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F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents'	F 583		

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

Michael W Marshall | Administrator | 9-29-23

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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private records were kept private during a medication pass by not ensuring the computer screen was not visible to anyone walking by the computer on top of the medication cart while the nurse administered medications inside of the residents' room for two sampled residents (Resident #5 and Resident #11) and one supplemental resident (Resident # 10) out of nine sampled residents. The facility census was 13 residents.

Review of the facility's policy, "Medication Administration," dated 9/1/22 showed:
-Medications were to have been administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.
-Provide privacy.

1. Review of Resident 5's face sheet showed he/she was admitted on 7/10/23 with the following diagnoses:
-Cognitive communication deficit (a disorder in which a person has difficulty communicating as a result of a brain injury).
-Depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act).
-Bipolar disorder (a disorder associated with episodes of manic highs and depressive lows).
-Dementia (a group of thinking and social symptoms that interferes with daily functioning).

Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff for care planning) dated 8/7/23 showed his/her Brief Interview for Mental Status (BIMS) score was 10 out of 15 indicating

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he/she was moderately cognitively impaired.

Observation on 9/7/23 at 7:15 A.M. of the medication pass with Licensed Practical Nurse (LPN) A showed:
-The nurse went into the resident's room to administer six medications to the resident.
-He/she had left the screen on the computer open for two minutes with the resident's information clearly visible.
-One staff member walked by the computer within two feet of the computer screen.

2. Review of Resident #10's Admission MDS dated 8/13/23 showed:
-He/she was admitted to the facility on 8/10/23.
-He/she had a complex medical history.
-His/her BIMS score was 15 out of 15 indicating he/she was cognitively intact.

Observation on 9/7/23 at 7:45 A.M. with LPN A showed:
-The nurse went into the resident's room to administer one medication patch to the resident.
-He/she had left the screen on the computer open for four minutes with the resident's information clearly visible.
-Two staff members walked by the computer within two feet of the computer screen.
-Three residents walked by the computer within two feet of the computer screen.

3. Review of Resident #11's Admission MDS dated 6/30/23 showed:
-He/she was admitted on 6/30/23 with the following diagnoses:
-Fractures (a complete or partial break in the bone).
-Obstructive Uropathy (a condition in which the

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flow of urine is blocked causing it to back up into the kidneys).
-Cerberbal Vascular Accident (CVA -damage to the brain from interruption of its blood supply).
-His/Her BIMS score was 00 out of 15 indicating he/she was severely cognitively impaired.

Observation on 9/7/23 at 8:26 A.M. with LPN A showed:
-The nurse went into the resident's room to administer two medications to the resident.
-He/she had left the screen on the computer open for three minutes with the resident's information clearly visible.
-One resident walked by the computer within two feet of the computer screen.

4. During an interview on 9/7/23 at 12:30 P.M. LPN A said:
-When staff were passing medications, they should have minimized the screen on the computer so anyone passing by could not have seen the resident's information.
-The facility had provided education on keeping the residents information private.

During an interview on 9/7/23 at 1:00 P.M. Certified Medication Technician (CMT) A said:
-Nursing should have minimized the screen if not in front of it when passing medications so no one passing by was able to see the resident's private medical information.
-The facility had given them education on ensuring the residents information stayed private.
-The Director of Nursing (DON) was ultimately responsible to ensure nursing was ensuring residents' information stayed private.

During an interview on 9/8/23 at 12:37 P.M. the

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F 583	Continued From page 4 DON said: -Nursing was to use the Hide Screen tab on the computer to ensure the medical information of the resident stayed private. -Ensuring residents' information stayed private was covered during orientation. -Privacy was inserviced with the staff at least annually. -Staff was observed during morning rounds to ensure the computer screens were hidden with no resident information visible. -He/she was ultimately responsible to ensure that staff was not leaving the computer screens open with resident information visible to anyone walking by the medication cart.	F 583		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		

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(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide continuity of resident care by not reviewing and revising resident comprehensive care plans (a document that specified health care and supported needs and outlined how the facility met resident requirements) for one sampled resident (Resident #269) out of nine sampled residents. This practice had the potential to effect the resident's safety and physical well-being. The facility census was 13 residents.

Review of the facility's Comprehensive Care Plans Policy, dated 9/1/2021, showed:
-It was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident.
-The comprehensive care plan described the services that were furnished to attain or maintain the resident's highest practicable physical well-being.
-The comprehensive care plan was prepared by the interdisciplinary team which included:
--The attending physician.
--A Registered Nurse (RN).
--A nurse aide.
--A member of the food and nutrition services staff.
--The resident and the resident representative.
--Other appropriate staff or professionals.
-The comprehensive assessment was reviewed

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and revised by the interdisciplinary team.

1. Review of Resident #269's face sheet, undated, showed he/she had the following diagnoses:
-Stroke.
-Hemiplegia and hemiparesis (lack of ability to move or control the muscles in the affected body part).
-Generalized muscle weakness.
-Alcohol abuse.

Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/21/23, showed:
-The resident scored a 15 on the Brief Interview for Mental Status (BIMS), an assessment tool that shows a score between 3 and 15 which shows the resident's mental status. This tool helps determine the resident's attention, orientation and ability to register and recall new information. These items were crucial factors in care planning decisions.
--This showed the resident was cognitively intact.
-The resident required extensive assistance with transferring (how a resident moves to and from surfaces including from bed to wheel chair, chair, standing, toilet) with two staff persons providing weight bearing support.
- The resident required maximal assistance with showering/bathing self.

Review of the resident's care plan, dated 8/28/23, showed the resident required a mechanical lift for transfers, requiring two staff members.

During an interview on 9/5/23 at 10:08 A.M., the resident said:

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-He/she received a bath/shower twice a week in the shower room.
-Staff did not put him/her in a mechanical lift.
-Staff just wheeled him/her down to the shower room and helped him/her as needed.

During an interview on 9/6/23 at 10:23 A.M., Certified Medication Technician (CMT) A said:
-The resident did not require a mechanical lift.
-The resident had supervision during bathing.

During an interview on 9/6/23 at 1:50 P.M., Licensed Practical Nurse (LPN) A said:
-The resident no longer required a mechanical lift.
-He/She needed to use one when he/she first was admitted.
-His/Her weight bearing improved and no longer needed a mechanical lift.

