STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265855	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Woods Village	2901 NE 72nd Street Gladstone, MO 64119

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interview, record review, and facility policy review, the facility failed to ensure residents' right to participate in the care planning process was honored for two of two residents (Resident (R) 11 and R32) reviewed for care plans out of 16 sampled residents. This failure placed the residents at risk for the provision of care not being person-centered. Findings include: Review of the facility's policy titled, Care Plans - Comprehensive, Person-Centered, revised July 2024, revealed .Policy Interpretation and Implementation. 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .3. The IDT includes: a. The Attending Physician; b. A registered nurse who has responsibility for the resident; c. A nurse aide who has responsibility for the resident; d. A member of the food and nutrition services staff; e. The resident and the resident's legal representative (to the extent practicable); and f. Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. 4. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care. 1. During an interview on 12/31/24 at 9:37 AM regarding discussions about care and medications received or a care conference or care plan meeting, R11 stated, No, we haven't had any meetings. Review of R11's admission Record from the electronic medical record (EMR) Profile tab showed a facility admission date of 09/17/24 with medical diagnoses that included chronic ischemic heart disease, presence of cardiac pacemaker, fibula fracture, scoliosis, coagulation defect, atrial fibrillation, gastroesophageal reflux disease (GERD), hypertension, insomnia, history of transient ischemic attack, and cerebral infarction. Review of R11's December 2024 Medication Administration Record (MAR) from the EMR Orders tab showed R11 received an anticoagulant medication for atrial fibrillation. Review of R11's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/23/24 showed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicative of moderate cognitive impairment. Review of the EMR Progress Notes tab filtered for the subject of Care Plan Conference Summary notes on 12/31/24 at 12:28 PM showed no documentation. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EMR Miscellaneous tab revealed a care plan conference letter scheduled for 01/02/25. Further review of R11's Progress Notes and Miscellaneous tab did not show evidence of the provision of her baseline care plan goals. During an interview on 12/31/24 at 2:00 PM, the MDS Coordinator (MDSC) stated R11 might not have had a care conference in the first three weeks as she (R11) had wanted to go home. Other than the care plan meeting coming up, the MDSC confirmed it had been over three months, and she would look for something. At 3:33 PM, the MDSC stated there was no signed baseline care plan, so she was unsure if R11 had been provided that document and confirmed there had not been a care plan meeting yet. 2. During an interview on 12/30/24 at 11:44 AM regarding whether care and medications were discussed or if there had been any care plan conferences, R32 responded, No, they don't talk to me. and stated she doesn't remember any care conferences. Review of R32's admission Record from the EMR Profile tab showed a facility admission date of 07/09/24 with medical diagnoses that included a knee periprosthetic fracture, dementia, posthemorrhagic anemia, sleep disorder, pain, chronic kidney disease (CKD), osteoporosis, and glaucoma.The facility census was 37. Review of R32's quarterly MDS with an ARD of 10/14/24 documented a BIMS score of 12 out of 15, indicative of moderate cognitive impairment. Review of the EMR Progress Notes filtered for Care Plan Conference Summary notes elicited no documentation and no care plan invitation letters were found under the Miscellaneous tab. A baseline care plan was found under the Miscellaneous tab, but the signature was not legible to know who received the copy. During an interview on 12/31/24 at 3:28 PM, MDSC stated R32 was on the list for a care plan letter but was planning on going home, then that changed, she was going to stay and the care plan meeting got missed. The MDSC confirmed no care plan conference has been held yet. During an interview on 01/02/25 at 3:47 PM, the Director of Nursing (DON) stated, Participating in care plans is ideal for residents and anyone the resident chooses. The DON stated an expectation they (residents) be involved and have an opportunity to meet with the interdisciplinary team.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. Based on record review, interview, and facility policy review, the facility failed to ensure the Ombudsman was notified two of two residents (Resident (R) 31 and R35) reviewed for emergent hospital transfer out of 16 sample residents. As a result of this failure, the residents would not have the added protection and/or advocacy of the Ombudsman's office to monitor the potential possibility of an inappropriate facility-initiated transfer or discharge. Findings include: Review of the facility's policy titled, Transfer or Discharge - Emergency, revised October 2024, revealed the policy did not address the required Ombudsman notification. Review of the facility's policy titled, Requirements for Emergency Discharge, revised October 2024, revealed: .Policy Interpretation and Implementation. 1. Notice before transfer. Before a facility transfers or discharges a resident, the facility must: a. Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. 