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
F600	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:***	04/08/2024
	Resident #3 had no adverse effects/ negative outcome from he alleged deficient practice. CMT A was terminated from employment on March 6th, 2024.	
	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken	
	All residents are at risk for the alleged deficient practice. All staff have been in-serviced regarding the facilities abuse and neglect policy by the Administrator and DON. This was completed on 3/8/24. All newly hired staff will be in-serviced on the abuse and neglect policy by Administrator DON and/or designee as part of the orientation process.	

	The Payroll Clerk and/or designee will audit new hire(s) to validate completion of abuse and neglect training for new employees, this will be completed 2-4 times per week for 2 weeks, weekly for 2 weeks, and monthly for 1 month and randomly thereafter to validate continued compliance.	
	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur	
	The facility Administrator will be the Abuse and Neglect Coordinator for the facility. The Activities Director and/or Designee in monthly resident council meeting will remind residents of the Abuse / Neglect Coordinator and grievance process. This will be done monthly times 3 monthly, quarterly times 3 quarters, and monthly ongoing to validate compliance. Abuse and Neglect training will be provided to employee's annually and upon allegations of abuse, this will be ongoing to validate compliance. The Administrator and Director of Nursing will be provided education on the reporting, investigating, appropriate forms, and facility process for any and all allegations, this will be completed by the Director of Regional Consulting prior to the compliance date of 4-8-24. The Administrator and/or Designee will validate that employee(s) have completed abuse and neglect training annually, this will be reviewed annually and upon reporting/ investigating and submitting allegations.	
	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system	
	Facility completed audits will be reviewed at the facility Quality Assurance Performance Improvement Meeting, this will be done monthly for 3 months, quarterly for 3 months, and ongoing to validate compliance until deemed no longer necessary by the committee. Areas of concern will be addressed immediately at the time of discovery through re-education.	

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.

PLAN OF CORRECTION

Provider Name:	Jefferson Health Care
Street Address, City, Zip:	615 SW Oldham Parkway, Lee's Summit, Mo. 64081
Date of Survey:	3/11/2024
Provider number:	265377

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Jefferson Health Care agrees with the allegations and citations listed on the statement of deficiencies. Jefferson Health Care maintains that the alleged deficient practices do not, individually and collectively, jeopardize the health and safety of the residents nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Jefferson Health Care's written credible allegation of compliance. By submitting this plan of correction, Jefferson Health Care does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Jefferson Health Care reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
A8023	***Refer to F600***	04/08/2024

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.

Matthew Woods, admin 4/4/24