During an interview on 9/7/23 at 6:47 A.M., Certified Nursing Assistant (CNA) B said:
-The resident did not require a mechanical lift.
-The resident used it when he/she first got to the facility.
-The resident no longer required maximum assist.
-The resident was able to stand and pivot.

During an interview on 9/7/23 at 6:57 A.M., LPN B said:
-He/she believed the resident used a mechanical lift.
-He/she worked nights and the resident did not usually need to be up at night.
-He/she did not get the resident up.

During an interview on 9/7/23 at 10:43 A.M., the Director of Nursing (DON) said:
-The resident did not use a mechanical lift.

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F 657	Continued From page 8 -The resident used a mechanical lift when he/she was first admitted. -The Kardex (a filing system for nursing records and orders) stated the resident was an extensive assist. During an interview on 9/7/23 at 1:25 P.M., the DON said: -The care plan should be updated as orders were changed. -He/she was able to go in and update care plans as necessary. -Some changes did not require a full care plan meeting. -If the resident no longer required a mechanical lift he/she would expect the care plan to be updated.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 661		

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(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to document information regarding the resident's personal belongings for one sampled closed record resident (Resident #15) out of two sampled closed records. The facility census was 13 residents.

Review of the facility's resident personal belongings policy revised 9/1/22 showed:
-All resident personal belongings would be inventoried at the time of admission and documentation kept in the medical record.
-Additional possessions brought in during the duration of the individual's stay would be added to the existing personal belongings inventory listing.
-Following the discharge of a resident, all personal belongings would be given to the designated resident representative.
-The inventory of personal belongings should be reviewed at time of discharge by Social Services and the resident's representative.
-The recipient of the resident's personal belongings would sign-off with their legal signature acknowledging receipt of all personal belongings presented.

1. Review of Resident #15's entry tracking form

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F 661	Continued From page 10 showed he/she admitted to the facility on 6/13/23. Review of the resident's long-term care facility to hospital transfer note dated 7/2/23 showed he/she was discharged to the hospital. Review of the resident's discharge assessment showed he/she was discharged from the facility on 7/2/23 and was not expected to return to the facility. Review of the resident's medical records showed no documentation regarding the resident's personal belongings. During an interview on 9/8/23 at 9:48 A.M., Licensed Practical Nurse (LPN) C said: -During the admission process, the nurses and/or Certified Nursing Assistants (CNA)s were supposed to document the resident's personal belongings on a paper form. -When the resident discharged from the facility, nursing staff were to document where the resident's belongings went upon/after discharge. During an interview on 9/8/23 at 12:37 P.M., the Director of Nursing (DON) said: -Their Social Worker was no longer employed there as of the previous week. -The CNAs have an inventory sheet they were supposed to fill out to put belongings on when residents bring in personal items. -The nurse should document what belongings the resident and/or their representative took with them and have them sign the inventory sheet upon discharge.	F 661		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§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 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 follow physician orders by not providing supervision for one sampled resident (Resident #269) out of nine sampled residents while the resident was alone in his/her wheelchair in his/her room. The facility census was 13 residents.

Review of the facility's Medical Provider Orders policy, dated 4/7/22, showed:
-The facility used uniform guidelines for the ordering and following of medical provider orders.
-Medical provider orders were reviewed prior to administration of medication and/or treatment to validate the orders contained all required elements.
-Staff should follow all valid medical provider orders timely unless there was an emergency that temporarily delayed the implementation of the order.

Review of the facility's Incidents and Accidents policy, dated 9/1/22, showed:
-The purpose of the policy was to ensure appropriate and immediate interventions were implemented and corrective actions taken to prevent recurrences and improve the management of resident care.

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1. Review of Resident #269's face sheet, undated, showed he/she had the following diagnoses:
-Stroke with hemiplegia and hemiparesis (the inability to move or control the muscles in the affected body part).
-Generalized muscle weakness.
-Difficulty walking.

Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/21/23, showed:
-The resident scored a 15 on the Brief Interview for Mental Status (BIMS - an assessment tool that shows a score between 3 and 15 which shows the resident's mental status. This tool helps determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in care planning decisions).
--This showed the resident was cognitively intact.
-The resident required extensive assistance with transferring (how a resident moves to and from surfaces including from bed to wheel chair, chair, standing, toilet) with two staff persons providing weight bearing support.

Review of the resident's physician order summary, dated 8/24/23, showed:
-The resident was not to be in his/her wheelchair unsupervised.
-When in room, ensure the resident was in his/her recliner.
-Ensure Dycem (material used to help stabilize objects, hold objects firmly in place, or to provide a better grip) was in wheelchair at all times.

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Review of the resident's Care Plan dated 8/26/23, showed:
-On 8/17/23 the resident slid from his/her wheelchair without injury.
-On 8/22/23 the resident had an unwitnessed fall in the activity room without injury.
-On 8/26/23 the resident slid from his/her wheelchair, no injury noted.

Observation on 9/5/23 at 11:13 A.M. showed the resident was in his/her room in his/her wheelchair without supervision.

During an interview on 9/6/23 at 10:23 A.M., Certified Medication Technician (CMT) A said:
-The resident had a Dycem pad in the wheelchair.
-The pad went on top of the cushion.
-It helped the resident from sliding out of the wheelchair.
-The resident needed supervision while in his/her wheelchair.
-A Certified Nurse Assistant (CNA) or nurse supervised the resident.
-The resident was not supposed to be left in the wheelchair.
-The resident should have been in his/her recliner if in his/her room.

During an interview on 9/6/23 at 1:50 P.M., Licensed Practical Nurse (LPN) A said:
-The resident slid out of the wheelchair two to three times.
-The resident was provided a Dycem pad and educated on call light use.
-Currently the resident was able to be in wheelchair unsupervised.

Observation from 9/7/23 from 6:35 A.M. to 6:45 A.M., showed the resident was in his/her room in

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his/her wheelchair, watching TV, unsupervised.

During an interview on 9/7/23 at 6:47 A.M., CNA B said:
-The resident had a Dycem pad on his/her wheelchair cushion.
-The resident was safe to be in his/her wheelchair on his/her own but staff kept an eye on him/her.
-The resident tried to get up on his/her own.
-He/she made sure the resident's call light was within reach and other items needed were close to the resident.
-He/she checked on the resident every 10 to 15 minutes when the resident was in his/her room.
-The resident did not like to be in his/her recliner.
-He/she knew the resident should be in his/her recliner.