1. During an interview on 12/30/24 at 12:39 PM, R31 stated she had been to the hospital at least once, they thought I was having hallucinations back in May and then been there regarding the catheter and getting it out. Review of the facility electronic medical record (EMR) Census tab revealed a status of Hospital Paid Leave on 05/17/24 and 07/23/24. Review of R31's admission Record from the EMR Profile tab revealed a facility admission date of 04/04/24 with medical diagnoses that included atherosclerotic heart disease, obstructive and reflux uropathy, thrombocytopenia, type II diabetes, chronic obstructive pulmonary disease (COPD), and history of transient ischemic attack (TIA), and cerebral infarction. Review of R31's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/24 documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15; indicative of being cognitively intact. Review of the facility EMR Progress Notes tab revealed a Transfer to Hospital Summary on 07/23/2024 at 7:30 AM, for R31 related to him becoming dizzy and then experiencing a change in responsiveness. A progress note dated 05/17/24 at 11:35 AM, revealed R31 being transferred to the emergency room related to a critical low hemoglobin level. Review of the facility provided reports to the Ombudsman on 01/02/25 at 9:00 AM did not show R31 was included in the May or July list of named transfers or discharges. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/02/25 at 10:22 AM, the Social Services Director (SSD) confirmed the printed reports provided was the printout of the report that was attached to the Ombudsman email. After reviewing the two reports, the SSD confirmed R31 was not included in either the May or July transfer or discharge reports printed. At 10:46 AM, the SSD stated she generated the reports again without success; had called her corporate office who also generated the reports unsuccessfully for R31; but it was discovered that both residents (R31 and R35) had paid bed holds. The SSD stated an EMR ticket was generated to discover the reason the reports did not include the paid bed hold residents showing on the reports.The facility census was 37. During an interview on 01/02/25 at 4:00 PM, the Executive Director expressed an expectation that the Ombudsman would be notified of all transfers and discharge residents monthly. 2. Review R35's Nurse's Note, dated 09/25/24 and located under the Progress Note tab of the EMR, revealed R35 was transferred to the hospital due to a change in condition and becoming non-responsive. According to the Nurse's Note, dated 09/27/24, she remained in the hospital until 09/27/24 when she was readmitted to the facility. During an interview on 01/02/25 at 10:22 AM, the SSD provided the list of discharges she emailed to the ombudsman on 10/03/24 at 11:20 AM for September 2024. The list did not include R35's name. She stated the list provided was the list she sent to the ombudsman, and she verified the resident's discharge in September was not included on the list. During an interview on 01/2/24 at 11:34 AM, the Ombudsman verified via telephone that she was not notified of R35's September discharge or transfer to the hospital.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure one of six residents (Resident (R) 5) had documented indications for an increase of an antipsychotic medication and failed to attempt a gradual dose reduction of the antipsychotic medication without clinical rationale of 16 sample residents. This failure had the potential for R5 to not receive the lowest effective dose of atypical antipsychotic medication. The facility census was 37. Findings include: Review of the facility's policy titled, Psychoactive Drug Monitoring, dated 01/21, revealed .Procedures. 1. Residents receive a psychoactive medication only if supporting documentation is provided in the medical record .6. All of the following conditions are satisfied prior to initiation and/or continuation of therapy: A. Possible reversible causes for the resident's distress have been ruled out. B. Use results in maintenance or improvement in the resident's functional status. C. Long-term daily use has been accompanied by unsuccessful gradual dosage reductions, unless clinically contraindicated. D. The need for and response to therapy are monitored and documented in the resident's medical record. E. If the resident's condition has not responded to treatment or has declined despite treatment, it is important to evaluate both the medication and the dose to determine whether the medication should be discontinued or the dosing should be altered, whether or not the facility has implemented gradual dose reduction(s) as required, or tapering. Review of R5's admission Record from the electronic medical record (EMR) Profile tab showed a facility admission date of 12/13/16, a readmission date of 03/11/20, with medical diagnoses that included congestive heart failure (CHF), dementia, and generalized anxiety disorder. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/27/24 documented a Brief Interview for Mental Status (BIMS) score of three out of 15, indicative of severe cognitive impairment. Review of R5's EMR Orders tab revealed an order, dated 09/27/24, for Seroquel (generic name quetiapine, an atypical antipsychotic medication) of 50 milligrams (mg) three times per day. Review of an Order Summary, effective 09/01/24, from the EMR Orders tab showed R5 had been receiving Seroquel 50mg in the morning and 25mg at bedtime. Review of the EMR September 2024 Medication Administration Report (MAR) and Treatment Administration Report (TAR) from the Orders tab, along with August and September Progress Notes from the EMR Progress Notes tab did not show an increased number of behaviors. During an interview on 01/02/25 at 8:30 AM regarding R5's Seroquel increase, the Director of Nursing (DON) stated, Hospice ordered the increase [of Seroquel], I didn't ask them for justification. At 10:20 AM, the DON provided behavior monitoring for the month of September 2024 that documented out of 90 chartings; 16 incidents of care rejection (one where with education she accepted her medication), one of repetitive movement, one biting, one kicking/hitting, and one pushing. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the documentation provided by the facility included a note from the Hospice Nurse on 09/27/24 at 1:53 PM, revealed Received a call from the patient's daughter [name of the non-healthcare power of attorney daughter (HCPOA)], she reports that her mother's behaviors are becoming more difficult to manage. She has concerns that staff will have difficulty providing cares while she is recovering from surgery and cannot be there. She is ready to increase Seroquel dose and/or frequency. Spoke to [name] NP [Nurse Practitioner] who gave the order to increase the dose to 50 mg t.i.d. [three times a day]. Phone call to [name] RN [Registered Nurse] at [Facility name], gave her the order. Review of the progress notes provided by the facility as indication for use revealed: -8/10/24 1712 [5:12 PM] Resident agitated today. Refused cares throughout the day. Cursed at this nurse and other staff with attempts to provide cares and even attempted to swat at CNA [Certified Nurse Aide] with hand. Dtr [Daughter] was concerned this morning that floor to bathroom was wet and res pants were wet. Spoke with CNAs . -08/25/24 1042 [10:42 AM] Res had shower this morning. More agitated than usual. She continues to have a decrease in urine and bowel output. Fluids encouraged. Will cont to monitor. -09/02/24 1106 [11:06 AM] Res more agitated this morning when giving her medications. Pushed nurses hand away. Was able to educate her on the importance of taking her medications which led her to finally taking them. -09/14/24 0438 [4:38 AM] CNA reported resident refusal when attempt was made to assist in changing visibly wet pants, this writer attempted as well, offering resident snacks per family request. resident non complaint [sic] with staff, and began attempting to hit this writer, unable to redirect resident at this time. Staff will try at a later time. Review of R5's EMR Progress Notes showed on 10/25/24 at 11:37 AM by the DON, revealed Note Text: Spoke with res [resident] and family about trail [sic] dose reduction for Seroquel order as she does not have an appropriate diagnosis. Res remains on hospice and family not agreeable at this time. Review of R5's Care Plan from the EMR Care Plan tab showed a focus of: I take anti-psychotic medication for Behavior management with an intervention of Consult with pharmacy, MD [doctor] to consider dosage reduction when clinically appropriate at least quarterly initiated 01/20/24. During an interview on 01/02/25 at 3:42 PM regarding the indications for the doubling of the atypical antipsychotic dose for R5, the DON responded, Clinically, I understand what the daughter is saying but clinically probably not. The DON stated it would be ideal if indications for use for psychoactive medications were documented.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility policy review, and Centers for Disease Control and Prevention (CDC) reference, the facility failed to ensure one undated opened vial of Mantoux tuberculin purified protein derivative (PPD) of three vials in the refrigerator was dated for residents' use. This failure could lead to inaccurate tuberculosis testing by the potential for a false positive (or false negative) result due to the components of the PPD solution being degraded.The facility census was 37. Findings include: Review of the facility's policy titled, Storage of Medications and Biologicals dated 01/21, revealed: Policy. Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . Review of the CDC Mantoux Tuberculin Skin Test, page 6, located at the website address: https://stacks.cdc.gov/pdfjs/web/viewer.html?file=https://stacks.cdc.gov/view/cdc/25732/cdc_25732_DS1.pdf, reviewed on [DATE], revealed .The label should indicate the expiration date. If it's been open more than 30 days or the expiration date has passed, the vial should be thrown away and a new vial used . Observation of the medication room located in the Nurse's Station on [DATE] at 9:28 AM revealed two Mantoux Tuberculin testing fluid boxes in a resealable plastic bag. One vial was still sealed (had the vial cap on) and the other vial was missing the cap (or open) with no open date on the vial or box; a third vial in a box in the refrigerator was open and had a documented open date. Licensed Practical Nurse (LPN) 1 present for the observation confirmed at 9:33 AM the box stated to discard 30 days after opening and there was no open date on the one open PPD vial; LPN1 set the vial aside to be discarded. During an interview on [DATE] at 3:44 PM, the Director of Nursing (DON) stated an expectation that when [a vial] was opened it was to be dated and when expired, discarded.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, record review, and facility policy review, the facility failed to accommodate one of one resident's (Resident (R) 11) dietary preferences reviewed for food choices of 16 sampled residents. This failure had the potential to result in reduced meal consumption and may potentially affect the residents' nutritional or health status. The facility census was 37. Findings include: Review of the facility's policy titled, Food and Nutrition Services, revised October 2018, revealed: Policy Statement. Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Policy Interpretation and Implementation. 