During an interview on 9/7/23 at 6:57 A.M., LPN B said:
-When the resident was in his/her room and not in bed, he/she was supposed to be in the recliner to prevent falls.
-The recliner helped position him/her better.
-The resident was usually very cooperative about sitting in the recliner.
-The resident required supervision while in the wheelchair.
-Supervision meant the resident was within eye sight.

Observation on 9/7/23 at 10:25 A.M. showed:
-The resident was seen leaving his/her room in his/her wheelchair.
-No staff were present in the area.

During an interview on 9/7/23 at 10:43 A.M., the Director of Nursing (DON) said:
-The resident had a Dycem pad between

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F 689	Continued From page 15 him/herself and the cushion on the wheelchair. -Nurses were responsible for ensuring the Dycem pad was in place. -There was no need for the resident to be in his/her recliner when in his/her room. During an interview on 9/7/23 at 1:36 P.M., the resident's physician said: -The resident had issues of being impulsive and attempted to do activities he/she was not capable of, such as transfers. -The resident was at high risk for falls if left in the wheelchair unsupervised. -He/she preferred for the resident to be supervised if the resident was in his/her wheelchair, or in a common area where staff could have him/her in eye sight. -He/she did not want the resident in his/her wheelchair without supervision. -He/she expected staff to follow physician orders.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for one sampled resident (Resident #68) who was the only resident receiving dialysis that resided at the facility. The facility census was 13 residents.	F 698		

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Review of the facility's dialysis policy revised 9/1/22 showed:
-There should be ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.
-The facility staff should coordinate and collaborate with the dialysis facility to assure that documentation requirements were met to assure that treatments are provided as ordered.

1. Review of Resident #68's all-inclusive admission with baseline care plans dated 9/3/23 showed the reason for the resident's admission was to receive therapy, cares and dialysis.

Review of the resident's Physician's Order Sheet dated September 2023 showed:
-The resident was to receive dialysis from 5:00 A.M. to 9:00 A.M.
-The resident's dialysis days were Monday, Wednesday and Friday.

Review of the resident's dialysis communication form dated 9/4/23 showed:
-The dialysis center information section included areas to document pre- and post-dialysis weight, vital signs, dialysis start time and end time, fluid removed, meal/snack intake, shunt location/status, new doctor's orders and additional information.
-The information section from the dialysis center was left blank.

During an interview on 9/5/23 at 2:30 P.M. the resident said:
-He/she just came to the facility the evening of 9/1/23.
-He/she went to dialysis once (on 9/4/23) since

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being admitted to the facility.
-The dialysis center took his/her weight before and after dialysis when he/she was there the day before.
-He/she was unsure if the dialysis center sent his/her weight or anything else to the facility.
-The facility van took him/her to dialysis and he/she was there at 5:00 A.M.

Observation on 9/6/23 at 9:56 A.M. showed the resident was being pushed into the building in his/her wheelchair (after returning from dialysis).

Review of the resident's dialysis communication form dated 9/6/23 showed:
-The dialysis center information section included areas to document pre- and post-dialysis weight, vital signs, dialysis start time and end time, fluid removed, meal/snack intake, shunt location/status, new doctor's orders and additional information.
-The information section from the dialysis center was not completed.

During an interview on 9/6/23 at 2:59 P.M., Licensed Practical Nurse (LPN) A said:
-The dialysis center was supposed to fill out the middle part (titled dialysis center information) of the dialysis communication form and send it back to the facility with the resident after dialysis.
-It was the responsibility of the nurse on duty to call the dialysis center and get the weights and information if the dialysis communication form did not come back with the resident after dialysis.

During an interview on 9/8/23 12:37 P.M., the Director of Nursing (DON) said:
-Nursing had not obtained weights from the dialysis center for Monday and Wednesday until

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F 698	Continued From page 18 the state surveyor requested the information. -They filled out the pre-dialysis information on the dialysis communication form, they made a copy and sent the form with the resident to the dialysis clinic. -The dialysis center was supposed to fill out the center section of the dialysis communication form and send it back to the facility. -When the resident returned to the facility, nursing staff were supposed to fill out the post-dialysis information section. -If the dialysis center did not fill out their section or send the form back to the facility, the nurse should call the dialysis center and request the form with the information completed.	F 698		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		

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§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide an annual dental exam for two sampled residents (Resident #2 and Resident #5) and to provide a dental consult for one sampled resident (Resident #12) who wanted to be evaluated for possible extractions of his/her teeth so he/she could obtain dentures out of nine sampled residents. The facility census was 13 residents.

Review of the facility's dental services policy revised on 9/1/22 showed:
-It was the policy of the facility to assist residents in obtaining routine and emergency dental care.
-The dental needs were to be identified through the physical assessment and Minimum Data Set

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(MDS-a federally required assessment tool completed by facility staff for care planning) assessment process and addressed in each resident's plan of care.
-Oral/dental status should be documented according to assessment findings.
-Residents and/or resident representative were notified of dental services available during the admission process.
-The Social Services Director maintained contact information for providers of dental services that were available to facility residents.
-The facility would assist the resident with making dental appointments and arranging transportation to and from the dental services location as needed.
-All information regarding dental services would be documented in the resident's medical record.

1. Review of Resident #2's entry tracking form showed he/she admitted to the facility on 8/20/20.

Review of the resident's dental records showed:
-The resident had a dental cleaning on 7/20/21.
-The resident had some teeth extracted on 11/18/21.
-No documentation of dental visits after 11/18/21.

Review of the resident's oral/dental section of the facility's all-inclusive quarterly screen dated 11/10/22 showed:
-Date of last dental exam was left blank.
-The resident had natural teeth that were in good condition.
-The resident did not have dentures, partials or implants.

Review of the resident's oral/dental section of the facility's all-inclusive readmission form dated

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2/22/23 showed:
-The date of last dental exam was left blank.
-The resident had natural teeth that were in fair condition.
-The resident did not have dentures, partials or implants.

Review of the resident's significant change MDS dated 2/28/23 showed staff assessment of the resident showed the resident had no dental issues.

Review of the resident's quarterly MDS dated 5/31/23 showed the following staff assessment of the resident:
-Had clear speech.
-Understood others and was understood by others.
-Was cognitively intact.
-Required set up assistance with hygiene.

Review of the resident's care plan dated 8/24/23 showed:
-The resident required set-up assistance with personal hygiene/oral care.
-It did not include anything else regarding the resident's teeth or dental needs.

Review of the resident's Physician's Order Sheet (POS) dated September 2023 showed an order dated 8/4/22 for dental services to be provided by facility selected provider.

During an interview and observation on 9/5/23 at 10:31 A.M.,showed:
-The resident said he/she had not seen a dentist in a long time, over a year and he/she would like to have a cleaning.
-The resident had some build-up on his/her teeth.

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During an interview on 9/8/23 at 9:48 A.M., Licensed Practical Nurse (LPN) A said there was an assessment where the nurses asked all the necessary questions including dental and then the Social Worker was responsible for setting up the dental appointments.

During an interview on 9/8/23 at 12:37 P.M., the Director of Nursing (DON) said:
-The Social Worker was supposed to track when annual dental appointments were due.
-Their Social Worker was no longer employed there as of the previous week.
-All residents should have an annual dental appointment if they wanted one.

2. Review of Resident #12's entry tracking form showed he/she admitted to the facility on 6/14/23.

Review of the resident's dietary profile dated 6/14/23 showed the resident:
-Received a mechanical soft diet (A texture-modified diet that restricts foods that are difficult to chew or swallow. Foods are finely chopped, blended, or ground to make them smaller, softer, and easier to chew. It differs from a pureed diet, which includes foods that require no chewing).
-Requested a mechanical soft texture due to only having a few teeth left.
-Ate independently without staff assistance.

Review of the resident's physician's history and physical note dated 6/16/23 did not include anything regarding the resident's teeth or oral condition.

Review of the resident's dental/nutrition section of

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the all-inclusive admission with baseline care plans dated 6/15/23 showed:
-The resident was on a regular, mechanical soft diet.
-The resident did not wear dentures.
-The date of last dental exam was left blank.
-The resident had some natural teeth that were in fair condition.
-The resident did not have dentures, partials or implants.
-The resident was independent with daily oral/dental care.

Review of the resident's admission/baseline care plan dated 6/15/23 showed:
-The resident had some natural teeth.
-A number of teeth were missing.
-The resident's teeth were in fair condition.
-The resident had a nutritional problem or potential nutritional problem related to being on a mechanically altered diet for chewing.
-The resident had significant weight loss in the hospital (prior to his/her admission to the facility).
-The resident was at risk for malnutrition and further weight loss.
-Instructions to provide and serve the resident's diet as ordered: (updated to) regular diet, regular texture and regular/thin consistency liquids consistency.

Review of the resident's admission MDS dated 6/20/23 showed the following staff assessment of the resident:
-Had clear speech.
-Understood others and was understood by others.
-Was cognitively intact.
-Required set-up assistance with eating.
-Had no dental issues.

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Review of the resident's nutritional assessment dated 6/27/23 showed the resident received a regular, mechanically altered diet.

During an interview on 9/5/23 at 11:12 A.M., the resident said:
-He/she had a lot of teeth extracted about five or six years ago.
-It was hard for him/her to chew.
-He/she was on a soft diet but he/she couldn't stand it so he/she talked to the doctor and his/her diet was changed back to regular consistency and he/she was doing better.
-He/she needed a dentist because he/she thought the rest of his/her teeth needed to be pulled so he/she could have dentures.

Observation on 9/6/23 at 12:27 P.M. of the resident's mouth showed the resident had eight front teeth on the bottom, no teeth on the top right and a partial on the left top.

Review of the resident's progress notes showed no dental progress notes and no notes about dental needs.

During an interview on 9/8/23 at 9:48 A.M., LPN A said:
-There's an admission assessment where the nurse asked all the necessary questions including dental and then the Social Worker was responsible for setting up the dental appointments.
-The resident had not told him/her that he/she needed any dental work.

During an interview on 9/8/23 at 12:37 P.M., the DON said:

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-The admitting nurse was responsible for assessing the resident for any dental needs, documenting it in the all-inclusive assessment and following-up with DON or the Social Worker.
-Their Social Worker was no longer employed there as of the previous week.
-He/She was not aware the resident wanted his/her teeth pulled so he/she could have dentures.
3. Review of Resident #5's face sheet showed he/she was admitted to the facility with the following diagnoses:
-Cognitive communication deficit (an acquired communication deficit after a brain injury).
-Depressive disorder (a common mental disorder. It involves a depressed mood or loss of pleasure or interest in activities).
-Bipolar disorder (a disorder with episodes of mood swings ranging from depressive lows to manic highs).
-Dementia (a group of thinking and social symptoms that interferes with daily functioning).

Review of the resident's care plan dated 9/20/21 showed:
-He/she had oral/dental health problems related to poor oral hygiene.
-Staff were to coordinate arrangements for dental care, transportation as needed/as ordered.
-Staff were to monitor/document/report as needed any signs or symptoms of oral/dental problems needing attention.

Review of the resident's last dental exam dated 11/17/21 showed:
-The Dentist had done a full mouth x ray on 11/11/21.
-He/she had recommended that the resident have tooth number #13 extracted.

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-The resident had declined treatment until the tooth became symptomatic.
-He/she would monitor for now.

Review of the resident's annual MDS dated 8/7/23 showed his/Her Brief Interview for Mental Status (BIMS) score was 10 out of 15 indicating he/she was moderately cognitively impaired.

During an interview on 9/5/23 at 3:45 P.M. the resident said:
-He/she had not seen the Dentist for two years.
-He/she had nice teeth and would like to to keep his/her teeth well.
-He/she had told the staff he/she wanted to see the Dentist but nothing had happened.

During an interview on 9/5/23 at 3:50 P.M. LPN C said:
-He/she did not know when the Dentist was at the facility last.
-He/she did not know when the resident had last seen the Dentist.
-He/she did not know if the resident had dentures or his/her own teeth.
-Social Services was responsible for making dental appointments.
-He/she could not remember if the resident had asked to see a Dentist.
-The facility was between Social Workers right now.
-He/she verified the last documentation of a dental visit was on 2/12/21.
-He/she did not know how often the residents were supposed to see a Dentist.

During an interview on 9/7/23 at 10:30 A.M. Certified Medication Technician (CMT) A said:
-The residents should see the Dentist annually.