1. The multidisciplinary team will assess each resident's nutritional needs, food likes and dislikes, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization .3. Reasonable efforts will be made to accommodate resident choices and preferences. Review of R11's admission Record from the electronic medical record (EMR) Profile tab showed a facility admission date of 09/17/24 with medical diagnoses that included chronic ischemic heart disease, permanent atrial fibrillation, presence of cardiac pacemaker, and history of transient ischemic attack, and cerebral infarction. Review of R11's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/23/24 showed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicative of moderate cognitive impairment. During an interview on 12/31/24 at 9:38 AM, R11 stated, I have CHF [congestive heart failure] a lot of stuff I'm eating I shouldn't have. I get bacon every morning and I shouldn't have it. R11 pointed out a list of foods she should not have posted on her bulletin board and said, I've told the staff here, they said they couldn't do it. Observation of the posted paper showed bacon was on the list as a 'do not eat' food. Observation of R11's breakfast tray on 01/02/25 at 8:17 AM showed one piece of French toast and two slices of bacon. Review of the tray card showed handwritten on the paper: French Toast, Bacon, Cranberry Juice. The tray card also contained a Notes section under the diet order that stated, NO BACON and under dislikes was listed bacon. During an interview on 01/02/25 at 8:20 AM regarding the handwriting on the tray card, the Dietary Aide (DA) that served the morning meal stated she wasn't sure where the handwriting came from, then stated, That's nursing. When asked if she reviewed the Notes or Dislikes sections of the tray card, DA stated, Well no, well sometimes. During an interview on 01/02/25 at 8:22 AM, the Director of Nursing (DON) stated the CNAs (Certified Nurse Aides) tell them [residents] what is on the menu and write down the choices. During a follow-up interview on 01/02/25 at 9:15 AM, R11 reviewed the tray card and denied requesting bacon for breakfast. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/02/25 at 9:20 AM the Restorative Aide (RA) stated, It was me, she requested sausage, and I wrote down bacon. When asked if she did the breakfast orders every day, RA responded, No, I was just helping out the CNAs this morning.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and facility policy review, the facility failed to ensure the sanitizer used to sanitize food contact surfaces was at a level effective to sanitize the surfaces and failed to ensure food stored in the walk-in refrigerator and the refrigerator on the unit was labeled and discarded after the use-by date and/or expiration date for 38 census residents residing in and receiving food from the dietary department. This had the potential to result in food borne illness and cross contamination. The facility census was 37. Findings include: Review of the facility's policy titled, Food Receiving and Storage with a revised date of October 2018, revealed all food must be labeled with a use by date. The policy did not reveal how long they could keep open or leftover food. Review of the facility's policy titled, Food Brought into Resident's from Outside Sources with a revised date of 11/06/17, revealed once food has been opened it will be discarded within seven days and foods would be thrown out based on the use by or best by date marked on the container. 1. During an observation in the kitchen and interview on 12/30/24 at 9:11 AM, three of three green containers with sanitizer and wiping clothes tested zero parts per million (ppm) of quaternary sanitizer. The [NAME] stated he used them (wiping rags) to clean and sanitize the food preparation counters. He stated he filled the containers about one or two hours ago. One of the containers was on the dirty end of the three-compartment sink; one of the containers was under the food preparation counter; and one container was under the food preparation counter next to the stove. The Culinary Director (CD) assisted with testing the buckets on 12/30/24 at 9:11 AM and verified they were not at the right ppm to sanitize the counters and stated it should have been 400 ppm. During an observation and interview on 12/31/24 at 3:15 PM, the quaternary sanitizer in the sanitizing containers with the wiping clothes was tested with the assistance of the Cook. Two of the three containers located on the shelves below food preparation counters tested zero ppm. He verified he had been using the sanitizer to clean and sanitize the food preparation counters. Review of the Manufacturer's instructions printed on the gallon container of TMA [Tetramethylammonium] Quaternary Sanitizer, revealed the sanitizer should be prepared to be 150 to 400 ppm to sanitize food contact surfaces. 2. During an observation and interview on 12/30/24 at 9:14 AM, the walk-in refrigerator contained one package of sliced turkey wrapped in plastic wrap dated 12/22/24; one package of turkey wrapped in plastic wrap with no date; a plastic bag of bologna and a plastic bag of corn beef each, dated 12/22/24; and an opened partially used container of beef base with no expiration date and an opened date of 10/18/24 marked on it. In addition, there was a two-gallon container of open mayonnaise with an open date of 11/26/24 and the outside of the container was heavily soiled with mayonnaise residue on the outside of the container. The CD verified the dates and stated it was the facility policy to discard food seven days after it was open. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an observation on 12/30/24 at 9:27 AM, the resident refrigerator located in the dining room on the unit, contained four (four-ounce containers) of yogurt. One of the yogurts had an expiration date of 12/07/24; one container had an expiration date of 12/11/24; and two of the containers had expiration dates of 12/21/24. The CD was present and verified this observation. During an interview on 12/30/24 at 9:15 AM the CD stated that food was supposed to be used by or discarded within seven days of opening.