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F 791	Continued From page 27 -The Social Worker made up a list and the Dentist saw who was on the list. -A new Social Worker was just starting this week. During an interview on 9/8/23 at 12:37 P.M. the DON said: -The Nurse was responsible to have assessed the residents teeth. -The Nurse or the Social Worker would schedule a dental appointment. -The Social Worker was to have ensured the residents were seen by the Dentist annually. -They had a new Social Worker who just started that week.	F 791		
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. (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:	F 812		

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Based on observation, interview, and record review, the facility failed to keep the kitchen and Dry Storage (DS) room floors clean; to maintain sanitary utensils and food preparation equipment; to safeguard against foreign material possibly getting into food; and to maintain plastic cutting boards in good condition to avoid food safety hazards (cross-contamination), in accordance with professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 13 residents with a licensed capacity for 60 residents at the time of the survey.

1. Review of the meal times provided by the Dietary Manager (DM) on 9/5/23 at 8:48 A.M. showed that breakfast was served at 8:00 A.M., lunch at 12:00 P.M., and dinner at 5:30 P.M.

Observation on 9/5/23 between 8:48 A.M. and 9:17 A.M. during the initial kitchen inspection showed the following:
-There was a large amount of unknown residue on the manual can opener blade.
-There were grease drips along the lower edge of a metal barrier under the range hood that hung over the stove.
-The red, blue, and green cutting boards were excessively scored to the point of plastic bits flaking off.
-On the bottom shelf of a rack by the stove was a 1 gallon (gal.) jug of soy sauce approximately (app.) 1/4 full with a label which read, "Refrigerate After Opening for Quality."
-There was a butter pod under the south rack in the kitchen, and cardboard and paper trash under the racks in the DS room.

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F 812	Continued From page 29 Observation on 9/5/23 between 11:27 A.M. and 11:43 A.M. during the kitchen inspection showed the following: -There was a large amount of unknown residue on the manual can opener blade. -There were grease drips along the lower edge of a metal barrier under the range hood that hung over the stove. -The red, blue, and green cutting boards were excessively scored to the point of plastic bits flaking off. -On the bottom shelf of a rack by the stove was a 1 gal. jug of soy sauce app. 1/4 full with a label which read, "Refrigerate After Opening for Quality." -There was a butter pod under the south rack in the kitchen and cardboard and paper trash under the racks in the DS room. Observation on 9/6/23 between 10:12 A.M. and 10:29 A.M. during the follow-up kitchen inspection showed the following: -There was a large amount of unknown residue on the manual can opener blade. -There were grease drips along the lower edge of a metal barrier under the range hood that hung over the stove. -The red, blue, and green cutting boards were excessively scored to the point of plastic bits flaking off. -On the bottom shelf of a rack by the stove was a 1 gal. jug of soy sauce app. 1/4 full with a label which read, "Refrigerate After Opening for Quality." -There was a butter pod under the south rack in the kitchen and cardboard and paper trash under the racks in the DS. Review of the maintenance paperwork provided	F 812		

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F 812	Continued From page 30 by the Director of Maintenance (DOM) showed the last professional range hood cleaning was performed on 6/5/23 with the next one due in December. Observations during the kitchen range hood inspection with the Regional Maintenance Director (RMD) on 9/6/23 at 1:22 P.M. showed the range hood baffles (metal filters that capture grease droplets from rising hot air and condenses them to drain into a filter tray, which drastically reduces the risk of spreading flames should a fire occur on the cooking surface, and with the intent of reducing food contamination) appeared overly greasy and were so to the touch. During an interview on 9/6/23 at 1:27 P.M. the DOM said that the dietary staff were responsible for cleaning the range hood baffles. During an interview on 9/7/23 at 10:29 A.M. the DM said the following: -All dietary staff were responsible for cleaning the floors throughout the day, at the end of the night, and as needed. -He/She would expect that if a food stuff label read it was to be stored at a certain temperature that it would be. -Dietary staff knew to report damaged food preparation items to him/her or put them in the office. -He/she would expect food to be free of foreign substances. -Food preparation items should be ran through the dishwasher after each use. -A professional company cleaned the range hood quarterly and they did it as needed.	F 812		
F 880 SS=E	Infection Prevention & Control	F 880		

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F 880	Continued From page 31 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to perform hand hygiene during cares for one sampled resident (Resident #12); to ensure nursing staff were cleansing their hands during medication pass, did not sanitize a pair of scissors used to open an sealed package counting a narcotic, and picked a tray lid up off of the floor without cleansing hands for one sampled resident (Resident #10) out of nine sampled residents and to follow their policy to complete

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testing to screen new employees and residents for tuberculosis (TB- a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) for two out of ten sampled new employees. The facility census was 13 residents.

Review of the facility's hand hygiene policy dated 9/1/21 showed:
-All staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors.
-Hand hygiene should be conducted after removing gloves.

1. Review of Resident #12's care plan dated 6/15/23 showed:
-The resident had bladder incontinence.
-Instructions to provide hygiene care after each incontinence episode.
-Instructions to provide preventive skin care.

Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 6/20/23 showed the following staff assessment of the resident:
-Cognitively intact.
-Required limited assistance of one person with toileting and hygiene.
-Occasionally incontinent of urine and continent of bowel.
-No skin issues.

Review of the resident's Physician's Order Sheet (POS) dated September 2023 showed a physician's order to apply barrier cream to the resident's buttocks (either of the two round fleshy

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parts that form the lower rear area of a human trunk), cover with gauze (per resident request to keep cream off of pants) every shift and as needed.

Observation and interview on 9/6/23 at 10:00 A.M. with Licensed Practical Nurse (LPN) A showed:
-He/she washed his/her hands, applied gloves and applied ointment on the resident's buttocks.
-He/she took off his/her gloves, left the room to get 4 x 4 gauze to cover ointment per the residents request.
-He/she did not wash his/her hands before applying gauze to the resident's buttocks.
-He/she took off his/her gloves and did not wash his/her hands before leaving the room.
-He/she said he/she should have washed his/her hands after glove changes before applying new gloves.

During an interview on 9/8/23 at 12:37 P.M., the Director of Nursing (DON) said employees' hands should be washed before putting on new gloves and after glove changes.
2. Review of Resident #10's Admission MDS dated 8/13/23 showed:
-He/She was admitted to the facility on 8/10/23.
-He/She had a complex medical history.
-He/she was cognitively intact.

Review of the resident's POS dated September 2023 showed he/she had an order for Lidocaine (medication used to decrease pain) patch 5 percent (%) to have been applied daily to his/her left knee.

Observation of medication pass on 9/7/23 at 8:15 A.M. with LPN A showed:

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-He/she cut open the package containing the medicated patch without cleansing the scissors that were in a drawer in the medication cart.
-He/she applied the medication patch to the resident.
-He/she returned the scissors to the drawer in the medication cart without sanitizing them after opening the package containing the pain patch.
-He/she picked up the lid of the resident's meal tray from the floor with his/her bare hands.
-He/she did not cleanse his/her hands.
-He/she left the room without cleansing his/her hands.
-He/she put on gloves without cleansing his/her hands.
-He/she proceeded to bleach wipe the top of the medication cart.

During an interview on 9/7/23 at 9:00 A.M. LPN A said:
-He/she should have cleansed his/her hands before and after applying gloves.
-He/she should have cleansed his/her hands after picking anything up off of the floor.
-He/she should have used an alcohol pad to clean the scissors before and after using them.

During an interview on 9/7/23 at 10:30 A.M. Certified Medication Technician (CMT) A said:
-Staff should clean the scissors before and after using them to open a medication package like a patch.
-Staff should wash their hands before and after wearing gloves.
-Staff should wash their hands after picking anything up off of the floor.
-The facility provided education on hand hygiene almost every month.
-The DON or Infection Preventionist was

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responsible for ensuring good hand hygiene was done by the staff.

During an interview on 9/8/23 at 12:37 P.M. the DON said:
-Staff should have washed their hands when entering a room.
-Staff should have washed their hands whenever they take off their gloves.
-Staff should have washed their hands if they had picked something up off of the floor.
-Staff should have cleaned the scissors with an alcohol wipe before and after using them.
-Staff was educated about hand washing a couple of times a week by the Assistant Director of Nursing (ADON).
-They had reviewed hand hygiene during the skills fair a couple of weeks ago.
-He/she was ultimately responsible for ensuring staff practiced good hand hygiene.

3. Review of the facility's employee TB testing policy dated 9/1/21 showed:
-At the time of employment, all new staff shall undergo pre-placement screening for TB, including an individual risk assessment, TB symptoms screen and a TB test.
-All new staff shall receive two TB Skin Tests (TST) given two weeks apart unless:
--A previously positive TST or positive TB blood test was reported.
--Evidence of completion of adequate therapy for active TB was reported.
--Two negative TSTs within the past twelve months, the more recent within the last three months.
-All initial and follow-up TSTs should be interpreted 48 to 72 hours after administration.
-An attachment to the policy included a flow chart

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from the Missouri Department of Health and Senior Services that showed if a new employee had documentation of a one-step TST with negative results within the past year that they should administer a second-step TST within one to three weeks of beginning employment.

Review of the "Long Term Care Infection Prevention and Control Manual," Chapter 5, Vaccinations and TB testing, created by the Quality Improvement Program for Missouri (QIPMO), dated February 2022 and the Missouri Department of Health rule 19 CSR 20-20.100, paragraph three dated 2/28/22 showed:
-All new long-term care facility employees who work ten or more hours per week should have the first of two TSTs within one month prior to starting employment in the facility.
-The results of the TSTs should be read within 48 to 72 hours from administration.
-If the initial TST result was zero to nine millimeters (mm) induration, the second test should be administered as soon as possible within three weeks after employment begins, unless documentation was provided indicating a two-step TST was completed in the past and at least one subsequent annual test within the past year.

Review of the facility's list of employees hired since the facility's last survey showed:
-Employee A was hired on 6/26/23.

-Employee B was hired on 6/23/23.

Review of Employee A's TB screening showed:
-A prior TST that was administered on 10/27/22 and read on 10/29/22 and the results were 0 mm (negative).

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F 880	Continued From page 38 -No additional TSTs. -No individual risk assessment or TB symptoms screening. Review of Employee B's TB screening showed: -A prior TST that was administered on 12/19/22 and read on 12/21/22 and the results were 0 mm (negative). -No additional TSTs. -No individual risk assessment or TB symptoms screening. During an interview on 9/7/23 at 8:19 A.M., the DON said: -He/she or the Assistant DON were in charge of TSTs for employees. -They usually did the TST when offering them a job and they would tell the new employee to come back in two to three days to have it read. -They were supposed to do a two-step TST if the employee had no TST in the past year. -Employee A and B should have had another TST.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		

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LEE'S SUMMIT PLACE	1501 SW 3RD STREET 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
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immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive

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the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide pneumococcal (lung inflammation caused by bacterial or viral infection) vaccines for one sampled resident (Resident #268) out of five residents sampled for immunizations. The facility census was 13 residents.

Review of the facility's Pneumococcal Vaccine Policy, dated 9/1/2021, showed:
-It was the facility's policy to offer residents immunizations against pneumococcal disease in accordance with current Center for Disease Control (CDC-the nation's health protection agency responsible for controlling the introduction and spread of infectious diseases) guidelines and recommendations.
-Each resident was assessed for pneumococcal immunization upon admission.
-Each resident was offered the pneumococcal immunization unless medically contraindicated or the resident was already immunized.
-Vaccinations were offered to residents 65 years or older, according to CDC guidelines.
-The resident's medical record included documentation that indicated the following:
--The resident or resident representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization.
--The resident received the pneumococcal immunization or did not receive the immunization due medical contraindication or refusal.

Review of the CDC guidelines for the

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pneumococcal vaccine, dated 9/11/23, showed people age 65 or older who previously received the pneumococcal polysaccharide vaccine (PPV23) should receive one dose of PPV23 at least 1 year after the PPV23 dose.

1. Review of resident #268's face sheet, undated, showed:
-The resident was over age 65.
-The resident's diagnoses included cellulitis (swelling of connective tissue under the skin), muscle weakness, and atrial fibrillation (an irregular and often very rapid heart).

Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/9/23, showed:
-The resident scored a 15 on the Brief Interview for Mental Status (BIMS), an assessment tool that shows a score between 3 of 15 which shows the resident's mental status. This tool helps determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in care planning decisions.
--This showed that the resident cognitively intact.

Review of the resident's electronic health record (EHR), undated, showed no pneumonia vaccines were noted.

Review of the resident's State Immunization Record, dated 9/6/23, showed the resident last received the PPV23 on 10/23/2018.

During an interview on 9/6/23 at 1:50 P.M., Licensed Practical Nurse (LPN) A said the Director of Nursing (DON) tracked resident

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immunizations.

During an interview on 9/6/23 at 2:16 P.M., the Assistant Director of Nursing (ADON) said:
-Immunizations for new admissions are tracked by the DON.
-That included flu and pneumonia vaccines.
-Vaccines were to be documented in the immunizations tab in the EHR.

During an interview on 9/7/23 at 10:43 A.M., the DON said:
-He/she used a phone application (app) from the CDC that showed vaccine guidelines for specific age groups.
-He/she utilized those guidelines when offering vaccines to new residents.
-He/she tracked when the vaccines were offered and which residents refused them.

Review of the resident's Physician Order Summary, dated 9/8/23, showed the resident did not have an order for a pneumococcal vaccine.

During an interview on 9/8/23 12:37 P.M., the DON said:
-The facility offered immunizations to all new residents, including the pneumonia vaccine.
-Education was provided if the resident refused.
-This should have been documented in the medical record.
-The resident should have had a pneumonia vaccine.
-The facility did not have any pneumonia vaccines available.
-The facility normally kept pneumonia vaccines on hand.

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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 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: 1. Refer to F880.	A4031		
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 F689. 2. Refer to F698. 3. Refer to F791.	A4075		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable	A4086		

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A4086	Continued From page 1 infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II. 1. Refer to F880. 2. Refer to F883.	A4086		
A4100	19 CSR 30-85.042(91) Social Service Program The facility shall designate a staff member to be responsible for the facility's social services program. The designated staff person shall be capable of identifying social and emotional needs, knowledgeable of methods or resources, or a combination of these to use to meet them and services shall be provided to residents as needed. II/III This regulation is not met as evidenced by: Class III. 1. Refer to F791.	A4100		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or	A7015		

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A7015	Continued From page 2 from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III 1. Refer to K812.	A7015		
A7048	19 CSR 30-87.030(46) Safe Plastic/Rubber Items, Food Contact Safe plastic or safe rubber or safe rubber-like materials that are resistant under normal conditions of use to scratching, scoring, decomposition, crazing, chipping and distortion, that are of sufficient weight and thickness to permit cleaning and sanitizing by normal dishwashing methods, and which meet the general requirements of this rule, are permitted for repeated use. III	A7048		

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A7048	Continued From page 3 This regulation is not met as evidenced by: 1. Refer to F812.	A7048		
A7057	19 CSR 30-87.030(55) Ventilation Hoods, Clean, Filters Removable Ventilation hoods and devices shall be designed to prevent grease or condensation from collecting on walls and ceilings and from dripping into food or onto food-contact surfaces. Filters or other grease-extracting equipment shall be readily removable for cleaning and replacement if not designed to be cleaned in place. III This regulation is not met as evidenced by: 1. Refer to F812.	A7057		
A7065	19 CSR 30-87.030(63) Food-Contact Surfaces Washed/Rinsed/Sanitized Where equipment and utensils are used for the preparation of potentially hazardous foods on a continuous or production-line basis, utensils and the food-contact surfaces of equipment shall be washed, rinsed and sanitized at intervals throughout the day on a schedule based on food temperature, type of food and amount of food particle accumulation. III This regulation is not met as evidenced by: 1. Refer to F812.	A7065		
A8029	19 CSR 30-88.010(28) Med Record Confidential, Written Consent All information contained in a resident's medical, personal or financial record and information concerning source of payment shall be held	A8029		

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A8029	Continued From page 4 confidential. Facility personnel shall not discuss aspects of the resident's record or care in front of persons not involved in the resident's care or in front of other residents. Written consent of the resident or his or her legally authorized representative shall be required for the release of information to persons not otherwise authorized by law to receive it. II/III This regulation is not met as evidenced by: Class III 1. Refer to F583.	A8029		
A8037	19 CSR 30-88.010(36) Personal Clothing/Possessions Each resident shall be permitted to retain and use personal clothing and possessions as space permits. Personal possessions may include furniture and decorations in accordance with the facility's policies and shall not create a fire hazard. The facility shall maintain a record of any personal items accompanying the resident upon admission to the facility, or which are brought to the resident during his or her stay in the facility, which are to be returned to the resident or responsible party upon discharge, transfer, or death. II/III This regulation is not met as evidenced by: Class III. 1. Refer to F661.	A8037		

PLAN OF CORRECTION

Provider Name:	**Lee's Summit Place**
Street Address, City, Zip:	**1501 SW 3rd Street, Lee's Summit, Missouri 64081**
Date of Survey:	**September 8th, 2023**
Provider number:	**265512**

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F583	1) **The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** LPN A was immediately educated that computer screens are to be minimized when not in use. 2) **The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place to ensure that the deficient practice does not recur includes:** All staff in-service on privacy and confidentiality. Educated that Computer screens are to be minimized any time the staff member is not actively using/in front of the screen. **4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** The Director of Nursing Services, or designee, will conduct a random audit of computer usage (2) x's weekly for four (4) then monthly x 2 months. Results from this audit will be	**10/09/23**

	discussed in QAPI to ensure substantial compliance is maintained. **5) The corrective actions will be completed on or before:** October 9th, 2023	
F657	**1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** Resident #269s care plan was immediately updated to reflect patient needs. 2) **The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** All residents have the potential to be affected by this alleged deficient practice. 3) **Measures put into place to ensure that the deficient practice does not recur includes:** DON and or assigned designee educated nursing staff on care plans and ensuring these are updated with new changes. 4) **The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** DON or assigned designee will monitor Care Plans Bi-weekly x 4 weeks, then monthly x2 months to ensure care plans are up to date. Results from this audit will be discussed in QAPI to ensure substantial compliance is maintained. **5) The corrective actions will be completed on or before:** October 9th, 2023	**10/09/23**
F661	1) **The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** Resident 15 has potential to be affected by deficient practice. This patient is no longer in the facility and was not at the time of the survey. **2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:**	**10/09/23**

	All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place to ensure that the deficient practice does not recur includes:** The DON or assigned designee will conduct an all-staff in-service, educating on the required documentation of personal belongings and the personal belongings policy. The DON or assigned designee will educate SW on ensuring all patients review inventory sheets upon discharge. **4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** The DON or assigned designee will conduct inventory sheet audits, (2) times a week for 4 weeks then one a month x2 months. Results from this audit will be discussed in QAPI to ensure substantial compliance is maintained. **5) The corrective actions will be completed on or before:** October 9th, 2023	
F689	**1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** The ADON spoke with the physician and clarified the residents' needs and subsequent orders. The supervision order was discontinued based on the residents' needs. 2) **The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place to ensure that the deficient practice does not recur includes:** The DON or assigned will hold an all-staff in-service, educating that physicians orders must be followed and to reach out to DON and MDS if they feel that the resident has changed and needs orders changed. **4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:**	**10/09/23**

	The DON or assigned designee will conduct random audits of resident orders and nursing compliance (2) times a week for four (4) weeks. Then Monthly x 2 months. Results from this audit will be discussed in QAPI to ensure substantial compliance is maintained. **5) The corrective actions will be completed on or before:** October 9th, 2023	
F698	1) **The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** The DON called the dialysis facility to correctly update the missing dialysis communication sheets for resident 68. 2) **The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** Each dialysis patient has the potential to be affected by the alleged deficient practice. 3) **Measures put into place to ensure that the deficient practice does not recur includes:** The DON or assigned designee held an in-service on the collaboration with the dialysis facilities. Educating that dialysis communication sheets are to be filled out prior to and upon return from dialysis. **4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** The DON or ADON or assigned designee will conduct random audits of dialysis communication sheets (2) times weekly for four (4) weeks then monthly x 2 months. Results from this audit will be discussed in QAPI to ensure substantial compliance is maintained. **5) The corrective actions will be completed on or before:** October 9th, 2023	**10/09/23**
F791	1) **The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:**	**10/09/23**

	Resident's #2 and #5 saw dentist on 9/15/23 with recommendations for routine follow-up with hygienist as available. Resident #12 saw dentist on 9/15/23 and no longer resides in the facility. All residents were offered dental services, all patients will be assessed upon admission and quarterly thereafter to ensure they are receiving dental services routinely. **2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place to ensure that the deficient practice does not recur includes:** Administrator educated nursing staff to inform Social Services of any follow-up appointments recommended and educated Social Services Director regarding importance of scheduling follow-up appointments to ensure resident needs are met. Will assess all patients upon admission and quarterly thereafter for any dental needs. **4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** Social Services Director or designee will complete audit of 3 random charts weekly x 4 weeks, then monthly x 2 months to ensure dental follow-up appointments have been scheduled and/or completed per recommendations. Results from this audit will be discussed in QAPI to ensure substantial compliance is maintained. **5) The corrective actions will be completed on or before:** October 9th, 2023	
F812	**1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** The floors in the kitchen and dry storage were cleaned and the range hood had all grease removed. The can opener blade was cleaned along with all food preparation equipment. The Cutting boards were discarded and replaced with new cutting boards. **2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:**	**10/09/23**

	All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place to ensure that the deficient practice does not recur includes:** Administrator educated the Dietary Manager and staff to proper food procurement, storage, preparation, and service with emphasis on infection control and maintaining an organized and sanitary department and equipment. The Dietary Manager created an itemized cleaning and organizational checklist to be completed daily x 4 weeks and then weekly thereafter. **4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** The Dietary Manager will audit the checklist daily x 4 weeks and weekly going forward. Results of the audit will be addressed as need and discussed in risk management and QAPI monthly to ensure compliance is maintained. **5) The corrective actions will be completed on or before:** October 9th, 2023	
F880	**1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** Nurse A was immediately in-serviced on proper hand hygiene, when to perform hand hygiene, and to clean scissors before and after each use. Residents 10 and 12 immediately assessed to ensure they had not been negatively affected. **2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** All residents have the potential to be affected by this alleged deficient practice. **3) Measures put into place to ensure that the deficient practice does not recur includes:** The DON or assigned designee will hold an in-service on proper hand hygiene and the facilities hand hygiene policies. As well as when appropriate to	**10/09/23**

	perform hand hygiene. The DON educated ADON and Business office manager on new hires and who requires a one or two step. **4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** The DON or assigned designee will conduct random audits on appropriate hand hygiene (2) times a week for 4 weeks then one a month x2 months. The DON or assigned designee will conduct random audits of employee TB. (2) times a week for 4 weeks then one a month x2 months. Results from this audit will be discussed in QAPI to ensure substantial compliance is maintained. **The corrective actions will be completed on or before:** October 9th, 2023	
F883	1) **The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** Resident 268 was given the pneumococcal immunization upon the delivery of the immunizations 9/19/23. An audit of all residents occurred; all residents that accepted PNU vax have received vax. All residents that declined PNU vax were educated and declination was placed in chart. **2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** All residents have the potential to be affected by this alleged practice. **3) Measures put into place to ensure that the deficient practice does not recur includes:** The DON and ADON or assigned designee will in-service staff The charges nurses are to ask whether or not the resident would like pneumococcal/influenza immunizations upon admission and annually thereafter and to document their acceptance or declination and administer PNU vax will be administered as received.	**10/09/23**

	4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following: The DON or assigned designee will conduct random audits of resident charts for the administration or declination of pneumococcal and influenza immunizations (2) times a week for four (4) weeks then monthly x 2. Results from this audit will be discussed in QAPI to ensure substantial compliance is maintained. **5) The corrective actions will be completed on or before:** October 9th, 2023	

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:	**Lee's Summit Place**
Street Address, City, Zip:	**1501 SW 3rd Street, Lee's Summit, Missouri 64081**
Date of Survey:	**September 8th, 2023**
Provider number:	**265512**

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
A4031	**See F880**	**10/09/23**
A4075	**See F689, F698, F791**	**10/09/23**
A4086	**See F880, F883**	**10/09/23**
A4100	**See F791**	**10/09/23**
A7015	**See F812**	**10/09/23**
A7048	**See F812**	**10/09/23**
A7057	**See F812**	**10/09/23**
A7065	**See F812**	**10/09/23**
A8029	**See F583**	**10/09/23**
A8037	**See F661**	**10/09/23**

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.